Bundle BSW Group Board 3 September 2026

Agenda
Item 1.0 BSW Hospitals Group Board Agenda 030926 Public Session Draft v0.6

1 Opening Business

1.1 Welcome and apologies

1.2 Declarations of Interest

1.3.1 Minutes of previous meetings
(a) Minutes of the Group Board meeting of 2 July 2026
(b) Minutes of the meeting of GWH Trust Board in public on 11 June 2026
(c) Minutes of the meeting of SFT Trust Board in public on 15 June 2026
Item 1.3 A BSW Hospitals Group Joint Committee PUBLIC MoM 2026.07.02 (draft) v3
Item 1.3 B SFT Draft Public Board mins 15 June 2026
Item 1.3 C GWH Board Minutes Public 11 June 2026 (draft) v2

1.3.2 Actions log review (Trust Boards held in public)
Item 1.3 GWH Board Action Log PUBLIC Jun-26
Item 1.3.2 BSW Hospitals GroupJC ActionsLog 270826 v1.0

2 Patient / Staff Story

2.1 Maternity Stories - GWH, SFT, RUH
Item 2.1 Patient story cover sheet to the Board of Directors September 2026

3 Chair and Chief Executive Reports

3.1 Group Chair's Report
Item 3.1 Group Board Chair Report 030926v0.2

3.2 Group Chief Executive Report
Item 3.2 Group Board Cover Sheet CEO report 030926v0.6

4 Group Reports

4.1 Group Executive Committee Upward Report
Item 4.1 Group Board Cover Sheet Group Executive Committee Upward Report v0.2

4.2 Group Integrated Performance Report
Item 4.2 Cover BSW Group IPR August 2026
Item 4.2 BSW Group IPR August 2026 - Final Version

4.3 Group Quality and Safety Report

4.3.1 Maternity & Neonatal 10-point plan development report
Item 4.3.1 Front sheet for Group Board NHSE 10-Point Action Plan
Item 4.3.1 Appendix 2 Briefing paper on the NHSE 10 point plan for Maternity and Neonatal Services sept board apppendix 2

4.3.2 Maternity & Neonatal quarterly safety report (RUH, SFT, GWH)
Item 4.3.2 SFT Maternity and Neonatal Safety 03.09.26 Q&S Report Quarter 1
Item 4.3.2 SFT Maternity and Neonatal Q&S Report Q1 Apr - Jun 26 (1)
Item 4.3.2 GWH Front sheet Q1 v3 22.07.2026
Item 4.3.2 GWH FINAL Maternity and Neonatal safety report Q1 21.07.26

Item 4.3.2 RUH COver Quarterly Quality Report 26-27 Upward Report
Item 4.3.2 RUH Q1 26-27 Quality Report

4.3.3 Fuller Inquiry: Board Assurance Statements (RUH, SFT, GWH)
Item 4.3.3_Cover Board Assurance Statements_Fuller NHSE letter 26th June 2026

4.3.4 Directors of Infection Prevention & Control Report
Item 4.3.4 group board-cover-sheet Annual infection Prevention and Control Report 2025 26 03 09 26

4.4 Group Finance Report

4.5 Group People Report
- Annual Responsible Officer Report (Medical Revalidation & Appraisal Annual Report)
Item 4.5 Cover CPO Report July 2026 V1.0
Item 4.5 BSW Workforce Oversight Meeting M03

4.5.1 Annual Responsible Officer Report (Medical Revalidation & Appraisal Annual Report)
Item 4.5.1.1 GWH Group Board Cover Sheet - GWH AOA HLRO Annual Report
Item 4.5.1.1 RUH Cover Private Group Board Report
Item 4.5.1.1 SFT 2526 RO report cover sheet

4.6 Group Digital Report
- Annual Cyber Report
Item 4.6 group board-cover-sheet BSW Hospitals Group Digital Service Report September 2026

5 Care Organisation Reports

5.1 GWH Managing Director's Report
Item 5.1 GWH MD Report Sept Board Cover Sheet Completed
Item 5.1 GWH MD Report June 2026 Board Draft

5.2 SFT Managing Director's Report
Item 5.2 SFT MD Report August GC 2026 inc Appendices (1)

5.3 RUH Managing Director's Report
Item 5.3 BSW MD Report - RUH - August 2026 vfinaljpREVISED

6 Risk and Assurance

6.1 Group Risk Register
Item 6.1 BSW Group Risk Register August 2026
Item 6.1 GRR Aug26 v7 dashboard
Item 6.1 GRR Aug26 v7 risk register

6.2 Risk & Assurance Committee Escalation Report
Item 6.2 RAC Chairs Report 3 Sept 2026 v1.0

6.3 Risk & Assurance Committee Terms of Reference
Item 6.3 GOV - B - 002 BSW Grp Bd RAC ToR FINAL 1.0

7 Strategic Delivery

7.1 Corporate Services Transformation
Item 7.1 Group Board Cover Sheet - Corporate Services - September 2026V2
Item 7.1 Appendix A - Corporate Services Transformation Programme Update Presentation - September 2026

7.2 Digital Report: EPR Programme
Item 7.2 Group Board Cover Sheet EPR Update 03.09.26v0.1
Item 7.2 A - Appendix A. EPR Programme Update July 2026

8 Group Governance

8.1 Board Assurance Framework
Item 8.1_Cover Group_Board Cover_Initial Group BAF_SEP26v0.4
Item 8.1 BSW Group Initial BAF Aug 2026 - GRR references tracked

8.2 Board Declaration of Interests Register
Item 8.2 Cover BSW Group Board - DoI Report Sept-26
Item 8.2 BSW Group Board DoI Register Sept-26 v2

9 Unitary Organisation Governance

9.1 GWH Unitary Governance
(a) Committee Assurance Reports
- Audit Risk & Assurance Committee report 24 June 2026
Item 9.1 A GWH Audit, Risk & Assurance Board Report Jun-26

9.2 RUH Unitary Governance
(a) Committee Assurance Reports
- Charities Committee 18 June 2026
- Non-Clinical Governance Committee 17 June 2026
Item 9.2 A - Charities Upward Report July 2026
Item 9.2 A - NCGC Upward Report July 2026

9.3 SFT Unitary Governance
(a) Committee Assurance Reports
- Clinical Governance Committee 30 June 2026
- People & Culture Committee 25 June 2026
(b) SFT Constitution Amendment
Item 9.3 A CGC 30 June 2026 escalation report to COMC
Item 9.3 A Assurance Committee Report PCC Jun 26
Item 9.3 B Group Board Cover Sheet SFT Constitution Amendment Sept 2026
Item 9.3 B SFT Constitution Amendment SID Deputy Chair v0.2

10 Forward look and closing business

10.1 Forward look (including items for next agenda)

10.2 Any Other Business

10.3 Written Answers to Public Questions
- Question to GWH and Response
Item 10.3 Questions from the public Gp Bd Aug-26

10.4 Reflections

10.5 Private Board - Business Summary

10.6 Date and time of next meeting

10.7 Exclusion of the Public and Press

11 Close

BSW Hospitals Group Board held in Public
3rd September 2026 at 9:00 - 14:30 hrs
to be held at
Dorothy House, Winsley
AGENDA (Draft)

Timings		Agenda	Presenter	Purpose
	1.	**Opening Business**		
09:00	**1.1**	Welcome and apologies [Apologies, Bernie Morley]	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 meetings (a) Minutes of the Group Board meeting of 2 July 2026 (b) Minutes of the meeting of SFT Trust Board in public on 15 June 2026 (c) Minutes of the meeting of GWH Trust Board in public on 11 June 2026 Actions log review [Trust Boards held in public.]	Chair	Approval
	2.	**Patient / Staff Story**		
09:10	**2.1**	Maternity Stories, GWH, SFT, RUH	LG	Reflection
	3.	**Chair and Chief Executive Reports**		
09.40	**3.1**	Group Chair's Report	Chair	Note
	3.2	Group Chief Executive's Report	CCB	Assurance
	4	**Group Reports**		
10:00	**4.1**	Group Executive Committee Upward Report	CCB	Note
	4.2	Group Integrated Performance Report	ME	Note
	4.3	Group Quality and Safety Report 1. Maternity & Neonatal 10- point plan development report 2. Maternity & Neonatal Quarterly safety reports [RUH, SFT, GWH] 3. Fuller Enquiry: Board Assurance Statements [RUH, GWH, SFT]. 4. Directors of Infection Prevention & Control Report	 LG/AA/JL LG/AA/JL LG/DM/JL LG/AA/JL	 Note Assurance Ratify Assurance

10:45		**Break**		
	4.4	Group Finance Report	SW	Assurance
	4.5	Group People Report	JG	Assurance
		• Annual Responsible Officer Report (Medical Revalidation & Appraisal Annual Report)	KB RM DM	Assurance
	4.6	Group Digital Report • Annual Cyber Report	JH	
	5.	**Care Organisation Reports**		
11:40	**5.1**	GWH Managing Director's Report	LT	Assurance
12:00	**5.2**	SFT Managing Director's Report	NJ	
12:20	**5.3**	RUH Managing Director's Report	JP	
12:40		**Lunch**		
	6.	**Risk and Assurance**		
13:10	**6.1**	Group Risk Register	ME	Assurance
	6.2	Risk & Assurance Committee Escalation Report	FC	Assurance
	6.3	Risk & Assurance Committee Terms of Reference	FC/ME	Approval
	7	**Strategic Delivery**		
13:25	**7.1**	Corporate Services Transformation	JG	Note
	7.2	Digital Report: EPR Programme	SH/JH	Assurance
	8	**Group Governance**		
13:45	**8.1**	Board Assurance Framework	ME	Assurance
	8.2	Board Declaration of Interests Register	ME	Note
	9.	**Unitary Organisation Governance** *For this meeting, Care Organisation Assurance Committee reports are presented to support transitional governance arrangements and ensure continued Board oversight of Care*		

		Organisation committee assurance during implementation of the Group reporting cycle		
14:00	**9.1**	GWH Unitary Governance (a) Committee Assurance Reports • Audit, Risk & Assurance Committee report, 24th June	FC/LT	Assurance
	9.2	RUH Unitary Governance (a) Committee Assurance Reports • Charities Committee, 18th June • Non-Clinical Governance Committee, 17th June	JL JL	Assurance
	9.3	SFT Unitary Governance (a) Committee Assurance Reports • Clinical Governance Committee 30th June 2026 • People and Culture Committee 25th June 2026 (b) SFT Constitution Amendment	 DM PC NJ	Assurance Approval
	10	**Forward look and closing business**		
14:15	**10.1**	Forward look (including items for next agenda)	Co Sec	Note
	10.2	Any Other Business	Chair	Note
	10.3	Written Answers to Public Questions • Question to GWH and Response.	Chair	Note
	10.4	Reflections	All	Reflection
	10.5	Private Board – Business Summary	Chair	Note
	10.6	Date and time of next meeting	Chair	Note
	10.7	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"		
14:30	**11**	Close		

MINUTES OF THE BSW HOSPITALS GROUP BOARD MEETING HELD IN PUBLIC
2 JULY 2026 AT 10.00AM
JENNER HOUSE, CHIPPENHAM

Present:

Paul von der Heyde (PVDH)	Chair *(Chair)*
Angie Ansell (AA)	Acting Chief Nursing Officer, SFT
Kathryn Bateman (KB)	Chief Medical Officer, GWH
Chris Burton (CB)	Non-Executive Director
Cara Charles-Barks (CCB)	Chief Executive
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
Simon Harrod (SH)	Non-Executive Director
Jonathan Hinchliffe (JH)**	Chief Transformation & Innovation Officer
Nick Johnson (NJ)	Managing Director, SFT
Jason Lugg (JAL)	Chief Nursing Officer, RUH
Joy Luxford (JLx)	Non-Executive Director
Peter Knell (PK)	Non-Executive Director
Bernie Morley (BM)	Non-Executive Director
Niall Prosser (NP)	Chief Operating Officer, SFT
Richard Samuel (RS)	Non-Executive Director
Samaher Sweity (SS)*	Associate Non-Executive Director
Lisa Thomas (LT)	Managing Director, GWH
Simon Wade (SW)	Chief Financial Officer

In attendance:

Caroline Coles (CC)	Company Secretary, GWH
Matt Foxon (MF)	Site HR Director, RUH
Ben Irvine (BI)	Programme Director, BSW Hospitals Group
Emma Mooney (EM)	Interim Director of Communications
Rhiannon Hills (RH)	Group Transformation Director (minute no. 015/26)
Fiona Bird (FB)	XXX (minute no. 015/26)
Deborah Rawlings (DR)	Board Secretary, GWH

Apologies:

Bernie Bluhm (BB)	Chief Operating Officer, RUH
Paul Cain (PC)	Non-Executive Director
Faried Chopdat (FC)	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Andrew Hollowood (AH)	Strategic Clinical Transformation Director
Richard Holmes (RH)	Non-Executive Director
Duncan Murray (DM)	Chief Medical Officer, SFT
John Palmer (JP)	Managing Director, RUH

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

Number of members of the Public: There were 8 members of the public in attendance (Sharon Manhi, Head of Patient Experience, RUH; Jane Podlinski, SFT Governor; Kate Cozens, RUH Lead Governor; Joanna Bennett, SFT Governor; Gordon Wilson, GWH Governor; Ashish Channawar, GWH Governor; Anna Beria, RUH Governor)

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Matters Open to the Public and Press

Minute	Description	Action
001/26	**Welcome and apologies** The Chair welcomed all to the first meeting of the BSW Group Board meeting to be held in public. Apologies were received as above.	
002/26	**Declarations of Interest** There were no declarations of interest.	
003/26	**Minutes of previous meetings** The minutes of the meeting of the RUH Trust Board held in public on 3 June 2026 were noted and approved as a correct record. **Actions log review** The outstanding actions arising from the RUH Trust Board meeting in public held on 3 June 2026 was noted and that there were no further matters arising.	
004/26	**RUH Patient Story** The Board received a patient experience film describing a family's experience of end-of-life care that had fallen below expected standards. The associated multidisciplinary team review, undertaken under PSIRF, identified shortcomings in care coordination, communication, symptom management and timely access to pain relief, which had contributed to a distressing experience for the patient and family. The Board noted the learning identified and that the film would be used in staff training to strengthen compassionate communication, openness and learning to improve end-of-life care. The Board reflected on the patient story and recognised the importance of involving patients and families in service design and improvement. Members questioned the alignment between complaints and patient safety investigations and were advised that work was underway to develop a more integrated approach and improve the timeliness of reviews. The Board also challenged whether existing assurance mechanisms provided sufficient oversight of compassionate care and communication. Jason Lugg, Chief Nursing Officer RUH acknowledged that further work was required to bring together patient feedback, complaints, staff insight and risk information to better identify concerns. The Board received assurance that learning from the multidisciplinary review was being embedded, that action was underway to strengthen patient voice and support vulnerable groups, and that compassionate, person-centred care remained a key focus for improvement. The Board **noted** the report.	
005/26	**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 May and June 2026. The Board noted the significant volume of national directives, reviews and reporting requirements being received from NHS England, which were placing additional pressures on organisations alongside the delivery of day-to-day services. It was	

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Minute	Description	Action

acknowledged that these requirements could not be avoided and that continued support for staff and leaders was essential in balancing national expectations with local priorities.

The Board received and noted the NED Membership of Committees and NED Champion roles.

The Board **noted** the report.

006/26 **Group Chief Executive's Report**

The Board received and considered the first Group Chief Executive's report

The Board noted that all three Care Organisations had continued to demonstrate resilience under sustained operational pressure, delivering improvements in elective, diagnostic and cancer performance while continuing to face challenges relating to urgent and emergency care, patient flow, workforce capacity and financial sustainability. The use of escalation areas and corridor care remained a key risk, with system-wide actions underway, including a UEC Summit and work to increase capacity and improve flow.

It was noted that resident doctors had accepted the national pay offer, reducing the risk of further industrial action.

The Board also noted the publication of the Ockenden Report and the national response, including the extension of Martha's Rule to maternity and neonatal services, which reinforced maternity and neonatal safety as a key priority.

The Board received an update on organisational performance within the National Oversight Framework, noting that the RUH had improved from Segment 4 to Segment 3, SFT had remained in Segment 3, and GWH had moved to Segment 4. The Board further noted progress in the development of Group governance arrangements, receiving assurance that a consistent approach to risk management was being established through the introduction of an initial Group Board Assurance Framework and a shared approach to risk across the Group.

In view of the patient story received earlier in the meeting, Board Members questioned arrangements for ensuring complaint responses were compassionate and learning-focused and were advised that responses were reviewed and, where necessary, returned for improvement, with further work underway to strengthen complaint handling processes. Further discussion on the Ockenden and Amos reports emphasised the importance of listening to patients, families and staff, considering lived experience alongside performance data, and maintaining strong Board visibility of frontline services. Actions were noted to develop a consistent Group response to the reports and deliver the required maternity safety improvements.

The Board also sought assurance on the use of data and emerging risks. It was acknowledged that opportunities existed to strengthen the use of data, intelligence and technology to identify risks earlier, while recognising current limitations in business intelligence capability. The Board received assurance that cyber security arrangements had significantly strengthened, with independent review providing significant assurance across all three Care Organisations, although ongoing vigilance remained necessary.

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The Board **noted** the report.

007/26 **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 April 2026. It was noted that the report reflected a developing group product, with a need to balance headline metrics with deeper analysis of future performance indicators.

The Board considered the IPR and noted that the overall position was consistent with the Managing Director reports, with key concerns remaining around urgent and emergency care, elective recovery, quality indicators and financial performance. Board Members questioned whether the data presented was sufficiently current and aligned to the information being reviewed by NHS England, and sought greater visibility of performance against agreed plans, trajectories and recovery actions. In response, it was acknowledged that the Board required clearer, more timely reporting focused on areas of concern, recovery actions and progress against plan.
Action: Chief Risk Officer

Robust discussion highlighted the need to balance detailed performance data with a clearer narrative on key risks, mitigations and expected improvements. Board Members noted the limitations of current reporting, including the challenge of understanding performance against targets and identifying where improvement actions were delivering change. It was agreed that future reporting should provide a more concise summary of priority issues, actions being taken and expected recovery milestones, supported by underlying performance data.
Action: Chief Risk Officer

The Board also questioned how assurance could be gained regarding system-wide actions influencing performance pressures, particularly patient flow and urgent care. Cara Charles-Barks, Chief Executive confirmed that a system-wide urgent and emergency care summit was being convened and that work was underway to develop a shared system dataset and action plan, enabling the Board to better understand the impact of partner organisations on performance.

The Board was assured that key performance risks were being actively managed, that reporting arrangements would be strengthened to improve oversight of recovery plans, and that future Board development would include greater focus on the interpretation of performance data and system-wide assurance.

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

008/26 **Group Finance Report**

The Board received and considered the Group Finance report which reported that Month 2 was materially off plan with an adverse financial position of £6.7m, driven by positions at GWH (£4.0m) and RUH (£2.6m). The principal drivers related to reduced elective activity, operational pressures and delays in delivering efficiency schemes which had contributed to the position. It was noted, however, that progress had been made in identifying and implementing savings schemes, with more than 80% of the efficiency programme now identified or in development.

The Board discussed key financial risks, including the impact of urgent and emergency care pressures, ongoing delivery of efficiency plans and deteriorating cash positions across all three organisations. Simon Wade, Chief Financial Officer advised the Board that temporary staffing costs had reduced and that the pay run

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rate was lower than the previous year, providing some positive indicators. The Board was assured that recovery actions were in place, efficiency programme delivery continued to improve, and the capital programme remained under review, although cash and capital constraints would require careful management throughout the year.

The Board **noted** the report.

009/26 **Group People Report**

The Board received the Group People Report which comprised of the Group and Care Organisation Staff Survey 2025 results and actions and 2026 Staff Survey Planning, and also the Group's response to the Lord Mann Review recommendations and plans to address antisemitism and islamophobia.

Staff Survey

The Board received and considered an update on the Group's response to the NHS Staff Survey. The Board Members noted that career development, access to training and appraisal opportunities were recurring themes across all three organisations and were advised that a Group-wide review of learning and education was underway to strengthen and align development opportunities. The Board also noted concerns relating to the experiences of global majority and disabled staff, declining recommendations of the organisations as places to work, and the opportunity to use data triangulation and shared learning across the Group to improve staff experience.

A discussion was held on Freedom to Speak Up (FTSU), with members highlighting themes within staff survey results that suggested concerns regarding speaking up, safety culture and the potential for detriment following the raising of concerns. It was noted that annual FTSU reports would be reviewed and that further consideration would be given to whether current reporting arrangements provided sufficient assurance. In response, it was confirmed that work was ongoing to strengthen management capability to listen, respond and escalate concerns appropriately.

The Board noted the focused work underway at each Care Organisation and the actions under development at Group level.

Lord Mann Letter – Group Response

The Board considered the key findings from Lord Mann's review into tackling racism and other forms of discrimination within the NHS and wider healthcare regulatory system. It was noted that the Group People Report outlined the immediate actions being taken by the Group in response to the review and reaffirmed the BSW Group EDI Team's commitment to fostering an inclusive, respectful and safe environment for all staff, patients and visitors.

RESOLUTION:

The Group Board:

a) approved the recommended actions and received assurance that local arrangements would align with emerging national requirements and that progress would continue to be monitored through established governance processes; and

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b) adopted the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility and [would] confirm this to the NHSE by 31 July 2026.

010/26 **Group Quality and Safety Report**

The Board received and considered the Group Quality and Safety Report which provided an overview of the strategic oversight and initiatives relating to Quality and Safety across the Group. This included an update on quality priorities and the Board noted that corridor care, maternity and neonatal services, stroke performance, and infection prevention and control metrics remained areas of concern and continued focus. Luisa Goddard, Chief Nurse explained that, while improvement work was progressing, infection control performance had not yet reached the required standard and there was a risk of increased gram-negative infections during periods of hot weather.

In discussing the recently published Ockenden Report (Findings, Conclusions and Essential Actions from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust, June 2026). It was noted that the report had identified that 444 maternity cases and 76 neonatal cases where different care might have or would be expected to have made a difference to the outcome. The report had identified 8 key headings for Immediate and Essential Actions (IEAs) for Trusts to address. The Board also sought assurance that patient voices would be incorporated into the development of the action plan, and it was confirmed that patient representatives and partnership groups were already being engaged and would contribute to the ongoing work.

The Board was informed that a system assurance statement in response to the Fuller Report was required by 31 July 2026 and, as the deadline fell before the next Board meeting, approval was sought to use delegated emergency powers to enable the Chief Executive and Chair to review, approve and sign the submission. The Board supported this approach and noted that a full report would be presented retrospectively.

The Board was assured that key quality risks were being actively monitored, patient involvement was being embedded in improvement work, and appropriate governance arrangements were in place to meet external assurance requirements.

The Board **noted** the report.

011/26 **SFT Managing Director's Report**

The Board received and considered the SFT Managing Director's report and noted that, despite sustained urgent and emergency care pressures, performance, cancer pathways and the financial position had remained broadly stable. The Group was advised that risks remained around quality, workforce capacity, cash flow and delivery of transformation and savings programmes, and that further progress would be required to maintain performance.

The Board sought assurance on the additional support needed to deliver improvements and was advised that focused action was underway across clinical transformation, corporate services, digital programmes and system-wide flow initiatives. A discussion took place on hospital-at-home and discharge arrangements, which highlighted concerns regarding medical oversight, governance and integration with primary and community care. It was agreed that further collaborative work was required to clarify pathways and responsibilities.

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The Board gained assurance that key operational, quality and financial risks were being actively monitored, with mitigating actions in place and continued oversight through leadership and governance structures.

The committee **noted** the report.

012/26 **RUH Managing Director's Report**

The Board received and considered the RUH Managing Director's report and noted continued pressures in quality, urgent and emergency care, estates and finance. Board Members were advised that improvement work was underway to address increasing pressure ulcers, infection control concerns, cancer performance challenges and patient flow issues, while progress had been made against national oversight measures.

The Board discussed the impact of extreme heat on estates, equipment, staff and patients and was assured that monitoring, mitigation and business continuity arrangements were in place. It was agreed that climate-related risks and escalation plans should continue to be reviewed and strengthened.

The Board gained assurance that key quality, operational, estate and financial risks were being actively managed, with targeted improvement actions, recovery plans and system-wide collaboration supporting organisational resilience.

The Board **noted** the report.

013/26 **GWH Managing Director's Report**

The committee received and considered the GWH Managing Director's report which provided an update on the significant operational pressures facing the organisation, noting that extreme demand, high bed occupancy and the heatwave had resulted in a prolonged critical incident. Group Members were advised that this was impacting patient care, staff wellbeing and quality outcomes, including increased risks relating to pressure ulcers, dehydration, delayed care and deconditioning. Assurance was provided that safety huddles, enhanced monitoring and mitigation measures were in place to manage risks and support patients and staff.

The Board discussed the underlying capacity challenges at GWH, the impact on urgent and emergency care performance, RTT recovery and financial delivery. Board Members sought assurance on actions being taken and were advised that recovery plans, performance validation, cost improvement support and system-wide escalation arrangements were in place. Concerns were also raised regarding maternity triage capacity, and it was agreed that an urgent solution would be progressed within the coming weeks.
Action: GWH Managing Director

The Board gained assurance that operational, quality and financial risks were well understood, that immediate mitigating actions were being taken, and that further support would be sought through group, system and regional channels to address underlying capacity and infrastructure challenges.

The Board **noted** the report.

014/26 **Group Risk Register**

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The Board received the Group Risk Register which had identified 42 risks scoring 12 or above across the three care organisations, compared with 35 in May 2026. An increase in recorded risks was noted, which was attributed to improved risk identification and escalation processes rather than an increase in overall organisational risk. Board Members were advised that further work was underway to strengthen the quality and consistency of risk descriptions and controls.

The Board questioned the absence of workforce, violence and aggression, maternity and neonatal risks from the Group Risk Register. It was explained that these risks were being reviewed through the escalation process and would be reflected more clearly in future iterations. Board Members also sought clarification regarding the RUH cash risk and were assured that controls were in place, although further refinement of risk descriptions and escalation arrangements was required.

The Board noted the growing prominence of estates and infrastructure risks and agreed that greater focus should be given to long-term strategic estate planning.

The Board was assured that the risk management framework continued to mature, key risks were being actively reviewed and escalated, and actions were in hand to strengthen oversight and reporting.

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

015/26 **Models of Care Transformation**

Rhiannon Hills, Group Transformation Director and Fiona Bird, RUH, joined the meeting for this item.

The Board received an update on the Group Clinical Transformation Programme and noted that work had progressed from planning into mobilisation and delivery. Revised governance arrangements had been established, priority specialties and transformation programmes had been identified, and resources had been allocated to support delivery. Board Members were advised that stroke transformation had been prioritised and that work was progressing on elective care, urgent and emergency care, pharmacy, digital innovation and the acute services review.

The Board questioned how success would be measured and how the programme would deliver sustainable service, quality and financial improvements. In response, it was explained that the initial work focused on high-risk and unsustainable services, while the wider acute services review would provide a longer-term blueprint for service transformation across the system. Board Members also challenged whether sufficient capacity, clinical leadership and resources were available to deliver the programme at pace. Assurance was provided that programme governance, executive sponsorship, clinical engagement and resource planning were being strengthened, although workforce, transformation capacity and competing organisational priorities remained key risks.

The Board highlighted the need for clear milestones, benefits realisation, patient involvement and alignment with wider programmes, including EPR implementation, but was assured that a structured transformation programme was in place, priority areas had been identified, and work was progressing to deliver both short-term improvements and a longer-term clinical strategy for the Group.

The Board **noted** the report.

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Minute	Description	Action
016/26	**Corporate Services Transformation** The Board received and considered an update on the Corporate Services Redesign Programme and noted that all eight workstreams had been established and were progressing from design into delivery. Early progress against savings targets, governance arrangements and operating model development was reported, with staff consultation and engagement activities underway. Group Members were advised that digital transformation opportunities, including finance systems integration and workforce systems alignment, continued to be developed, whilst recognising associated delivery risks. The Board expressed concern regarding the pace of progress and sought assurance that the programme remained on track to deliver the planned £15m savings. It was confirmed that proposals could only proceed once required savings targets had been achieved and approved through the Design Authority process, and that confidence remained in delivering the overall savings target despite some delays arising from consultation requirements and job evaluation processes. The Board also discussed risks relating to digital enablement, workforce capacity and staff impact. It was acknowledged that competing priorities were affecting the pace of some digital initiatives, and management agreed to continue reviewing opportunities to accelerate delivery. The Board **noted** the report.	
017/26	**Digital Report: EPR Programme** The Board received and considered an update on the EPR Programme and noted that technical delivery remained on track. Board Members were advised that the principal risk related to releasing staff and subject matter experts from operational duties to support programme development, testing and training, particularly given ongoing operational pressures across the hospitals. The Board discussed the wider role of digital transformation in enabling service redesign, risk mitigation and programme delivery, and questioned whether existing governance arrangements provided sufficient oversight of digital ambitions beyond EPR. It was agreed that a future Board development session would be arranged to provide a broader overview of the Group's digital strategy, opportunities and future plans. **Action: Company Secretary** The Board **noted** the report and was assured of the continued prioritisation of the EPR programme across the BSW Hospitals Group.	
018/26	**Group Strategy & Planning Report** The Board received and considered an update on development of the Group Strategy and noted that work remained on track. Group Members were advised that extensive engagement had been undertaken, generating significant staff feedback that would inform the draft strategy. It was confirmed that partner engagement also continued and that a draft strategy would be presented to a Board workshop to focus on strategy development planned for August 2026. The Board considered requests for approved delegated authority for decisions relating to the Swindon sexual health services opportunity and the Bath PET-CT scanner opportunity, to enable timely decision-making. It was agreed that	

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outcomes of decisions taken under delegated authority would be reported back to a future Board meeting.

RESOLUTION:

The Group Board:

a) approved the delegation of authority to GWH Managing Director and Group Chief Financial Officer to approve the final submission in response to the procurement for the Swindon Integrated Sexual Health Service; and

b) approved the delegation of authority to RUH Managing Director and Group Chief Financial Officer to approve the final submissions in response to the procurement for the PET-CT service.

019/26 **Group Instruments & Policies for Approval & Adoption**

The Board received and considered the following reports to either approve or note as part of the new governance arrangements.

Group Risk Management Policy

The Board received the Group Risk Management Policy and noted that transitional arrangements for the new risk management system were in place. Group Members sought assurance that risk management processes would be applied consistently across all three care organisations and were advised that aligned standard operating procedures would support a common approach.

The Board **approved** the Group Risk Management Policy

Group Performance Management Policy

The Board received the Group Performance Management Framework Policy and noted that it had previously been approved by the Joint Committee and recommended by the Risk & Assurance Committee. Board Members were advised that the performance metrics appendix would be updated in line with the revised national framework.

It was confirmed that the framework sets out escalation triggers and support arrangements and was intended to support improvement rather than be punitive. Board Members noted that aspects of the framework had already been implemented through the Financial Sustainability Task & Finish Group. The Board **approved** the policy and gained assurance that a consistent approach was in place to oversee performance and escalation across the Group.

Initial Group BAF

The Board received the initial Group Board Assurance Framework mapping document, noting that it provided a baseline assessment of existing risks and historic risk appetite positions rather than a formal Group risk appetite. Board Members discussed the dependency on the Group strategy to fully define strategic risks and develop the future risk appetite framework.

In response to a question regarding timescales, it was confirmed that the risk appetite work was expected to be progressed during September and October 2026. Board Members highlighted the importance of ensuring wider strategic, regulatory and reputational risks were reflected and noted identified gaps that would be addressed as the framework developed. It was agreed that the work would be aligned with the emerging strategy and supported through dedicated workshops.

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The Board **approved** the initial Group BAF mapping as a baseline.

Maternity Oversight Framework

The Board received the proposed maternity and neonatal safety oversight arrangements and noted the governance structure for scrutiny, escalation and reporting, including processes for serious incidents and safety alerts. Board Members acknowledged concerns from clinical colleagues regarding the revised arrangements but were advised that the approach aimed to strengthen oversight while avoiding duplication and would be kept under review.

Board Members discussed alignment with emerging national requirements, including Board visibility of clinical leads and reporting arrangements. It was confirmed that existing safety champion forums would continue to support scrutiny and learning.

The Board **noted** the arrangements and gained assurance that robust governance and escalation processes were in place to oversee maternity and neonatal safety risks.

Group Data Sharing Agreement

The Board received the Joint Data Sharing Agreement and was advised that it was required to support the operation of the Group and had been reviewed through relevant expert forums.

A question was raised regarding the Caldicott Guardian arrangements, and it was clarified that responsibility sat with Chief Medical Officers across the organisations and that the wording would be amended for clarity.

The Board **approved** the agreement.

Group Board Cycle of Business

The Board **noted** the Group Board Cycle of Business and that further updates would be received as the cycle of business continued to evolve.

Register of Interests

The Board **noted** that the Register of Interests was currently in development and would be received in its final format at the next meeting.
Action: Company Secretary

Statutory Responsibilities

The Board received the schedule of statutory and mandated responsibilities and noted that it formed part of the Group's governance arrangements. Board Members were advised that the allocation of responsibilities had been completed, with Board-level responsibilities and those assigned to Vice Chairs to be finalised following the meeting.

The Board **noted** the Statutory Responsibilities.

RESOLUTION:

The Group Board:

a) adopted the Group Risk Management Policy;
b) approved the Group Performance Management Policy;

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c) approved the initial Group BAF;
d) noted the Maternity Oversight Framework;
e) approved the Group Data Sharing Agreement;
f) noted the Group Board Cycle of Business;
g) noted the Register of Interests for the Group Board is in development; and
h) noted the allocation of Statutory responsibilities at Board level.

020/26 **GWH Unitary Governance**

GWH Quality & Safety Assurance Report
The Board received and noted the assurance report from the GWH Quality & Safety Committee June 2026 meeting. No issues were highlighted for reporting to the Board.

021/26 **RUH Unitary Governance**

RUH Audit Committee Assurance Report
The Board received and noted the assurance report from the RUH Audit Committee June 2026 meeting. It was highlighted that the RUH Audit Committee had received the external auditor's ISA 260 Audit Report and noted that no material concerns had been identified. Auditors had highlighted value for money considerations relating to financial sustainability and governance and confirmed that management estimate assumptions had been appropriately reviewed and were reasonable. The RUH annual report and accounts had been submitted on time.

RUH People Committee
The Board received and noted the assurance report from the RUH People Committee June 2026 meeting. It was highlighted that the main areas of focus had been appraisals compliance and workforce planning, together with a more detailed review of the staff survey.

022/26 **SFT Unitary Governance**

SFT Audit Committee Assurance Report
The Board received and noted the assurance report from the SFT Audit Committee June 2026 meeting. It was highlighted that a small number of issues had been raised during review, all of which had been resolved prior to submission and were not material in nature. The Audit Committee confirmed it was satisfied with the final position and had recommended sign-off of the SFT annual report and accounts.

023/26 **Forward look (including items for next agenda)**
The Board noted that the Group Board cycle of business had been reviewed earlier in the agenda and that items had been identified for future meetings.

024/26 **Any Other Business**
There was no urgent business to report.

025/26 **Written Answers to Public Questions**
There were no public questions to receive.

026/26 **Reflections on Today's Group Board Meeting**
The committee reflected on the session and any learning taken forward.

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Minute	Description	Action
027/26	**Date of Next Private Meeting** 3 September 2026 at 10.00am at Jenner House, Chippenham	
028/26	**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.	

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Salisbury NHS Foundation Trust

Minutes of the Public Trust Board meeting held at 10am on Thursday 15th June 2026, Boardroom/MS Teams Salisbury NHS Foundation Trust Boardroom

Board Members:

Paul von der Heyde (PVH)	Chair
Mark Ellis (ME)*	Group Chief Risk Officer
Nick Johnson (NJ)	Managing Director
Niall Prosser (NP)	Chief Operating Officer
Jonathan Hinchcliffe (JH)*	Group Chief Digital and Innovation Officer
Judy Dyos (JD)	Chief Nursing Officer / Group Strategy Officer
Duncan Murray (DM)	Chief Medical Officer
Jude Gray (JG)*	Group Chief People Officer
Andrew Hollowood (AH)*	Group Strategic Clinical Transformation officer
Simon Wade (SW)	Group Chief Finance Officer
Richard Samuel (RS)	Non-Executive Director
Peter Knell (PK)	Non-Executive Director
Anne Stebbing (AS)	Non-Executive Director

In Attendance:

Alex Talbott (AT)	Director of Improvement (Teams)
Kylie Sanders (KS)	Head of Corporate Governance (minutes)
Vicki Marston (VM)	Director of Midwifery (items 5.1-5.5)
Helen Rynne (HR)	PALS (item 1.2)
Ian Crowley (IC)	Director of HR (item 3.1)

Apologies

Paul Cain (PC)	Non-Executive Director
Richard Holmes (RH)	Non-Executive Director
Eiri Jones (EJ)	Non-Executive Director
Cara Charles Barks (CCB)	Chief Executive Officer

Observers

Jane Podkolinski (JP)	Governor
Diana Rae (DR)	Governor
Frances Owen	Governor (Teams)
Joanna Bennett (JB)	Governor (Teams)
Angie Ansell (AA)	Deputy Chief Nursing Officer
Henry Wilding (HW)	Deputy Chief Nurse, Frimley Health NHS Foundation Trust
Barry Burton (BB)	Xyla Services

**Non-voting Director*

ACTION

TB1 15/6/1 OPENING BUSINESS

PVH welcomed everyone and informed those present that this was a meeting held in public, not a public meeting.

PVH reminded the Board to approach the meeting using the Improving Together Program methodology, the quality improvement tool used by the Trust in the delivery of change and transformation.

TB1 15/6/1.1 **Presentation of SOX Certificates**

PVH informed everyone that the SOX Nominations recognised staff in the organisation for their contribution to the development of the Trust strategy and patient care, and announced the following the SOX nominations:

- March SOX of the month – Endoscopy Central Booking Team
- March Patient Centred SOX – Surgery
- April SOX of the month – Mathew Chapman, IT
- April Patient Centred SOX – AMU
- May SOX of the month – Megan Duggan, Cancer Services
- May Patient Centred SOX - Midwifery

PVH confirmed that certificates would be presented by members of the Executive Team.

Discussion:
AS commented on the diversity of the nominations and the powerful stories behind them, noting the positive impact of recognising staff contributions across the organisation. AS asked if there were plans to continue sharing SOX stories and nominations within the Group Board arrangements. NJ highlighted that the nominations reflected a broad cross-section of the organisation and confirmed that they are shared through the monthly cascade briefing, with the stories read out to staff. NJ also noted that the SOX Board displayed at the front entrance provides a visible means of celebrating and recognising staff achievements.

TB1 15/6/1.2 **Patient Story**

It was noted that due to technical issues, the video could not be shared although many of the Board had seen the video at a previous meeting.

HR introduced the patient story, which described the experience of a patient diagnosed with advanced breast cancer. The patient shared her journey through diagnosis, treatment and subsequent breast reconstruction surgery, highlighting the compassionate care, professionalism and support received throughout her pathway. The Board welcomed the story and recognised it as a testament to the dedication and expertise of the Trust's Breast and Plastic Surgery teams.

Discussion:
AS reflected on the patient story and noted that Salisbury NHS Foundation Trust provides specialist breast reconstruction services to a wider population beyond the Trust's immediate catchment area. While the patient’s experience demonstrated the excellent care provided by the service, AS acknowledged that access to reconstruction surgery is not always as timely as it should be and emphasised the importance of understanding how such positive experiences can be consistently delivered for all patients. AS highlighted the particular challenges associated with access to primary reconstruction procedures.

NP acknowledged the pressures facing the service and advised that the Plastics team had increased the use of locum staff to support capacity in the short term. NP further reported that a business case was being developed to establish a sustainable long-term staffing model and improve access to reconstruction services for patients.

The Board noted the update and welcomed the actions being taken to support the sustainability of the service.

PVH thanked HR for sharing the patient story and for their contribution to the meeting. HR left the meeting.

TB1 15/6/1.3 **Welcome and Apologies**

PVH welcomed everyone to the meeting and noted the above apologies.

TB1 15/6/1.4 **Declarations of Conflicts of Interest, Fit and Proper/Good Character**

There were no declarations of interest pertaining to the items on the agenda.

Register of Attendance

The register of attendance was noted.

ME noted that LT should be removed.

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TB1 15/6/1.5 **Minutes of the Part 1 (Public) Trust Board meeting held on 13th May 2026**

PVH presented the minutes from the Public Board meeting held on 13th May 2026.

Decision:
The Board APPROVED the minutes of the meetings held on 13th May 2026 as a true and correct record.

TB1 15/6/1.6 **Matters Arising and Action Log**

KS presented the action log. It was noted that all items were either on the agenda or otherwise being progressed.

The Board noted the action log and there were no other matters arising.

TB1 15/6/2 **ASSURANCE AND REPORTS OF COMMITTEES**

TB1 15/6/2.1 **Chair's Business**

PVH reported on matters considered by the Group Board to Board on 7 May and at the Trust Board meeting on 13 May 2026. PVH noted that the Board had received updates on the establishment of the Group's Safe to Start arrangements, the NHS England Self-Certification process (Constitutional Standard 7), the annual review of Fit and Proper Person requirements, and the annual review of Directors' Declarations of Interest.

PVH advised that the Council of Governors met on 18 May 2026 and that several meetings had also taken place with the Lead Governor. Governors had been assured that the statutory role and responsibilities of the Council of Governors remain unchanged. The introduction of the Group Board does not alter the Council's legal functions, and the Council of Governors will continue to meet separately and undertake its duties in accordance with the Trust's Constitution.

PVH noted that Eiri's term of office came to an end on 30th June and expressed sincere thanks for the support provided during this period, noting that she had delivered a comprehensive induction and had been extremely helpful. PVH recorded his appreciation for Eiri's commitment, guidance and support in her role as NED and interim Chair.

The Board noted the Chair's report.

TB1 15/6/2.2 **Chief Executive/Managing Director Report**

In CCB's absence NJ presented the report highlighting highlighted a number of key developments and areas of focus for the Trust.

- Delivery of the 2026/27 Operational Plan remains a key organisational priority. The Board noted the regional team's acceptance of the plan and the Trust's response outlining progress against agreed objectives.
- Continued pressures were being experienced across urgent and emergency care services, including management of the recent Critical Incident.
- The Shadow Group Board had now met, and this meeting represented the final regular meeting of the standalone SFT Board under the current arrangements.
- Progress continues on transformation programmes, including plans for the implementation of the Electronic Patient Record (EPR).
- National developments included the appointment of a new Secretary of State and the progression of NHS legislation, which may have implications for NHS governance arrangements, including the future role of governors.
- Quarter 4 remained a challenging period across the NHS. Within the National Oversight Framework, SFT maintained its Segment 3 position despite a fall in league table rankings, while RUH improved from Segment 4 to Segment 3.
- The introduction of car parking charges had generated some social media reaction, although direct representations to the Trust had been limited. NJ thanked the Communications Team for their effective management of stakeholder communications.
- NJ advised that JD would be taking up the role of Group Chief Strategy Officer on an 18-month basis. Recruitment and transitional arrangements for the role would be confirmed in due course.
- NJ thanked all staff involved in the successful Trust Open Day held on 16 May 2026, with particular recognition given to the Communications Team.

Discussion:
AS sought assurance regarding the recent network outage experienced by the Trust. NP explained that network connectivity had been intermittently disrupted, resulting in periods where access to systems, including aspects of the Patient Administration System (PAS), was unavailable. Consequently, some services reverted to paper-based processes for approximately 48 hours. NP reported that the Trust had implemented its Gold, Silver and Bronze command structure, which had operated effectively throughout the incident. No patient harm had been identified, and disruption to services had been limited, although a small number of elective procedures had been postponed.

JH advised that the issue related to the infrastructure connecting Trust applications rather than a complete loss of network capability. JH noted that intermittent outages can present greater operational challenges than total outages due to the uncertainty they create for staff attempting to access systems.

In response to a question from AS regarding the likelihood of recurrence, JH acknowledged that the aging nature of parts of the Trust's digital infrastructure continued to represent a residual risk. Ongoing capital investment was therefore required to replace systems and technology approaching end of life and to improve overall resilience.

PK sought assurance regarding governance arrangements for cyber security and organisational resilience. JH explained that oversight would be provided through both the Group Digital Governance arrangements and Care Organisation governance structures. Cyber security teams were working collaboratively across the Group, supported by a single risk register, established governance processes and targeted investment programmes. JH advised that capital funding was being used to strengthen infrastructure resilience, supported by a dedicated technology refresh programme funded through both capital and revenue resources.

PK further asked whether implementation of the EPR would increase or reduce risks associated with network outages. JH confirmed that the EPR programme would improve the Trust's overall position through modernised infrastructure and enhanced digital resilience.

JD noted that Datix reports relating to the outage had been reviewed through the patient safety reporting processes and weekly Patient Safety Meetings. JD recognised the professionalism and commitment demonstrated by staff in maintaining safe patient care throughout the disruption and thanked colleagues for their efforts.

NP informed the Board that a deep dive review of Finance and Performance measures was underway to support continued achievement within the National Oversight Framework, particularly as additional performance metrics are introduced.

JD also highlighted ongoing work to improve the Trust's use of business intelligence and performance information. Referring to discussions at the Shadow Group Board, JD noted that the organisation held extensive data but needed to strengthen its ability to translate that information into actionable insight. The development of the Integrated Performance Report would support improved oversight, understanding and decision-making across the Group.

The Board noted the report.

TB1 15/6/2.3 **Integrated Performance Report (IPR) (April)**

DM presented the Integrated Performance Report for Month 1 (April 2026) and highlighted that the Trust continued to operate under significant and sustained operational pressures, including the impact of six days of industrial action during the month.

The Board received an update on progress against the Trust's Breakthrough Objectives and noted continued strong compliance with NEWS2 recording and escalation processes. DM advised that changes to the composition and methodology of the Sentinel Stroke National Audit Programme (SSNAP) metrics had impacted the way performance was reported and should be considered when reviewing current scores.

Performance in relation to pressure ulcers remained above the agreed threshold, although levels had stabilised. Overall quality metrics were reported as broadly stable and showing signs of improvement despite ongoing operational pressures.

Urgent and emergency care pathways continued to experience significant demand pressures; however, elective care performance remained strong. DM concluded that, overall, the organisation remained in a balanced but stretched position across operational, quality and financial measures.

Discussion:
NP advised that, when benchmarked against regional and national peers, the Trust continued to perform well in elective care and remained within the top half of organisations for four-hour emergency care performance, although performance remained below the standards the organisation aspired to achieve.

The Board discussed progress in reducing corridor care, noting the national ambition to eliminate corridor care by April 2027. It was reported that the removal of a number of escalation beds was anticipated from October, which would help support progress. JD highlighted the importance of ensuring a consistent understanding of corridor care definitions across the Group and noted that some capacity challenges were also being influenced by ward refurbishment works.

PK sought clarification regarding deficit support funding and the Trust's financial position. SW explained that the Trust had received support funding for Quarter 1; however, there remained uncertainty around the longer-term arrangements and the extent to which funding may be adjusted or recovered. SW noted that the Trust's financial plan was based on achieving break-even with support funding included and that, without access to this funding, the organisation would be off plan. PK expressed concern regarding the potential financial risk and observed that the position appeared binary, with a significant gap emerging if support funding were not received. The Board noted that, while organisations remained individually accountable for financial performance, the implications of deficit support funding would need to be considered within the context of the wider Group financial framework. SW advised that liquidity and cash flow represented the most significant risks in this regard.

PVH sought assurance regarding reports of bullying and inappropriate behaviour within the organisation. NJ advised that, while isolated incidents continued to arise and were taken seriously, there was no evidence of an underlying cultural issue across the organisation.

JD referred to recent discussions regarding antisemitic and anti-Muslim behaviour within the NHS, following the Lord Mann review. This highlighted the importance of maintaining curiosity and vigilance in understanding staff experiences. JD noted that there were no wider concerns identified within the organisation and that staff survey results indicated lower levels of harassment

from patients than seen in many comparator organisations. An update had also been provided through the Joint Committee on 2 July. NP added that significant work had been undertaken through the People Promise programme over the previous two years to strengthen organisational culture and staff experience.

The Board noted the report.

TB1 15/6/2.4 Finance and Performance Committee – 31st March, 28th April, & 28th May 2026

PK presented the report from the Finance and Performance Committee meetings held on 31 March, 28 April and 28 May 2026.

The Committee had received significant assurance regarding delivery of the Cost Improvement Programme (CIP), including the establishment of a dedicated programme team, robust governance arrangements and positive delivery against Month 1 targets. The Committee noted that the programme had adopted a pragmatic, forward-looking and risk-based approach to delivery. Whilst early progress was encouraging, members acknowledged that significant risks remained in achieving the full-year plan.

The Committee had also undertaken detailed consideration of the Statement of Going Concern as part of its review of the draft Annual Report and Accounts. Having reviewed the nature of the financial risks and mitigating actions in place, the Committee was satisfied that it could support the Going Concern assessment and recommend its approval to the Board.

Discussion
AS welcomed the progress being made and emphasised the importance of ensuring that identified mitigation plans continued to gain traction and deliver measurable benefits.

NP provided an update on CIP and advised that NHS England had reviewed the Trust's plans using its assurance and risk assessment framework. The Trust remained on track to deliver its planned savings and good progress had been made across a number of schemes. Each department had been set a specific CIP target and work would commence later in the summer to begin planning for the 2027/28 financial position.

NP noted that a number of the required mitigations sat both within and beyond the Trust's direct control. Internally, improvements were being driven through Care Organisation arrangements, clinical transformation programmes, corporate service reviews and coding improvements. Externally, a number of system-wide dependencies existed, including the development of out-of-hospital models of care and support from system partners to improve patient flow. NP reported that there had been a positive shift in behaviours across the system, with greater recognition of the actions required collectively to improve flow and performance. It remained important, however, to maintain clarity regarding key dependencies, including the effective operation of Hospital at Home and Virtual Ward services. PVH added that he had met with HCRG alongside colleagues prior to commencing leave and had discussed the role of community services in supporting these objectives.

AS highlighted the increasing use of Advice and Guidance services and questioned whether this was creating an additional route for referrals which

General Practitioners may not have sufficient capacity to manage. Members discussed the changing referral thresholds associated with Advice and Guidance and agreed on the importance of obtaining clinical feedback to understand the wider impact of these arrangements.

PVH reflected on the scale of services provided by the Trust, noting that specialist services supported a population of approximately one million people across a large geographical area, presenting particular challenges in relation to health and social care provision and system integration.

The Board noted the report.

IC joined the meeting.

TB1 15/6/2.5 **Clinical Governance Committee – 31st March & 28th April**

AS presented the report from the Clinical Governance Committee meetings on 31st March & 28th April and asked the Board to take the report as read.

The Board noted the report

TB1 15/6/2.5 **People and Culture Committee – 20th April**

PVH noted that PC was not in attendance to present.

AS noted the update reporting on compliance with safeguarding training.

The Board noted the report.

TB1 15/6/3 **PEOPLE & CULTURE**

TB1 15/6/3.1 **National Staff Survey Results**

JG presented the annual NHS Staff Survey results and highlighted the key themes arising from the findings.

The survey showed that staff remained proud of the care provided to patients and valued the support of their colleagues. However, scores relating to engagement, morale and advocacy had declined, with sustained operational pressures, organisational change and workforce challenges impacting staff experience. Feedback referenced workload pressures, exhaustion and a culture of "firefighting".

Scores relating to leadership and trust had also reduced, including measures of compassionate leadership. Some staff reported feeling disconnected from senior leaders and insufficiently involved in how change is delivered, particularly in the context of wider Group developments. Themes relating to fairness, favouritism and communication were also raised.

JG noted the need to strengthen leadership visibility, staff engagement, learning and career development opportunities. While the Trust continued to perform well in relation to equality, diversity and inclusion, there had been a decline in scores relating to kindness and respect between colleagues.

Areas requiring particular focus included change management, communications, financial controls and recruitment. Trust-wide and divisional action plans were being developed in response to the findings.

Discussion
IC noted that the results were broadly consistent with previous trends and highlighted that learning and development continued to be one of the lower-scoring areas for the Trust.

JD commented that, following significant improvements in previous years, some reduction in scores had been anticipated, particularly given the pressures arising from workforce controls and organisational change.

AS queried themes emerging from the free-text comments, including perceptions regarding management structures. IC advised that there was no evidence of growth in middle management roles and that management numbers had reduced in some corporate areas. However, staff perceptions needed to be understood and addressed. NJ added that middle managers play a key role in shaping staff experience and are often viewed by staff as part of the senior leadership team.

NJ questioned whether the proposed actions placed sufficient emphasis on leadership visibility and engagement, noting that some appeared operational rather than cultural in focus. NJ also reflected that the different engagement approach adopted to align with Group arrangements may have influenced staff responses.

AS requested an update on the quarterly pulse survey results to understand whether progress was being made in addressing key themes. The Board agreed that this would provide valuable insight into the effectiveness of the actions being implemented.

The Board noted the report.

IC left the meeting.

TB1 15/6/3.2 **Nursing Safer Staffing Review**

D presented the report and noted that the review of nursing establishment levels had been completed following an extensive piece of work, thanking Jayne Sheppard and colleagues for their significant contribution.

The Board noted that usage of temporary staffing remained below the national average and received assurance that staffing establishments had been reviewed using recognised workforce planning methodologies. The report also highlighted ongoing work across the Group to align workforce assessments, measurement approaches and reporting arrangements.

The Board was advised that the Trust remained compliant with nine of the ten safer staffing standards and that work was continuing to strengthen assurance processes and ensure consistency across services. The review also considered the impact of increased bed capacity and service demands on staffing requirements.

Discussion

AS sought clarification regarding staff unavailability metrics and asked whether annual leave figures included statutory bank holidays. JD confirmed that they were included within the calculations.

NJ commented that a significant amount of work had been undertaken to produce the review and noted that it provided a strong level of assurance regarding nursing establishments. NJ observed that Care Hours Per Patient Day (CHPPD) remained comparatively low and reflected the organisation's efforts to balance quality and financial sustainability. NJ noted that there was limited scope for further reductions and that the review provided a useful baseline for future workforce planning. NJ also highlighted the relationship between staffing pressures and themes emerging from the Staff Survey, noting that whilst staffing levels remained above the required threshold, they were relatively close to minimum expectations.

AS queried the calculation of CHPPD and whether the methodology was fully aligned across organisations. JD advised that work was underway with SF and Group colleagues to ensure a consistent approach to calculating and reporting CHPPD measures. JD further noted that the use of escalation beds had contributed to some of the challenges reflected within the data.

The Board noted the report.

TB1 15/6/4 **GOVERNANCE**

TB1 15/6/4.1 **Board Assurance Framework and Corporate Risk Register**

AT presented the report, highlighting the current position of the Board Assurance Framework (BAF) and the ongoing development of risk management arrangements across the Trust and wider Group.

The Board noted that the BAF continued to provide oversight of the Trust's key strategic risks, including those associated with EPR deployment. Whilst progress had been made across a number of areas, the principal risks remained consistent with matters previously discussed by the Board. Members also received an update on the development of the Group Board Assurance Framework, which would be introduced during July and aligned with the emerging Group Strategy due to be finalised later in the year.

AT advised that the Care Organisation Risk Register had been refreshed using the new 5+5+5 risk management methodology. The revised register contained 34 risks and provided a clearer representation of the principal risks facing the organisation. Seven risks remained above the agreed tolerance level, and ongoing monitoring would focus on both the number and nature of risks within the portfolio.

Members were advised that Risk 8344 had demonstrated a reduction in overall risk score as management actions and controls had strengthened. Work was also continuing to strengthen the alignment between strategic risks within the BAF and operational risks contained within underlying risk registers. Divisions had been asked to review and score their principal risks using the new methodology, with plans for all Trust risks to be reassessed under the 5+5+5 framework by October 2026.

Discussion:

ME advised that the Shadow Group Board Governance arrangements had reviewed the initial Group BAF, which would go live in July. The existing Trust BAF would then be retired, with the new framework providing assurance against the Group's strategic planning framework and objectives.

JH reported that the EPR risk position had improved since the reporting period covered by the BAF. The programme was no longer experiencing delays following the approved reset and progress had resulted in the risk rating reducing to Amber, with further reductions anticipated as delivery milestones were achieved.

Members discussed the importance of establishing a consistent risk appetite and risk management language across the Group to support effective oversight and assurance.

ME reported that work was also underway to validate the application of controls and control effectiveness across the organisation. This included support from an independent expert to ensure the new framework was implemented consistently and robustly. Over time, the Board would receive greater assurance regarding the effectiveness of controls and the overall maturity of risk management processes.

AS referred to the earlier discussion regarding digital infrastructure issues and queried how organisation-specific risks, particularly those relating to the Salisbury estate and infrastructure, would be appropriately reflected within the new arrangements. ME advised that strengthened Corporate Services risk registers would ensure organisation-specific risks were captured and escalated appropriately into Group reporting structures, in the same way as risks arising from Care Organisation services. JH added that a dedicated Group Digital Risk Register was now in place to support oversight of technology and infrastructure-related risks.

AS also sought assurance that sufficient focus would be maintained on local risks within the new governance arrangements. JH confirmed that the Group Digital Governance Board would report through executive-led committees and the Care Organisation Management Committee, with significant risks escalated to the appropriate Group forums. PVH noted that this would also be reflected through the Managing Director's report and other routine assurance mechanisms.

The Board noted the report.

AT left the meeting.

TB1 15/6/4.2 Statutory Governance Framework to support implementation of the BSW Hospitals Group

KS presented the report seeking approval of the remaining statutory governance instruments required to support implementation of the BSW Hospitals Group governance model from 1 July 2026. The Board noted that the proposed changes aligned governance arrangements across the three Care Organisations whilst preserving the sovereignty and statutory responsibilities of each Trust Board.

The Board was advised that the Scheme of Reservation and Delegation and Standing Financial Instructions had been aligned across the Group to provide clear accountability arrangements and support the lawful exercise of functions

through the Group Board. Members also received the proposed Terms of Reference for the Audit Committee and Remuneration Committee, which would operate as Committees in Common under the Group model.

KS highlighted that the framework did not create any new statutory powers but clarified how certain functions would be exercised jointly through the Group Board within agreed limits. The Board also considered a proposed amendment to the quorum requirements of the General-Purpose Joint Committee (Group Board), requiring the presence of at least one Executive Director in addition to the existing quoracy arrangements.

Decision:
The Board:

- **Approved** the Scheme of Reservation and Delegation of Salisbury NHS Foundation Trust.
- **Approved** the Standing Financial Instructions of Salisbury NHS Foundation Trust and delegated authority to the Group Chief Finance Officer to make amendments as set out within the report.
- **Approved** the Terms of Reference for the Audit Committee.
- **Approved** the Terms of Reference for the Remuneration Committee.
- **Approved** the amendment to the quoracy requirements of the General Purpose Joint Committee (Group Board) to require the presence of at least one Executive Director.

TB1 15/6/5 **QUALITY AND RISK**

TB1 15/6/5.1 **Maternity & Neonatal Bi-Annual Staffing Report – March 2026**

VM joined the meeting and presented the Maternity and Neonatal Bi-Annual Staffing Report covering the period September 2025 to March 2026. The Board noted that the report had been prepared to support compliance with the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme requirements and provided assurance regarding maternity and neonatal workforce planning and staffing arrangements.

VM highlighted that the required standards had been met, including the use of an evidence-based approach to determining midwifery staffing establishments, provision of one-to-one care in active labour, maintenance of supernumerary labour ward coordinator arrangements, and regular Board oversight of staffing and safety issues. The Board also noted the ongoing challenges relating to workforce recruitment and demand pressures, together with mitigating actions in place. Particular note was made of neonatal qualified-in-specialty compliance, which stood at 64% against a 70% target, with training and development plans continuing to increase compliance levels. The report also advised that a further Birthrate Plus assessment would be undertaken later in 2026.

Discussion
Members noted that the report provided a clear executive summary and a comprehensive overview of maternity and neonatal workforce pressures, risks and mitigations. The Board received assurance that appropriate workforce planning processes were in place and that the required CNST standards had been met. Members also welcomed the actions underway to address recruitment challenges and improve neonatal specialist training compliance.

The Board noted the report and received assurance regarding maternity and neonatal staffing arrangements and compliance with CNST reporting requirements

TB1 15/6/5.2 **Perinatal Quality Surveillance Report (February data)**

VM presented the Perinatal Quality Surveillance Report for March 2026, noting that the report provided an overview of maternity and neonatal activity, outcomes and performance data for February 2026.

Discussion:
PK noted that the mitigating actions section of the report had not been completed and sought assurance regarding the actions in place to manage identified risks.

In response, VM advised that an acuity tool had recently been introduced within the antenatal ward areas, providing a prospective assessment of staffing requirements and supporting safer workforce deployment. VM further reported that two daily acuity huddles were undertaken to review staffing levels and patient needs, although the national acuity tool remained challenging to apply consistently in practice.

The Board discussed compliance with British Association of Perinatal Medicine (BAPM) standards and the implications for Maternity Safety Support Programme (MNSI) assurance and sign-off. Members acknowledged that this represented an area of concern requiring continued monitoring and escalation.

VM advised that a review of the paediatric consultant workforce had been completed and that the associated business case was being revised to reflect the workforce requirements identified through that review.

DM confirmed that addressing the paediatric workforce position remained an action for the Trust. While recognising the importance of meeting the required standards, DM noted that any additional consultant appointments would have significant financial implications and that the Trust would first need to assure itself that there was no available capacity elsewhere within the system before progressing further investment.

The Board noted the Perinatal Quality Surveillance Report for March 2026.

TB1 15/6/5.3 **Perinatal Quality Surveillance Report April 2026 (March data)**

VM presented the Perinatal Quality Surveillance Report for April 2026, noting that the report reflected maternity and neonatal activity and outcomes for March 2026. VM advised that the data was reviewed across the BSW system, enabling consistent oversight, benchmarking and comparison across the Group.

VM highlighted concerns raised by Safety Champions regarding IT connectivity issues affecting the outreach service in Tidworth, where some of the most vulnerable women receive care. Connectivity problems had affected the ability to scan patients and had contributed to missed appointments. VM noted that some factors were outside the Trust's direct control as the service operates on Ministry of Defence land. JH advised that the issue related to the provision of the Trust's own network infrastructure and was being actively pursued through formal

channels. The Board noted that the matter had been recorded on the maternity risk register.

The Board was advised that supernumerary labour ward coordinator status had been achieved in 99% of cases during the reporting period, with one exception recorded. VM also noted receipt of a Maternity Outcome and Safety Support (MOSS) report relating to stillbirths occurring in March.

The Board also received an update on maternity theatre capacity. VM advised that the service continued to operate with a single maternity theatre and that an options appraisal was being developed to consider the case for a second theatre, recognising that capacity constraints had become increasingly challenging.

Discussion
DM emphasised the importance of understanding how future activity growth could be absorbed safely and flexibly within existing and future service models.

AS reflected on the challenges faced by smaller maternity units operating within the context of a gradually reducing birth rate and noted the importance of understanding changing patient behaviours and demand patterns when planning future service capacity.

The Board noted the Perinatal Quality Surveillance Report for April 2026.

TB1 15/6/5.4 **MBRRACE – UK Perinatal Mortality Report 2024 Births**

VM presented a summary of the MBRRACE-UK Perinatal Mortality Report for 2024 births, noting that whilst the data was retrospective, it remained an important source of external benchmarking and assurance.

The Board noted that the Trust's perinatal mortality rate at the end of 2024 was 2.84 per 1,000 births, which was within the expected range for organisations of a similar size and population profile. The data included cases involving congenital anomalies.

VM advised that, overall, the Trust's outcomes remained within expected limits and did not identify any significant areas of concern.

Discussion:
PVH sought assurance regarding the reported mortality rate and asked whether VM was satisfied with the Trust's performance.

VM confirmed that, whilst there had been some variation in performance over time, the overall position remained within the expected range and was consistent with national benchmarking for comparable maternity services.

The Board noted the report.

TB1 15/6/5.5 **MOSS Critical Safety Alert**

VM presented the MOSS Critical Safety Alert report.

VM reported that the service had experienced three stillbirths between 36 and 37 weeks' gestation. Reviews had been undertaken and no common themes had been identified across the three cases.

Discussion:
PVH noted the importance of ensuring appropriate support was available for affected families and recognised the role of community midwives, social care colleagues and other partner agencies in providing ongoing support where required.

VM advised that the service would continue to review practice, outcomes and learning arising from the cases, ensuring that any actions taken remained proportionate to the findings of the reviews.

AS noted that the Clinical Governance Committee had recommended that the three Care Organisations consider the MOSS alert collectively to understand both the benefits and limitations of different approaches to analysing the data. This work was ongoing and would support learning across the Group.

JD highlighted the significant level of scrutiny currently applied to maternity services nationally and emphasised the importance of maintaining perspective. While every stillbirth was a tragedy, JD noted that national stillbirth rates were at their lowest recorded level and that positive outcomes remained the norm for many women and babies receiving care.

The Board noted the report.

VM left the meeting.

TB1 15/6/5.6 **Quality Account**

DM presented the Quality Account and sought Board approval for submission to NHS England.

DM thanked Ben Browne for the considerable work undertaken in preparing the document and noted that no new national guidance had been issued during the reporting period.

Members noted that the Trust had been invited to discuss the Quality Account with the Health Select Committee, which had responded positively to the document, particularly the inclusion of a summary and glossary introduced in the previous year. AS highlighted a small number of factual amendments required prior to submission.

Discussion
The Board welcomed the Quality Account and recognised the significant achievements delivered by staff during a period of sustained operational pressure. AS encouraged a final review of the document to ensure factual accuracy before submission.

NJ thanked all teams involved in delivering the improvements reflected within the report and acknowledged the commitment demonstrated across the organisation. The Board also noted the ongoing lack of clarity from national

bodies regarding future Quality Account requirements and agreed that further guidance should be sought. **ACTION: PVH**

Decision
The Board APPROVED the Quality Account for submission to NHS England, subject to the completion of final factual accuracy checks.

TB1 15/6/6 STRATEGY AND DEVELOPMENT

TB1 15/6/6.1 Improving Together Update Report

AT presented the Improving Together Update Report.

- The programme was entering its fifth year, with the methodology increasingly embedded in how staff think, behave and respond to complex issues across multidisciplinary teams.
- The programme continued to focus on key areas for improvement.
- A growing number of staff had completed training and leadership development linked to the methodology.
- AT highlighted the need to sustain the approach through clear governance and strategic alignment, and to ensure that the corporate services review did not destabilise the core teams supporting delivery.

Discussion
NJ welcomed the significant progress made and noted that the Trust was fortunate to have an established methodology that had been implemented in a way which encouraged commitment and engagement from staff.

NJ noted that a number of risks would need to be managed as the organisations came together as a Group. The approach should be viewed as an Operating Management System and reinforced accordingly. Members also noted that the methodology was being shared with partners.

JD observed that other organisations were at slightly different levels of maturity and advised that the Trust had re-engaged with Catalysis. AH would hold Improving Together within his portfolio. JD emphasised the importance of ensuring the Strategic Planning Framework was clear and linked effectively to each hospital site.

AS welcomed the re-engagement with Catalysis. NP advised that little change was expected to the methodology or approach and noted that Daily Performance Reviews remained the golden thread. NP confirmed the organisation's recommitment to the model.

PK sought further assurance regarding the work to ensure the methodology continued to support improvement and enable synergies across the three organisations. JD emphasised the scale of alignment required, including establishing a shared understanding of the approach and setting the Strategic Planning Framework at Group level to support learning across organisations. ME noted the need to balance Group-wide strategic initiatives with locally led delivery, supported by infrastructure that increased local capacity.

NJ commented that future reporting should more clearly describe the improvement being delivered, both locally and across the Group, rather than focusing solely on implementation activity.

The Board noted the importance of including process, cultural and oversight metrics in future reporting.

AT reinforced that the corporate services review also provided an opportunity to develop cross-Group working and evolve the approach further, while continuing to support teams. Members agreed that the core principles of staff development, people focus and improvement should remain central as the model develops.

Thanks were recorded to Emma Cox and the wider team for their work on the report.

The Board noted the report.

TB1 15/6/7 **CLOSING BUSINESS**

TB1 15/6/7.1 **Any Other Business**

The Chair extended thanks to a number of colleagues for their contributions and service to the Trust. Appreciation was expressed to EJ for her support and commitment.

The Board also thanked Anne Stebbing for her significant contribution during her tenure, noting that this was her final Board meeting.

Thanks were extended to JD for her leadership and contribution in her role as Chief Nursing Officer (CNO), noting she was now Group Chief Strategy Officer for BSW.

The Board further recognised AT for his support as Director of Improvement, acknowledging the valuable improvement perspective and challenge he has brought to Board discussions and decision-making.

TB1 15/6/7.2 **Agreement of Principle Actions and Meeting Reflection**

The Board reflected on the key themes arising from the meeting and agreed the following actions and areas of ongoing focus:

- **ACTION - Quality Account Guidance:** Seek escalation and clarification regarding future national guidance and requirements for Quality Accounts. **PVH**
- **AQCTION - Digital and IT Risk:** Maintain oversight of digital infrastructure resilience following the recent network outage, with NJ and JH leading further consideration of IT-related risks, mitigations and investment requirements. **NJ/JH**

TB1 15/6/7.3 **Public Questions**

None

TB1 15/6/7.4 **Governor feedback**

Wish you all the very best in the Group Structure.

TB1 15/6/7.5 **Date of Next Public Meeting**

The next Public Trust Board meeting will be a Group Trust Board held on 2nd July 2026

TB1 15/6/8 **RESOLUTION**

TB1 15/6/8.1 Resolution to exclude Representatives of the Media and Members of the Public from the Remainder of the Meeting (due to the confidential nature of the business to be transacted).

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF TRUST BOARD HELD IN PUBLIC
11 JUNE 2026 AT 9.30AM
INSTITUTE OF TECHNOLOGY, NORTH STAR CAMPUS, SWINDON / MS TEAMS (HYBRID)

Present:

Paul Von der Heyde (PVDH)	Chair, BSW Hospitals Group
Kathryn Bateman (KB)	Chief Medical Officer
Emily Beardshall (EB)	Acting Chief Officer of Improvement & Partnerships
Chris Burton (CB)	Non-Executive Director
Faried Chopdat (FC)	Non-Executive Director/Deputy Chair
Julian Duxfield (JD)	Non-Executive Director
Judy Dyos (JDy)* **	Chief Nursing Officer
Mark Ellis (ME)	Chief Risk Officer
Luisa Goddard (LG)	Chief Nurse
Benny Goodman (BG)	Chief Operating Officer
Sandra Gordon (SG)	Non-Executive Director
Jude Gray (JG)*	Chief People Officer
Bernie Morley (BM)	Non-Executive Director
Claudia Paoloni (CP)	Non-Executive Director/Senior Independent Director (joined 11.00am)
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Lisa Thomas (LT)	Managing Director
Simon Wade (SW)	Chief Financial Officer

In attendance:

Neil Clark (NC)*	Associate Non-Executive Director
Caroline Coles (CC)	Company Secretary
Samaher Sweity (SS)*	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Kath Townsend	Infant Feeding Specialist Midwife (item 029/26)
Angela Morris	Senior People Partner, Medicine Division (item 034/26)
Lynsey Hewitson	Chief Registrar (item 035/26)
Eleanor Tindall	Chief Registrar (item 035/26)

Apologies:

Cara Charles-Barks (CCB)	Chief Executive
Jonathan Hinchliffe (JH)	Chief Digital & Transformation Officer
Andrew Hollowood (AH)	Chief Clinical Transformation Officer

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

Number of members of the Public: There were 2 members of the public in attendance (Chris Shepherd, Governor and Daniel Kazmi, Liaison Workforce)

Matters Open to the Public and Press

Minute	Description	Action
024/26	**Apologies for Absence and Chair's Welcome** The Chair welcomed all to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. Apologies were received as above.	
025/26	**Declarations of Interest** There were no declarations of interest.	

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Minute	Description	Action

026/26 **Minutes of the previous meeting (public)**
The minutes of the Board meeting held in public on 9 April 2026 were adopted and agreed as a correct record.

027/26 **Outstanding actions of the Board (public)**
There were no outstanding or future actions for the Board to consider.

028/26 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

029/26 **Care Reflection – Critical Care**
Kath Townsend, Infant Feeding Specialist Midwife joined the meeting to present this item.

The Board received a presentation on the achievement of the UNICEF UK Baby Friendly Initiative Gold Award, which recognises sustained excellence in infant feeding support. Assurance was provided that effective leadership, staff engagement, robust audit arrangements and positive feedback from families and staff had enabled the service to maintain high standards and achieve national recognition.

The Board congratulated the team on this significant achievement and discussed a range of factors influencing infant feeding outcomes, including social media, cultural attitudes to breastfeeding, community support and the long-term sustainability of the programme. It was noted that further investment, particularly within children's and community services, would support continued progress and development. The Board was assured that the programme promotes informed parental choice and positive parent-infant relationships, irrespective of feeding method.

The Board also discussed opportunities to share learning more widely across the organisation and through partnership working across BSW. In response to a question regarding microplastics in infant feeding bottles, the Board noted that related work is being explored within neonatal services.

The Board commended the team on securing Gold Award status and received assurance that appropriate leadership, governance and continuous improvement arrangements are in place to support the ongoing sustainability of the programme.

The Board **noted** the staff story.

030/26 **Chair's Report**
The Board received the Chair's Report and noted the key matters highlighted within it.

The Chair provided an update on progress towards the establishment of the BSW Hospitals Group, reporting that the necessary agreements had been completed, joint committees and the Shadow Joint Board had met, and assurance had been received that the Group was ready to proceed to implementation on 1 July 2026. The Board recognised the significant effort required to deliver the transition and recorded its thanks to all those involved for their commitment and support.

The Board noted that all required constitutional changes had been approved, providing assurance that the necessary governance arrangements were in place and that implementation remained on track. The Chair also reported positive engagement with Governors, staff and stakeholders and noted increasing confidence that the new arrangements would support the long-term sustainability of district general hospital services across the BSW system.

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Minute	Description	Action

The Board noted the Chair's appreciation to the former Chair, Liam Coleman, for his support and constructive handover arrangements, which had assisted a smooth transition.

The Board **noted** the report.

Fit & Proper Person Test Compliance 2025/26

The Board received the annual Fit and Proper Persons Test (FPPT) compliance report for 2025/26 and was assured that appropriate arrangements were in place and that all requirements of the annual assessment process had been satisfactorily completed. The Board confirmed compliance with the FPPT requirements.

RESOLUTION:

The Board

- ***(a) noted the content of the report; and***
- ***(b) recorded that the FPPT has been conducted for the period 2025/26 and that all current Board members satisfy the requirements.***

031/26 **Chief Executive's Report**

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

The Board received and considered the Chief Executive's report and noted the significant pressures facing the organisation, particularly in relation to finance, RTT performance and urgent and emergency care. While recognising positive achievements, including strong staff engagement reflected in the recent staff awards nominations, it was acknowledged that regulatory scrutiny was likely to continue and that further work was required to address performance and financial challenges.

GWH Medium Term Financial Plan (MTFP) – Contract conditions and the Trust's response

The Board received and considered the Trust's response to the NHS England contract closedown letter issued in April 2026, which provided formal feedback on the Trust's Medium Term Financial Plan submitted in March 2026. The Board noted that the plan had been assessed as "compliant with conditions", with the conditions relating to financial performance, workforce, elective recovery and cancer standards. The Board also noted that updates on the maturity and delivery of the Cost Improvement Programme (CIP) would continue to be reported through the established governance arrangements.

The Board discussed the financial governance arrangements supporting delivery of the plan and sought assurance that accountability for performance, quality and financial outcomes remained embedded at divisional and operational level. Assurance was provided that work was underway to simplify governance arrangements where appropriate and strengthen local ownership of performance improvement.

The Board noted that external support had been commissioned to provide additional capacity, capability and expertise to support delivery of improvement priorities and to help embed sustainable ways of working.

The Board also discussed the importance of balancing immediate recovery priorities with longer-term strategic objectives and ensuring that financial decision-making remained aligned with quality and operational performance. Assurance was provided that established governance processes remained in place for the consideration of new clinical developments and that work was continuing to align Trust and Group priorities as part of the transition to the BSW Hospitals Group.

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Minute	Description	Action

The Board received assurance that appropriate governance and oversight arrangements were in place to support delivery of the Trust's financial improvement plans and strategic objectives.

The Board concluded that, despite the scale of the challenges, appropriate governance, recovery arrangements and strategic planning processes were in place, while recognising the need to simplify structures and maintain focus on sustainable improvement.

The Board **noted** the report.

032/26 **Integrated Performance Report**

The Board received the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in April 2026.

Board Assurance Reports

Our Performance

Performance, Population & Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population & Place Committee (PPPC) at its meeting on 29 April 2026 and the following was highlighted.

The challenges were noted relating to referral-to-treatment performance, urgent and emergency care pressures and financial recovery remained, although diagnostic performance continued to be strong and improvements were being seen in cancer standards.

The impact of increasing emergency demand on patient flow, planned care delivery and staff wellbeing, together with the effectiveness of system-wide arrangements to support discharge and reduce avoidable attendances. Assurance was provided that partnership working continued across the system, although wider capacity pressures remained a challenge.

The Board sought assurance regarding support for staff working under sustained operational pressure and actions to address rising demand. It was advised that work continued to increase capacity, improve patient flow and support operational recovery. The Committee's discussion on health inequalities was also noted, with assurance provided that targeted partnership initiatives were underway to address areas of identified need.

The Board acknowledged the scale of the operational challenges facing the organisation and received assurance that recovery plans, improvement initiatives and system-wide partnership arrangements were in place to support sustainable improvement.

The Board **noted** the report.

Our Care

Quality & Safety Committee Chair Overview

The Board received an overview of the discussions held at the Quality & Safety Committee meetings on 26 April 2026 and 21 May 2026. The Board noted progress and ongoing improvement work across a number of quality and safety priorities, including infection prevention and control, stroke services, deconditioning, maternity services and theatre capacity. It was noted that improvement plans were in place and that risks continued to be monitored and managed through established governance arrangements.

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Minute	Description	Action

The Board noted continued progress within the stroke pathway, supported by executive oversight and partnership working, whilst recognising that further improvement was required to achieve the expected performance standards. The Board also noted the actions being taken to address capacity pressures within maternity services associated with increasing demand and activity.

Members were advised that future reporting arrangements would place greater emphasis on exception reporting and outcome measures, providing clearer visibility of performance, improvement activity and areas requiring further attention.

The Board noted the ongoing focus on quality improvement across the organisation and received assurance that appropriate oversight, risk management and improvement arrangements were in place to support the delivery of safe and high-quality patient care.

The Board **noted** the report.

Our People

People & Culture Committee Chair Overview

The Board received an overview of the detailed discussions held at the People & Culture Committee (PCC) at its meeting on 27 May 2026 and the following was highlighted.

The Board received an overview of the discussions held at the People and Culture Committee. The Committee had reviewed the Fit and Proper Person process and noted that revisions would be required to reflect the introduction of new Group roles.

The Board noted the 2025 Staff Survey results and reports relating to the National Education and Training Survey, including feedback from undergraduate, postgraduate, allied health professional and midwifery groups. Improved staff absence rates were noted, providing assurance that wellbeing and attendance initiatives were having a positive impact despite ongoing workforce pressures.

The Board also noted discussions regarding delivery of the workforce plan. While workforce reductions had been agreed, detailed implementation plans remained under development. Assurance was provided that a range of measures, including vacancy management, were being considered as part of the approach, with further work continuing to align workforce, financial and operational plans.

The Board discussed findings relating to bullying, discrimination and staff experience highlighted through survey feedback. It was noted that work was underway with education, equality, diversity and inclusion leads, together with external partners, to strengthen improvement plans addressing areas including racial discrimination, sexual safety and patient-to-staff incidents.

The Board received assurance that appropriate actions were being taken to address the issues identified through staff feedback and that progress would continue to be monitored through established governance arrangements**.**

The Board **noted** the report.

Use of Resources

Finance, Infrastructure & Digital Committee Chair Overview

The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at its meetings on 27 April 2026 and 26 May 2026 and the following was highlighted.

The Board received an update on fire safety improvements across the Trust and was advised that good progress continued to be made. It was noted that the Fire Service had

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Minute	Description	Action

recognised the improvements achieved to date whilst acknowledging that further work remained. The importance of ensuring that appropriately informed representatives attend Committee meetings was also noted to support effective scrutiny and assurance.

The Board noted the Month 1 financial position and the challenges associated with delivery of the efficiency programme. Assurance was provided that financial controls remained effective and had been positively reviewed through internal and external audit processes. The Board discussed key financial risks, including workforce and cashflow assumptions, and was advised that these continued to be actively monitored, with detailed workforce plans under development.

The Board noted that the Committee had approved the Health and Safety Annual Report and received assurance regarding improvements in health and safety management and reporting. The Committee had also supported the staff and student accommodation project for consideration by the Board.

The Board acknowledged the scale of the financial challenge facing the Trust and noted that delivery of the required savings would require sustained transformation and service improvement. The Board received assurance that appropriate governance, oversight and risk management arrangements were in place to support delivery of the Trust's priorities.

The Board **noted** the report.

Integrated Performance Report
The Board noted strong diagnostic performance, providing assurance that this continued to support patient pathways, although significant challenges remained in urgent care, RTT performance and corridor care. An update on infection prevention and control highlighted a recent deterioration in bacteraemia rates. Assurance was received that actions were underway to address rising infection rates through strengthened hand hygiene measures and enhanced infection control leadership.

The Board received a positive update on the deconditioning programme, with early evidence of cultural change and multidisciplinary engagement. Concerns were noted regarding the continued impact of corridor care on patient outcomes and length of stay, while assurance was provided that workforce indicators, including sickness absence and equality metrics, were improving. In response to a question regarding the Trust's carbon footprint, assurance was provided that progress was being made through a range of initiatives, with a fuller update to be presented through the annual report process.

The Board **noted** the report.

033/26 **Charitable Funds Committee Board Assurance Report (May 2026)**
The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) at its meeting on 6 May 2026 and the following was highlighted.

It was noted this was the final meeting with current participants, with two of the three NEDs involved stepping down at the end of June 2026. The committee had discussed possible options for future governance but a final decision would be needed on the structure of the governance relationship between the Trust and the charity.

CFC had reviewed fundraising performance and noted that, although income had declined over the previous 18 months, more encouraging results had been seen in the most recent quarter. The committee discussed the ongoing challenge of rebuilding fundraising capacity and received assurance that work was underway to strengthen the team and support future growth.

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Minute	Description	Action

CFC also reviewed progress in reducing the number of charitable funds through a new divisional structure. Early feedback had indicated that the new arrangements were operating effectively, although ongoing monitoring would be required. In response to a question raised regarding future fundraising ambitions and charity reserves, it was confirmed that growth remained an objective, supported by learning from other trusts, while maintaining only a modest reserve and seeking to maximise charitable spending on agreed priorities. The committee had gained assurance that governance arrangements and oversight of charitable funds remained effective.

The Board **noted** the report.

034/26 **Staff Survey Results 2025**

Angela Morris, Chief People Officer joined the meeting to present this item.

The Board received the 2025 Staff Survey results and noted a strong response rate, with participation and overall staff experience remaining above sector averages. Positive progress was reported in staff wellbeing, flexible working, equality, diversity and inclusion, team working, recognition and staff engagement, providing assurance that improvement initiatives were having a positive impact.

A discussion was held on the key themes emerging from the survey, including concerns regarding career progression, pressure to attend work when unwell, staff confidence in speaking up and the increasing incidence of violence towards staff. The Board welcomed the Trust's response, including targeted work on workforce culture, patient care, speaking up, staff safety and communication. Further questions were also raised regarding action being taken to address violence and aggression towards staff, and it was confirmed that preventative measures, partnership working with the police and escalation processes were in place, although challenges remained in securing prosecutions and managing incidents.

The Board supported the new staff survey breakthrough objective focused on ensuring patient care remained the organisation's top priority and received assurance that clear countermeasures, governance arrangements and divisional actions had been established to address identified concerns and drive further improvement.

The Board **received** the report.

035/26 **Resident Doctor Peer Lead Board Report**

Kathryn Bateman, Chief Registrar and Eleanor Tindall, Chief Registrar joined the meeting to present this item.

The Board received the Resident Doctors' report and noted improvements in trainee experience and survey results, despite ongoing operational pressures. Concerns were highlighted regarding bullying, discrimination, sexual safety and a lack of confidence among some resident doctors that concerns raised would be addressed. The Board was advised that these issues were not unique to resident doctors and that further work was underway to strengthen action plans and organisational responses.

Questions were raised regarding progress against the Resident Doctor 10-Point Plan, payroll issues and support for locally employed doctors. Assurance was provided that progress against the plan compared favourably across the region, improvement work on payroll and multiple payslip issues was ongoing, and proposals to strengthen educational support for locally employed doctors were being developed. Will Smart, Non-Executive Director questioned the timescales for resolving resident doctor payroll issues and sought assurance on progress. It was confirmed that significant progress had been made, although resolution had not yet been completed. An action was agreed to resolve this as soon as practical.

Action: Chief Financial Officer

DRAFT

Minute	Description	Action

The Board welcomed the positive feedback on the impact of existing initiatives and the strong engagement of the postgraduate medical education team. The request to maintain a direct resident doctor voice within future governance arrangements was supported and the Chief Registrars received assurance that mechanisms would be established to ensure continued oversight and monitoring of resident doctor experience.
Action : Chief Medical Officer

RESOLUTION:

The Board

- ***(a) received the report;***
- ***(b) requested that a resolution of resident doctor payroll issues be provided in the next quarterly report; and***
- ***(c) agreed to maintain a direct resident doctor voice within future governance arrangements as part of the transition to the Group Board model.***

036/26 **Delegation of authority for approval of Annual Report & Accounts 2025/26**

The Board was requested to delegate authority to the Audit, Risk & Assurance Committee to approve the final Annual Report & Accounts 2025/26 in order to meet the deadline of 26 June 2026.

RESOLUTION:

The Board approves the delegation of authority to the Audit, Risk & Assurance Committee to approve the final Annual Report & Accounts 2025/26 before the deadline of 26 June 2026.

037/26 **Statutory Governance Framework to support the implementation of BSW Hospitals Group**

The Board considered the statutory governance framework documents required to support the new Group arrangements, including committee terms of reference, the Scheme of Reservation and Delegation, and Standing Financial Instructions. Board Members sought assurance on the level of scrutiny applied and whether governance arrangements remained constitutionally appropriate. It was confirmed that the documents had been developed using established guidance, reviewed through relevant governance groups and aligned with existing arrangements.

A question was raised regarding Audit Committee reporting arrangements and whether references should explicitly state reporting to Trust Boards. An amendment was agreed to clarify the wording. Subject to this change, the Board was assured that the proposed framework provided consistent and appropriate governance arrangements and approved the documents.
Action: Company Secretary

RESOLUTION:

The Board

- ***(a) requested clarification on the wording regarding Audit Committee reporting arrangements and whether references should explicitly state reporting to Trust Boards;***
- ***(b) approves the Scheme of Reservation and Delegation of Great Western Hospitals NHS Foundation Trust;***
- ***(c) approves the Standing Financial Instructions of Great Western Hospitals NHS Foundation Trust and give delegated authority to the Group CFO to make any further changes as set out in the report.;***
- ***(d) approves the Terms of Reference for the Audit Committees-in-Common;***

DRAFT

Minute	Description	Action

(e) approves the Terms of Reference for the Remuneration Committees-in-Common; and

(f) agreed the amendment to the quoracy of the General Purpose Joint Committee (Group Board) to ensure at least one Executive Director is present.

Consent Items

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

038/26 **Ratification of Decisions made via Board Circular**

None.

039/26 **Urgent Public Business (if any)**

The Chair formally thanked departing Executive and Non-Executive Directors for their contributions, recognising the significant support, challenge and leadership they had provided to the Board, its committees and the Executive team. The Board acknowledged the positive impact of their work and expressed appreciation for the difference they had made to the organisation during their tenure.

040/26 **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.

The meeting finished at 12.54hrs

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Great Western Hospitals NHS Foundation Trust

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – September 2026				
ARAC – Audit, Risk and Assurance Committee, CFC – Charitable Funds Committee, FIDC – Finance, Infrastructure & Digital Committee, PPPC – Performance, Population and Place Committee, PCC – People & Culture Committee, QSC – Quality & Safety Committee, RemCom – Remuneration Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
11 June 2026	035/26	**Resident Doctor Peer Lead Board Report** (a) Resolution of resident doctor payroll issues. (b) In the transition to the group board model, we request the board consider how the resident doctor voice from each care organisation will be represented.	Chief Financial Officer CMO	For resolution in the Care Organisation. Added to Group Board annual cycle of business – May-27
11 June 2026	037/26	**Statutory Governance Framework to support the implementation of BSW Hospitals Group** Clarification to be provided on the wording regarding Audit Committee reporting arrangements and whether references should explicitly state reporting to Trust Boards.	Company Secretary	Closed. Amended terms of reference.

Future Actions				
None				

BSW HOSPITALS GROUP

NHS

Group Board Actions Log

Latest update 28/08/26;

NHS Great Western Hospitals NHS Foundation Trust

NHS Royal United Hospitals Bath NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

Public Group Board Open Actions [28/08].

Open on track	Open overdue	Ongoing progres sing	Closed/ To Close

Ref	Date GB 10	Item	Action/ Decision	Lead	Target Date	Progress/update	Status
GB 02	02/07/26	4.1	**Action: IPR:** Develop simple visual means to display where we are off-track, and what are we doing about delivery recovery – what by when.	ME	03/09/26	• ME Update.	*Open*
GB 04	02/07/26	5.3	**Action: GWH Maternity Triage Capacity**. It was agreed that an urgent solution would be progressed within the coming weeks.	LT/ LG	03/09/26	• LG Update.	*Open*
GB 05	02/07/26	7.3	**Action: Board Development - Digital Session**. A Board development session should be arranged to provide a broader overview of the Group's digital strategy, opportunities and future plans.	BI/JH	05/12/26	• Plan for December 2026 Board development session.	*Open*

BSW Hospitals Group Board

Agenda item	
Report title	Care reflection story
Date of meeting	3rd September 2026
Sponsor	Luisa Goddard, Chief Nurse, Great Western Hospital Jason Lugg, Chief Nurse, Royal United Hospital Angie Ansell, Chief Nurse, Salisbury Foundation Trust
Prepared by	
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
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

Patient stories help to bring patient experiences to life. The BSW Hospitals Group is committed to listening and acting on what matters most to patients and their families.

Background and context

These Care Reflections highlight experiences from three maternity pathways across the BSW maternity group services.

Maternity Care: Rachel, Carlos and Isabella (RUH)

Following successful IVF treatment, Rachel was admitted to Mary Ward at 37 weeks for induction of labour due to pre-eclampsia (high blood pressure in pregnancy). Having experienced significant anxiety throughout her pregnancy, she received support from the Ocean team to help her prepare emotionally for birth.

Baby Isabella Rose was born with the aid of forceps in Bath Birthing Centre on 19 April, weighing 5lb 2oz. Following birth, Isabella required support for jaundice from the neonatal and infant feeding teams. Rachel's reflections on feeling calm, safe and reassured throughout her care illustrate the importance of trauma-informed, individualised care. Her experience demonstrates how listening, kindness and care tailored to individual needs can have a profound and lasting impact on families.

Neonatal Care: Janna and Kelly and Hazel (GWH)

Baby Hazel was born prematurely at 27 weeks. She was transferred, just before Christmas, to the Neonatal Unit at the Great Western Hospital, following her birth at a system network unit. Due to her prematurity, she required complex clinical interventions and life support for her to develop and thrive. Her mums, Kelly and Jana, wanted to share their very positive experience of the care that they received and wished to thank the whole team who had provided such kindness to them and excellent care to Hazel. In line with the Ockenden and Amos recommendations, the personal experience reflects work undertaken by the team to ensure families are actively involved, listened to and provided with clear information.

The full Care Reflection can be viewed at: Care Reflections - Hazel (youtube.com)

Bereavement Care: Shannon, Jimmy and Baby Grace (Aliases have been used) (SFT)

Following 3 to 4 years of trying to conceive and undergoing fertility investigations, Shannon (36) and Jimmy (42) spontaneously conceived in December 2025. At their routine 20-week anomaly scan, concerns were identified regarding Grace's head circumference, which measured below the 3rd centile. The couple were referred to the Fetal Medicine Unit (FMU) at their nearest tertiary centre for further assessment. Over the following seven weeks, Shannon and Jimmy attended multiple scans, reviews and investigations as clinicians closely monitored Grace's wellbeing. Sadly, during a planned FMU appointment, Grace passed away in utero. Shannon and Jimmy were transferred back to Salisbury for the birth of their daughter and to receive ongoing postnatal and bereavement care. Here they were supported with decision making, creating memories and spending time with their baby on the bereavement suite.

The couple shared their experience through the Perinatal Mortality Review Tool (PMRT) process, supporting a culture of safety, openness and learning. Their reflections highlighted the importance of listening to women and families, particularly during the most challenging circumstances, and demonstrated how compassionate communication and involvement in decision making can positively influence a family's experience of care.

Shannon and Jimmy's feedback also emphasised the value of continuity of care and safe staffing levels in enabling maternity teams to provide personalised, high-quality labour care and bereavement support.

These are positive reflections of lived experiences but have also identified some areas where care could be further improved. The feedback and actions reflect improvements already undertaken in line with recommendations from the Ockenden review and Amos Independent investigation.

RECOMMENDATION

The Group Board is asked to:

[State clearly what is being asked, using Receive / Note / Approve / Endorse.]

1. Receive the report for assurance of the high standard of care delivered within maternity services across the BSW hospitals group.
2. Note the positive personal lived experiences shared by patients across separate maternity pathways of care.

APPENDICES

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

a. Neonatal care	GWH
b. Maternity care	RUH
c. Bereavement care	SFT

BSW Hospitals Group Board

Agenda item	3.1
Report title	Chair Report
Date of meeting	3rd September
Sponsor	Paul Von Der Heyde
Prepared by	Ben Irvine, Kylie Sanders
Approval Process: (where has this paper been reviewed and approved)	[Chair 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
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:

- Governance Developments
- Non-Executive Directors Update
- Council of Governors – Key Meeting Dates
- Chair - Key Meetings
- NHSE Board Development Programme

RECOMMENDATION

The Group Board is asked to:

1. Note the Chair's Report.

APPENDICES

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

Chair's Board Report

1. Introduction

July and August have seen significant development for BSW Hospitals Group, with the Partnership Agreement approved in May 2026, coming into full effect. The Group leadership team and governance arrangements have been established, our group strategy development is well underway, and teams are focussing on operational and financial performance recovery. These developments have taken place against a backdrop of sustained operational pressure across urgent and emergency care, and interventions from NHSE both at a National and Regional level.

2. Establishment of the Group Board

From 1 July 2026, the Boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust have operated collectively as a Group Board.

This arrangement will:

- Ensure strategic alignment across the Group
- Improve consistency of oversight of quality, performance and finance
- Enable delivery of priorities at scale

3. Governance and Assurance

Our new Group governance cycle has been established. Developments in July and August included the following:

- Care Organisation assurance committees all met as planned through July and August.
- The monthly Non-Executive Director-led Group Risk and Assurance Committee (RAC) chaired by Faried Chopdat, met on 19th August.
- The monthly Non-Executive Director-led Financial Sustainability Committee met on 30th July and 27th August.
- The EPR Assurance Committee, chaired by Simon Harrod, will have met on 1st September.

These arrangements will mature and are designed to provide robust Board assurance and maintain clarity of accountability.

4. Non-Executive Directors

The Non-Executive Directors have begun operating as a single, collective Group team, providing independent oversight, scrutiny and challenge across the full range of Group activities.

Monthly NED team meetings started in July to support alignment across the Group enabling coordinated oversight of risks and priorities.

July saw confirmation of the appointments of Bernie Morley as Vice Chair and Paul Fairhurst as Senior Independent Director. A Group Associate Non-Executive Director model has been confirmed.

The programme of NED visits and bi-annual walkarounds is being planned by the company secretaries.

5. Councils of Governors

The Councils of Governors continue in their statutory roles for each Care Organisation, retaining their existing duties and functions under the NHS Act 2006 and their respective Constitutions.

Work programme for 2026-27. Lead governors met on 7 July with the Chair, CEO and Chief Risk Officer to consider the rhythm and focus of our work together, including finding a balance between local Care Organisation and collective activities. A series of local and joint Council of Governor meetings is planned for the year ahead.

The following table outlines the meetings, training and events during July & August 2026 that governors in SFT, GWH and RUH participated in:

July-August 2026 – Governor Activity

Date	Event	Purpose/ Primary Content
7th July	SFT, GWH & RUH Lead Governors	To consider rhythm and focus of our work together
20th July	SFT Governors	Assurance on key aspects of Care Organisation performance and governance, patient experience.
30 July	RUH Governor Membership and Outreach Working Group	To support Governors to engage with members and the public, including membership development and communication with constituencies.

RUH Governor Elections: The nominations stage of the RUH Council of Governors elections is now underway. The RUH is seeking to elect six Public Governors and three Staff Governors to ensure that the views of members, staff and local communities continue to be represented through the Council of Governors. Members can nominate themselves for election until 5pm on 8 September 2026. Further information is available on the election website: www.cesvotes.com/RUH2026.

Annual General Meetings

Annual General Meetings are to be held in September for each organisation as follows:

- GWH Annual General Meeting, 14th September
- SFT Annual General Meeting, 28th September
- RUH Annual General Meeting, 29th September

The AGMs will provide an opportunity to review each organisation's performance and achievements during 2025/26 and will be followed by an informal engagement session with Governors and members of the Board of Directors.

5. Chair Meetings during July & August 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
BSW Group Board Session on Strategy	To develop BSW Hospitals Group Strategy

Meeting	Purpose
BSW Hospitals Financial Sustainability Committee	To provide overview and scrutiny of Recovery Plan for financial sustainability
Remuneration Committee	Executive leadership team appointments, terms & conditions
Remuneration & Nominations Committee	Approval of NED recruitment process
Visit to Sulis Hospital	Visit with Chief Executive
NHSE Board Development Programme – BSW Hospitals Group	

6. National Board Development Programme

BSW Hospitals Group is to be in the first wave of NHS providers to take part in the new NHSE Board Development Programme. The nationally mandated programme comprises a 12-month development package which we will shape, aligning with BSW Hospitals Group's current context. The Chair and Chief Executive held an initial planning discussion with the programme delivery team earlier in August and agreed that the programme will focus on:

- The Board's role and purpose in our specific Group context
- The Board's role in balancing grip and transformation
- Translating Board development into the wider leadership system
- Building long-term value creation.

There will be three in-person whole-board development days over the next 12-months, starting in October.

Close.

BSW Hospitals Group Board		
Agenda item	3.2	
Report title	CEO report	
Date of meeting	3 September 2026	
Sponsor	Cara Charles-Barks, Chief Executive Officer	
Prepared by		
Approval Process: (where has this paper been reviewed and approved)	CEO 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
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☐ Improving health equity	

BOARD ASSURANCE FRAMEWORK LINK	
BAF risk ID	**Principal risk title**
R1	Becoming an Effective Group
R3	Delivering Digital Maturity
R4	Transforming Models of Care
R5	Increasing Financial Sustainability
R6	Reducing Waits

KEY MESSAGES

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Following the last public board meeting the group has been undertaking a range of activities.

It is important that this report is read in conjunction with the Group Executive Committee escalation report to ensure a full and comprehensive picture of activities across the group.

For the three Care Organisations, June was a particularly busy month with a continued focus on elective, diagnostic and cancer recovery. This was delivered alongside significant urgent and emergency care, flow, workforce and financial challenges.

Recovery of our financial position and long-term financial sustainability remain a priority across the group. Finance capacity and capability, grip and control, forecasting and recovery delivery are being strengthened ahead of approval and submission of the revised group recovery plan.

The executive team remains focused on recovery over the next six months to support a return to the operational and financial plan.

The Group's risk and assurance arrangements continue to mature. The report presents three key risks for each Care Organisation, with actions and updates from the August Group Risk Register and latest Managing Directors' reports.

RECOMMENDATION
The Group Board is asked to: • Receive the report and note the assurance it provides on the position across the Group and the wider system. • Note the key operational, financial and risk escalations and the actions which will be discussed throughout today's board meetings that are underway through the wider group and each Care Organisation to manage these.

APPENDICES
None

Introduction

This report aims to provide the Board with both an update on our strategic context and cover the most significant developments across BSW Hospitals Group. It will also highlight matters for board attention and oversight.

Strategic initiatives and priority activities for the Group

Our five Group strategic initiatives remain central to recovery of today but also the transformation that we need for the future. As a reminder our areas of focus are transforming models of care, our people, increasing sustainability, delivering digital maturity and developing our Group. As each of the programs has matured, the interdependence of each program is becoming more apparent. Financial recovery depends on clinical and corporate transformation, workforce availability and productivity; operational recovery depends on system flow and discharge; and implementation of transformational change depends on digital, estates and leadership capacity and capability.

Operational performance and recovery

Quality, safety and maternity

The Managing Directors' reports highlight a number of areas that require continued oversight. Actions being taken to manage and mitigate these risks will be covered in the Managing Directors update to Board. Issues highlighted are:

- GWH: Operational pressure, corridor care, maternity triage estate constraints and neonatal staffing.
- RUH: Infection prevention and control, corridor-care exposure, End of Life Care capacity and maternity safety.
- SFT: The Care Quality Commission's surgical-services findings have been met with an improvement response and continued inspection readiness.
- Maternity and neonatal safety remains a Board-level priority across the Group.

Urgent and emergency care, patient flow and winter planning

Urgent and emergency care remains the most pressured operational area across the Group.

- GWH reported sustained emergency demand, high occupancy, repeated critical incident status and incidence of corridor care.
- RUH continues to face rising demand, delayed discharge, incidence of corridor care and a risk regarding available capacity for winter.
- SFT reports high occupancy, patients no longer meeting the criteria to reside and ambulance handover delays as key constraints.
- The common issue across the group is end-to-end flow which requires stronger internal control and improved out-of-hospital and system capacity.

Winter planning is well underway. As a reminder, our plan, which we are developing with BSW system partners, must be submitted to NHSE by the Board at the end of September.

At both public board and private board today, we will be reviewing the recovery actions for UEC in each organisation and across the system, as we remain committed to continuing to improve access and experience of all our urgent care services.

Referral to treatment and elective recovery

We are seeing good recovery of our elective care position across the group. Both RUH and SFT show sustained control of very long waits and performance above trajectory. GWH continues to require enhanced focus on RTT recovery and validation. GWH have shown sustained week-on-week improvement and are now meeting their recovery trajectory. . Across the Group we are actively sharing best practice and insight to ensure that we can recover to the planned levels of performance as quickly as possible.

Cancer and diagnostics

Cancer recovery is improving but remains inconsistent, with a number of pathway-specific pressures across the three organisations. Across the group there are recovery plans in place to respond to these pressures, but we are seeing a significant increase in demand which we are discussing with commissioning colleagues to ensure that we can respond and right size our service delivery as appropriate.

Diagnostic performance is similarly challenged in places across the group. RUH remains ahead of trajectory, SFT is below plan in a small number of areas, and GWH continues to perform strongly whilst addressing capacity and access issues. Mutual aid, pathway redesign and specific workforce actions remain important Group strategies for managing performance.

Financial sustainability

Financial sustainability is the most significant shared challenge across the group. The common risks are the scale and pace of savings required. In particular, ensuring identified opportunities are delivered, cash position is managed and we have the capacity to deliver transformation while managing day-to-day operational pressure. The Group has taken action to strengthen finance team capacity and capability and improve senior turnaround leadership. This has been necessary to ensure that we have the appropriate level of grip and control, consistency of reporting and forecasting, and the pace needed to ensure delivery of our recovery plan. This is intended to complement, not replace, the accountability of Group leaders and the Care Organisation, importantly it is designed to build sustainable in-house capability.

The revised recovery plan will be reviewed through the Financial Sustainability Committee and is due for submission to NHS England on 10 September 2026. An extraordinary Group Board is proposed for 9 September 2026 to approve the plan before submission. The plan will also form a central part of preparation for the Board-to-Board session on 5 October 2026.

Weekly executive recovery meetings have been established to support delivery and to drive the pace of recovery needed.

Workforce and culture

There are several areas of focus across the group pertaining to workforce and overarching culture. Workforce availability, sickness absence, use of temporary staffing and the capacity to deliver change remain key constraints. There are a number of established priorities across the group designed to ensure they address the key pressure points as they differ in each of the organisations. SFT continues to focus on staff unavailability as a breakthrough objective; RUH is progressing its Healthier Workforce Programme and targeted recruitment; and GWH is addressing safer staffing, sickness, temporary staffing and clinical leadership capacity.

As we focus on recovery of the financial position and responding to operational pressure, workforce usage and planning are areas of increased oversight and scrutiny across the Group.

Main capital schemes

We have a number of large capital schemes underway across the group.

- At SFT, the DASH program is intended to replace our aging day-surgery and diagnostic infrastructure. The business case has identified a £6m capital gap, with further redesign and alternative funding routes being explored. SFT's Urgent Treatment Centre remains on track for opening in the autumn and is central to its front-door redesign and reducing crowding in the emergency department.
- At RUH, the modular Urgent Treatment Centre supports the UEC 100-day program and reconfiguration of urgent pathways.

Delivery of all of these programs requires continued oversight of affordability, mitigation of any construction risk and ensuring that cost remains within the allocated capital envelope.

Risks across the Care Organisations and BSW system

The risks listed below are the three key risks reported for each Care Organisation. These and the subsequent mitigations are covered in each of the care organization reports which we will discuss in detail later in the meeting.

Great Western Hospitals

Key risk	Why it is being escalated
Patient flow and high bed occupancy	This remains the most significant operational risk at GWH. June was characterised by sustained emergency demand, high occupancy, critical incident escalation and corridor care. It continues to require Board visibility because of its direct effect on patient safety, privacy, dignity and access, and its dependencies on discharge capacity and wider system flow.
Financial sustainability and delivery of the savings programme	Delivery of the financial plan remains challenging because of the scale of recurrent saving required and the need to deliver transformation alongside operational pressure. Governance and recovery controls are in place, but delivery remains dependent on scheme maturity, recurrent benefit and sufficient organisational capacity.
Elective access and RTT recovery	RTT recovery remains an area of enhanced visibility. GWH continues to experience pressure on waiting times and elective performance, requiring sustained operational focus, reliable validation and performance information, and continued use of Group improvement approaches.

Royal United Hospitals Bath

Key risk	Why it is being escalated
Urgent and emergency care performance and flow	Flow and capacity remain the most significant operational challenge at RUH. Rising demand, discharge constraints, corridor-care exposure and the projected winter bed-capacity gap create material risks to performance, quality and patient experience. Several mitigations remain dependent on commissioner and system-partner action.
Delivery of the financial plan and savings programme	Financial recovery and cash sustainability remain the organisation's highest strategic concern. The position is materially adverse to plan and requires sustained savings delivery, productivity improvement and tighter recovery trajectories. Cash resilience continues to require active executive and Group oversight.
Ageing estate, backlog maintenance and fire safety compliance	The RUH estate continues to present strategic and operational challenges, including infrastructure capacity, backlog maintenance, fire-safety compliance and the ability to support future development. Its scale, compliance implications and capital requirements cannot be managed solely through routine controls.

Salisbury

Key risk	Why it is being escalated
Financial recovery and delivery of the savings programme	Delivery of the break-even plan remains dependent on a sizeable savings and transformation programme, productivity gains and active management of cash-flow pressures. It remains the principal organisational risk because delivery risk increases through the year and several dependencies sit beyond the Care Organisation.
Urgent care flow and discharge	High occupancy, delayed discharge and patients who no longer meet the criteria to reside continue to constrain performance. This remains the principal operational

	challenge, with improvement dependent on both internal flow actions and a step-change in out-of-hospital and system capacity.
Workforce availability	Workforce availability remains a breakthrough objective and a critical enabler of performance, productivity, resilience and financial recovery. Staff unavailability remains materially above target and continues to affect temporary staffing expenditure and delivery capacity.

Group and system risks

As detailed in my Group Executive Committee report there are several risks across the group. These include capacity to deliver the scale of recovery and transformation needed at this time, financial sustainability and cash position; UEC flow, occupancy and discharge; workforce availability and use of temporary staffing; estates and capital affordability; digital and EPR readiness; and capacity to deliver multiple transformation programs at the pace needed.

To support mitigation and management of these challenges we are in the process of establishing a delivery approach that ensures the right level of daily and weekly focus on immediate recovery and a more integrated and ambitious approach to longer-term transformation.

Group strategy and Board development

Board strategy development workshop

The Board strategy development workshop brought together feedback from staff, volunteer, governor, partner and community engagement and enabled the Board to clarify the ambition of the proposed Group vision and strategic priorities.

The meeting was positive and clearly set out a shared ambition for the future. It also provided the board with the opportunity to ensure that we all progress with the same level of clarity.

We will continue to develop this over coming months to align the delivery of the strategy and our longer-term recovery plan.

Board development programme

The Group will participate in the first wave of NHS England's Board Development Program. It is a requirement that all boards undertake this program over the next 4 years. Initial engagement and baseline activity are underway and will also be aligned to the Group's development priorities. The program will provide an opportunity to strengthen collective leadership, clarify how the Group Board leads to serve our collective population and build the assurance and governance disciplines needed to ensure successful delivery of our ambition and strategy.

Recovery, oversight and external engagement

Forthcoming Board-to-Board session

NHS England has scheduled a Board-to-Board session for 5 October 2026. At this meeting we will focus on the revised recovery plan, which includes both operational and financial delivery plans. We will also share how the Group model is being used to accelerate improvement. The recovery plan is due to be submitted to NHS England on 10 September, following the proposed extraordinary Group Board on 9 September.

Leadership team

Rebecca Maxwell joined RUH in August as Chief Medical Officer. Rebecca is joining us at an important point in our clinical transformation program and EPR delivery. Rebecca is also taking a lead role in supporting our preparations for winter. I would also like to thank Emma-Kate Reed for her contribution and support to the organisation and colleagues over the past six months as acting CMO at RUH. In July we also welcomed Angie Ansell as interim Chief Nursing Officer in SFT.

Chief Executive external meetings

Since my last public report, I have continued to engage with local Members of Parliament, national NHS leadership teams and the NHS England South West regional team. The principal themes included access and operational performance,

financial sustainability and recovery, winter readiness, maternity and neonatal assurance, provider oversight and the ongoing development of the BSW Hospitals Group.

Conclusion

It remains a very busy time for the Group, and I would like to thank both the executive team and our wider staff for their continued passion and commitment to deliver services of high standard. As a Group we have shown genuine improvement in a number of areas. Having said that there are several risks including UEC flow, finance, workforce, estates and transformation capacity that require ongoing oversight and mitigation. Over the last two months the Group has continued to mature in its way of working, which will translate into sustained delivery supported by a credible recovery plan focused on improving services and experience for patients and staff.

BSW Hospitals Group Board

Agenda item	4.1
Report title	Group Executive Committee Upward Report
Date of meeting	3rd September 2026
Sponsor	Cara Charles-Barks, CEO
Prepared by	Cara Charles-Barks, Helen Perkins, Ben Irvine
Approval Process: (where has this paper been reviewed and approved)	CEO 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
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☒ Improving health equity	

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
R4	Transforming Models of Care
R5	Increasing Sustainability
R6	Reducing Waits

KEY MESSAGES

Executive Summary

This is a report from the meeting held on 11th August 2026.

The three care organisations continue to demonstrate progress and sustained improvement across planned care, diagnostics and cancer recovery. However, all organisations remain under significant pressure across several key areas: urgent and emergency care demand, patient flow, workforce sustainability, financial recovery and delivery capacity. The two critical recovery areas for the group are urgent and emergency care and financial recovery. As an executive team our focus is delivery over next 6 months along with the required transformation over the next 3 years to support a long term sustainable financial and operational position.

A key emerging risk across the group is the cumulative impact of operational pressures running alongside EPR implementation, corporate service transformation and financial recovery programmes.

RECOMMENDATION

The Group Board is asked to:

1. Receive and note the report, and to note the assurance it provides on the position across the three Care Organisations and the BSW system.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix 1	NHSE

Chief Executive Report following Group Executive Committee on 11th August 2026

Key Themes, Risks and Executive priorities

Executive Summary

The three care organisations continue to demonstrate progress and sustained improvement across planned care, diagnostics and cancer recovery. However, all organisations remain under significant pressure across several key areas: urgent and emergency care demand, patient flow, workforce sustainability, financial recovery and delivery capacity. The two critical recovery areas for the group are urgent and emergency care and financial recovery. As an executive team our focus is delivery over next 6 months along with the required transformation over the next 3 years to support a long term sustainable financial and operational position.

A key emerging risk across the group is the cumulative impact of operational pressures running alongside EPR implementation, corporate service transformation and financial recovery programmes.

Key Group-Wide Risks

1. Capacity to deliver turnaround and transformation

There are several shared issues across the 3 sites

- Recovery priorities to deliver return to plan
- Capability and capacity with the finance team
- Pace of recovery needed
- Capacity to build the long-term transformation
- Conflicting full on available resource

Executive actions:

- Group Turnaround recovery director appointed and commencing on Monday 7th August.
- Additional senior finance resource in place at GWH and being evaluated for RUH
- Internal EOI to fill Clinical Transformation Director role to progress programs that have stalled

- Group recovery Director to review corporate services program to extend the scope and ambition
- Weekly executive turnaround meeting chaired by CFO
- Reframing of and narrowing of work programmes to ensure focus is on turnaround and the key strategic changes we need to progress to deliver long-term sustainability.
- All existing resource and programs of work to be evaluated to prioritise resource against the most critical programs. This will be evaluated monthly via the group engine room.

2. Financial Sustainability and Cash

This is now the most significant Group-wide risk.

Royal United Hospitals (RUH)

- Financial position - for M3 £7.6m deficit which is £2.8m adverse to plan, for M4, it is £10.6m deficit which is £5.7m adverse to plan
- Forecast will reach a critical cash position in September/October and is likely to require emergency NHS England cash support.
- Deficit remains adverse to plan and is dependent on delivery of recurrent savings and ongoing discussions with commissioners regarding funding gaps.

Salisbury NHS Foundation Trust (SFT)

- Currently on plan, however delivery remains highly dependent on a £32.5m CIP programme.
- Cash is identified as the organisation's most significant financial risk during the second half of the year.

Great Western Hospital (GWH)

- Month 3 deficit £10.9m, £6.3m adverse to plan.
- Cash flow forecasts indicate significant risk later in the year.
- Recovery remains dependent on delivering £47m savings and increase in associated productivity.

Executive Actions: Recovery plans are being developed. Both SFT and RUH are working on plans to deliver breakeven for the year. Cash support application being developed for board sign-off in September. Additional actions are being developed across the group to support a group wide return to plan thereby supporting the GWH challenge. Will be shifting to a group

wide recovery approach. Financial recovery plans are increasingly dependent on transformation delivery, workforce reductions and operational improvements occurring at the same time. The risk of delivery slipping as we head into winter is high across all three organisations so ongoing focus and commitment to agreed plans at all levels across the group and care organisations is essential.

3. Urgent and Emergency Care, Flow and Winter Resilience

UEC remains pressured across all 3 sites

Shared Issues

There are a number of shared issues across the 3 sites and system

- High occupancy and demand.
- Delayed discharges/NCTR.
- Corridor care and escalation spaces.
- Ambulance handover delays.
- Impact on quality of care and increased incidence of poor patient experience
- Increased costs and reduced productivity.
- Difficulty in sustaining staff morale

RUH

- NCTR performance and Hospital at Home present a significant risk to winter plan.
- Risk of up to 72 adult bed deficit during winter equating to 15.2% of bed base.

SFT

- ED performance 66.3%.
- Average ambulance handover 37 minutes.
- NCTR 77 patients against plan of 45.
- Continued use of escalation capacity and critical incident periods.

GWH

- Highest ED attendances of the year.
- Critical incident status for much of June.

- Corridor care increased to 1,224 episodes.
- Occupancy significantly exceeding core bed stock; June peaked at 588 beds at midnight against core general and acute beds of 509 (115.5%).

Executive Actions: Each organisation has a clear action plan focussing on their internal trust actions, which will be presented at board in September. All organisations are working on their trajectories to return to plan. We have made the decision to establish an Acute@Home service across the group to ensure that we have acute step down capacity in place for winter. Urgent treatment centre opening at SFT in October and is expected to support circa 80-90 patients a day being pulled out of the Emergency Department and have a 4.4 % improvement on 4-hour performance. Urgent treatment centre relocation at RUH in place by January 2027 and is expected to have 9.6% improvement in 4-hour performance.

In addition to the internal actions there is also a system side improvement plan focussing on community discharge capacity, presentation and admission avoidance, and primary care capacity and returning NCTR numbers to levels originally set out in the 2026/2027 plan. As a group we are actively engaged with all partners. Delivery of financial, quality and waiting list ambitions is likely to remain constrained whilst the UEC pathway remains pressured.

4. EPR Readiness and Organisational Capacity

Whilst the position has improved and the team are actively working to mitigate risks the EPR continues to be a major strategic and delivery risk across the Group.

Shared Issues

A number of shared issues remain

- Workforce release and backfill requirements.
- Clinical leadership capacity.
- Data quality concerns.
- Operational productivity impacts during implementation.
- Competing transformation priorities.

RUH

Key concerns:

- Data quality.
- CNIO/Clinical Safety Officer capacity.
- Standardisation of Outpatient templates.
- Releasing people to undertake training

SFT

Key concerns

- Balancing operational pressure with our need to focus on getting people operationally ready for EPR
- Multiple out-of-scope requests which need evaluating.

GWH

Key concern

- Significant concern regarding organisational capacity to deliver EPR while maintaining recovery activity.

Executive Actions: The organisational risk is no longer the deployment of the EPR but how we balance leadership, clinical and operational capacity across multiple major programmes. As part of recovery planning all resources and programs across all three care organisations are being reviewed to ensure that resource is allocated against our immediate priorities. Anything outside of these will be paused to ensure all available resource is allocated to the areas that will make the biggest difference. This will be presented as part of the wider recovery plan that is focusing on immediate recovery over the next six months and a second plan around strategic change.

5. Workforce Sustainability

Workforce issues continue to affect how robust we deliver operational standards, productivity improvements and pace of transformation.

Shared Themes

A number of shared themes have been identified

- Sickness absence.
- Workforce costs – significant use of temporary staffing above total staffing plan
- Workforce reductions not occurring in line with agreed plan
- Capacity to manage significant change.
- Safe staffing.
- Staff morale and engagement

Significant Risks

RUH

- Recent birthrate plus review indicates maternity workforce gap of 21.74 WTE which represents a current deficit of 9.9% against the current funded establishment.
- Sickness absence remains above trajectory

SFT

- Staff unavailability 21.2%. This is largely driven by high rates of sickness, pregnancy related unavailability and high levels of maternity leave.
- Mandatory training and appraisal compliance below expected standard.
- Risk around HR and change management capacity.

GWH

- Balancing workforce reductions while delivering recovery plan.
- Permanent Workforce above plan by 104 WTE.
- Deterioration in staff experience metrics.

Executive actions: as part of the development of the recovery plan all workforce plans are being reviewed. Attention is being paid to temporary staffing usage and recruitment pipelines. Local action plans in place regarding addressing gaps in the required standards around sickness, mandatory training and staff experience.

6. Quality and Patient Safety Risks

Several quality risks require continued oversight.

Maternity and Neonatal Services

There are several concerns showing at each of the sites which means as a group maternal and neonatal services continue to require close scrutiny.

RUH

- Recent birthrate plus review indicates significant maternity workforce gap requiring urgent review and agreed mitigation. This is being driven by increased complexity, acuity and dependency of women. Whilst birth numbers have reduced by 5.5% since 2023, there has been a substantial increase in the proportion of women requiring high acuity care, with 76% now falling into the highest risk categories compared to 63% in 2023.

SFT

- Escalated risk relating to lack of dedicated second obstetric theatre.
- Ongoing compliance concerns regarding neonatal workforce; neonatal medical workforce is not compliant with British Association of Perinatal Medicine (BAPM)

medical staffing ratios/standards (2022 - updated 2026). A Neonatal workforce review and business case are due to be completed.

GWH

- Solution for accommodation of the maternity triage service has still not been resolved, thereby compromising our ability to meet the required standards effectively.
- Ongoing compliance concerns regarding neonatal workforce.

Executive Action – Chief Nursing Officers are working together to develop an overarching ambition for maternity and neonatal services across the group. As part of local mitigation plans, they are actively sharing learning to ensure we move towards consistency in approach around service delivery and experience.

Infection Prevention and Control

Most significant concern at RUH:

- Outlier position for C. difficile and E. coli infection rates within the South West. The causes are considered multifactorial, and a programme of targeted quality improvement workstreams is in place to improve performance. Ribotyping findings indicate limited evidence of nosocomial transmission.

Executive Action – At the request of the RUH Chief Nursing Officer, the NHS England South West regional IPC team will undertake an external review on 3 September.

End of Life Care

- RUH reporting significant sustainability concerns within the current end-of-life care model, with demand exceeding available capacity and limiting organisational resilience and assurance. A key risk is insufficient medical capacity, alongside broader workforce and service pressures. A clear investment case is therefore required to demonstrate how capacity, workforce and long-term service sustainability will be addressed and to provide the level of assurance expected by the CQC.

Executive Action – Work is underway with Dorothy House to review the current model of care and explore a sustainable future model across RUH and the wider health and care system. In parallel, RUH is reviewing the future multiprofessional workforce model required to support safe, resilient and sustainable service delivery.

CQC

- SFT overall location rating revised to Requires Improvement following publication of inspection findings and rating recalculation.

7. Areas of Positive Assurance

Despite pressures, all three organisations report improvement across several areas.

Planned Care and Diagnostics

- RUH diagnostics and RTT recovery continue ahead of trajectory.
- SFT RTT performance improving and ahead of plan
- SFT cancer performance achieved plan and backlog continues to reduce.
- GWH elective activity showing signs of improvement.
- GWH diagnostic performance remains strong

Executive action – all organisations have action plans in place to ensure that RTT, Diagnostics and Cancer performance are delivered in line with 2026/2027 plan

Governance and Group Maturity

- New care organisation governance structures have commenced across our group and all three care organisations.
- All care organisations reported improved risk visibility and triangulation.

Executive Action: GWH have undertaken an effectiveness review of the first cycle of meetings at care organisation. Learning will be shared and adopted as needed at all three sites. Full external governance review being planned for December to ensure that we can test the framework and make any amendments for the new financial year

Group Working

Continued progress on:

- Group elective transformation programme. A detailed elective transformation delivery plan is to be introduced to the Group Board in October by Nick Johnson (SRO) and Simon Sethi. This briefing will include updates on Advice and Guidance expansion, and Elective Referral Centre development.
- Leadership development alignment. A refreshed leadership development programme is being designed to address priorities for the next 6 – 12 months. A programme summary will be introduced by Jude Gray, CPO, at the October Group Board.
- Commercial programme development (SRO John Palmer): a detailed proposal is included in September 3rd Group Board papers.

Summary

The most significant strategic risk across the Group is no longer any single performance metric but the combined impact of operational pressure, financial recovery, EPR implementation, workforce constraints and organisational change competing for the same leadership and delivery capacity. While each of the sites are demonstrating progress in diagnostics, elective recovery and governance maturity, the ability to sustain improvement will depend on addressing UEC, financial sustainability, workforce resilience and EPR readiness at both Group, organisational and where relevant system level. Our predominant focus remains around what we must do as a group and at organisation level rather than focussing purely on external solutions.

Close.

BSW Hospitals Group Board

Agenda item	Integrated Performance Report. Item 4.2
Report title	Group Integrated Performance Report
Date of meeting	3 September 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

☒ 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 June 2026 IPR presents a mixed position rather than a single improving Group trajectory. Elective access remains ahead of trajectory at RUH and SFT, ambulance handover continues to improve, SHMI is within the expected range at all three Trusts and no healthcare-associated MRSA was reported. However, deterioration or unresolved risk remains evident in GWH: RTT, urgent and emergency care flow, NCTR and discharge delays; RUH: C. difficile; SFT: pressure ulcers and staffing resilience, and the affordability implications of vacancy and establishment positions. The Board should triangulate these

signals with care organisation escalation reports and seek explicit recovery trajectories, owners and dates where the IPR currently describes actions without demonstrating impact.

RECOMMENDATION

The Board is asked to:
• Receive the June 2026 Group IPR and note the mixed assurance position.
• Seek focused assurance on GWH elective recovery, UEC flow/NCTR, RUH C. difficile, SFT pressure ulcers and CHPPD, and workforce affordability.

APPENDICES

BSW Group Integrated Performance Report, August 2026 (June 2026 data)	

Purpose

The purpose of this paper is to provide a triangulated, exception-based assessment of Group performance in June 2026, read across to risks raised. It distinguishes sustained improvement from isolated in-month movement, identifies deterioration and unresolved risks, and highlights material omissions that limit assurance.

Executive summary

The IPR evidences improvement in several important areas, but does not yet demonstrate that the principal operational and workforce risks are reducing consistently across the Group. The strongest positive signals are ambulance handover, SHMI, MRSA, GWH diagnostics and the continued elective position at RUH and SFT. The most material adverse signals are GWH RTT and long waits, UEC flow and NCTR, RUH C. difficile, SFT pressure ulcers and staffing resilience, and workforce establishment/affordability misalignment.

Alert, advise, assure

Status	Evidence and read-across
ALERT	GWH RTT 18-week performance reduced to 56.7% and remained below plan; 1,091 patients were waiting over 52 weeks, 17 more than in May and substantially above the plan of 361. This is consistent with previous governance escalation that GWH remained off trajectory and required additional support.
ALERT	UEC remains a Group-wide risk. No Trust is delivering the planned four-hour position; two care organisations deteriorated on 12-hour waits; NCTR remains the most significant system challenge; and SFT continues to experience the longest P1-3 delays. Improved ambulance handover has not yet translated into reliable whole-pathway flow.
ALERT	RUH reported 15 C. difficile cases in June with no clear cause identified. The position has deteriorated despite established IPC controls and case review.
ALERT	SFT hospital-acquired pressure ulcers increased from 2.07 to 3.79 per 1,000 occupied bed days; MASD also increased. SFT CHPPD remained under pressure, with unfilled shifts and high ETOC demand.
ADVISE	Workforce signals require cautious interpretation. RUH remained over-recruited by 92 WTE, GWH reported 249 WTE vacancies however this figure does not take full account of CIP targets and is therefore unaffordable, and SFT moved to a low vacancy position following an establishment reset. Low voluntary turnover may constrain planned workforce reduction.
ASSURE	SHMI is statistically within the expected range at all three Trusts. No healthcare-associated MRSA was reported in June. GWH DM01 improved to 93.5%, and ambulance handovers continued to improve across the Group. RUH reduced its 52-week cohort, while RUH and SFT remained ahead of RTT trajectory.

Direction of travel by domain

Domain	Assessment	Evidence of improvement/deterioration	Read-across to governance risk
Elective access	**Mixed / deteriorating at GWH**	RUH and SFT remained ahead of trajectory, but both had some in-month weakening. GWH 18-week flat and its 52-week cohort rose.	Confirms prior concern that GWH recovery is not yet secure. IPR signals credible action, but evidence of impact is not yet demonstrated.
Diagnostics	**Improving but fragile**	Group DM01 was 89.5%; GWH recovered to 93.5%. RUH and SFT remain affected by modality-specific workforce and capacity constraints.	Workforce gaps and CDC funding/capacity dependencies remain active delivery risks.
Cancer	**Improving in part, below standard overall**	Group 62-day performance improved to 70.1% in May and SFT achieved 75.1%; 28-day performance remained below standard at Group level.	Recovery remains dependent on outpatient, diagnostic, reporting and workforce capacity in vulnerable pathways.
Urgent and emergency care	**No sustained Group improvement**	Ambulance handover improved, but four-hour delivery remained off plan, 12-hour waits deteriorated in two care organisations, and NCTR/discharge delays persisted.	Consistent with governance escalation on corridor care, system flow and community capacity. Improvement at one interface has not resolved pathway-wide risk.
IPC	**Mixed, with deterioration at RUH**	MRSA remained at zero and GWH/SFT C. difficile was stable, but RUH reported 15 C. difficile cases and E. coli remained above	Controls are described, but efficacy is not consistently evidenced. RUH C. difficile requires stronger exception reporting.

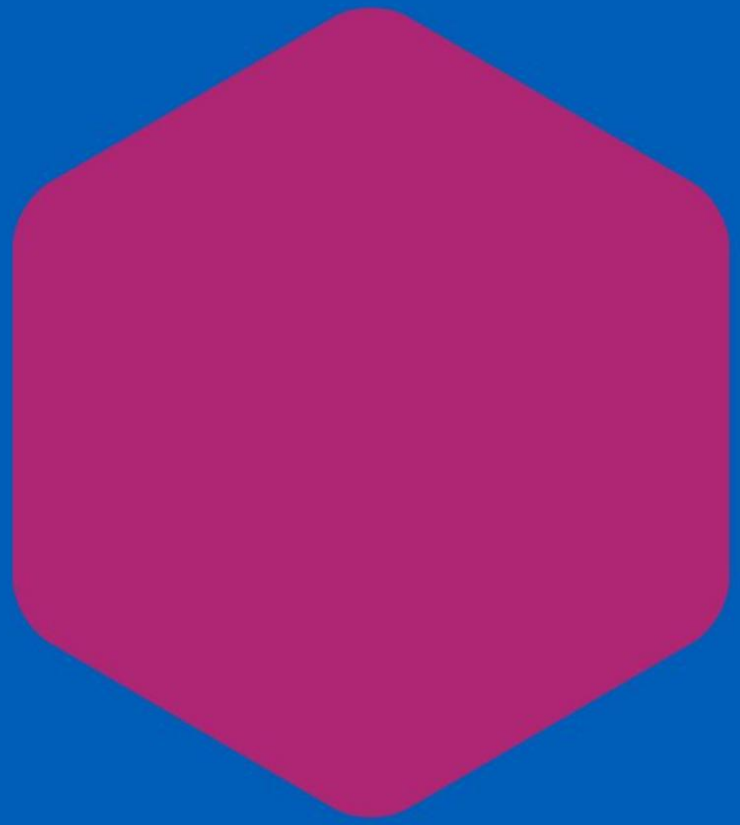
		trajectory/South West average.	
Patient safety and staffing	**Mixed / deteriorating at SFT**	Falls remained better than national average overall, although data definitions differ. SFT pressure ulcers and MASD increased; CHPPD and ETOC demand remained pressured.	Supports prior concerns about operational pressure, escalation capacity, sickness and safe staffing resilience.
Workforce	**Improving sickness, affordability unresolved**	RUH sickness improved over five months. Vacancy and turnover signals are distorted by establishment resets, and CIP methodology.	The IPR does not yet provide sufficient assurance that workforce movement is aligned to financial recovery or safe staffing requirements.
Mortality	**Assured**	All three Trusts remained statistically within the expected SHMI range.	Consistent coding and reporting remain important controls.

BSW HOSPITALS GROUP

NHS

BSW Group Integrated Performance Report

August 2026 (June 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			Jun-26	4				Common Cause Variation
MSSA	GWH			Jun-26	3				Common Cause Variation
MSSA	RUH			Jun-26	1				Common Cause Variation
MSSA	SFT			Jun-26	0				Common Cause Variation
MRSA	Group			Jun-26	0				Common Cause Variation
MRSA	GWH			Jun-26	0				Common Cause Variation
MRSA	RUH			Jun-26	0				Special Cause Improving - Below Lower Control Limit
MRSA	SFT			Jun-26	0				Common Cause Variation
Ecoli	Group			Jun-26	23				Common Cause Variation
Ecoli	GWH			Jun-26	12				Special Cause Concerning - Run Above Mean
Ecoli	RUH			Jun-26	10				Common Cause Variation
Ecoli	SFT			Jun-26	1				Common Cause Variation
Cdiff	Group			Jun-26	23				Common Cause Variation
Cdiff	GWH			Jun-26	6				Special Cause Concerning - Run Above Mean
Cdiff	RUH			Jun-26	15				Common Cause Variation
Cdiff	SFT			Jun-26	2				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		Jun-26	63.1%				Common Cause Variation
ED 4 Hour Performance	GWH	All Types	78.0%	Jun-26	65.0%	✗			Special Cause Concerning - Below Lower Control Limit
ED 4 Hour Performance	RUH	All Types	72.0%	Jun-26	57.8%	✗			Common Cause Variation
ED 4 Hour Performance	SFT	All Types	76.1%	Jun-26	66.3%	✗			Common Cause Variation
ED 12 Hour Performance	Group	Type 1 and Type 2 attendances		Jun-26	13.7%				Special Cause Concerning - Two Out of Three High
ED 12 Hour Performance	GWH	Type 1 and Type 2 attendances	13.0%	Jun-26	15.3%	✗			Common Cause Variation
ED 12 Hour Performance	RUH	Type 1 and Type 2 attendances	0.0%	Jun-26	11.3%	✗			Special Cause Concerning - Two Out of Three High
ED 12 Hour Performance	SFT	Type 1 and Type 2 attendances	5.7%	Jun-26	15.6%	✗			Special Cause Concerning - Above Upper Control Limit
Cancer 62 Day Performance	Group			May-26	70.1%				Common Cause Variation
Cancer 62 Day Performance	GWH		76.0%	May-26	64.5%	✗			Common Cause Variation
Cancer 62 Day Performance	RUH		75.0%	May-26	70.9%	✗			Common Cause Variation
Cancer 62 Day Performance	SFT		78.9%	May-26	73.9%	✗			Common Cause Variation
Cancer 28 Day Performance	Group			May-26	75.3%				Common Cause Variation
Cancer 28 Day Performance	GWH		81.0%	May-26	67.3%	✗			Common Cause Variation
Cancer 28 Day Performance	RUH		75.0%	May-26	79.0%	✓			Special Cause Improving - Two Out of Three High
Cancer 28 Day Performance	SFT		80.0%	May-26	78.7%	✗			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
RTT wait times top versus bottom quintile of social deprivation	GWH			Jun-26	-2.0%				Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	RUH		0.0%	Jun-26	-3.2%	✗			Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	SFT		0.0%	Jun-26	-3.8%	✗			Common Cause Variation
RTT 18 week %	Group			Jun-26	65.7%				Special Cause Improving - Above Upper Control Limit
RTT 18 week %	GWH		60.0%	Jun-26	56.7%	✗			Special Cause Concerning - Below Lower Control Limit
RTT 18 week %	RUH		67.7%	Jun-26	70.4%	✓			Special Cause Improving - Above Upper Control Limit
RTT 18 week %	SFT		65.0%	Jun-26	72.5%	✓			Special Cause Improving - Above Upper Control Limit
RTT % Over 52 Weeks	Group			Jun-26	1.2%				Special Cause Improving - Run Below Mean
RTT % Over 52 Weeks	GWH		1.0%	Jun-26	2.6%	✗			Special Cause Concerning - Increasing Run
RTT % Over 52 Weeks	RUH		1.0%	Jun-26	0.3%	✓			Special Cause Improving - Decreasing Run
RTT % Over 52 Weeks	SFT		0.0%	Jun-26	0.3%	✗			Special Cause Improving - Below Lower Control Limit
DM01 Performance	Group			Jun-26	89.5%				Special Cause Improving - Above Upper Control Limit
DM01 Performance	GWH		99.0%	Jun-26	93.5%	✗			Special Cause Improving - Two Out of Three High
DM01 Performance	RUH		99.0%	Jun-26	88.2%	✗			Special Cause Improving - Above Upper Control Limit
DM01 Performance	SFT		87.0%	Jun-26	86.2%	✗			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
% of NCTR	Group			Jun-26	20.3%				Common Cause Variation
% of NCTR	GWH			Jun-26	20.6%				Common Cause Variation
% of NCTR	RUH			Jun-26	21.8%				Special Cause Concerning - Two Out of Three High
% of NCTR	SFT			Jun-26	18.4%				Common Cause Variation
Average days between discharge ready date and discharge date	Group			Jun-26	2.1				Special Cause Concerning - Above Upper Control Limit
Average days between discharge ready date and discharge date	GWH			Jun-26	2.7				Common Cause Variation
Average days between discharge ready date and discharge date	RUH			Jun-26	3.3				Common Cause Variation
Average days between discharge ready date and discharge date	SFT			Jun-26	0.5				Special Cause Concerning - Above Upper Control Limit
Average handover time	Group	Minutes		Jun-26	55				Special Cause Improving - Run Below Mean
Average handover time	GWH	Minutes		Jun-26	68				Special Cause Improving - Run Below Mean
Average handover time	RUH	Minutes	30	Jun-26	53	✗			Common Cause Variation
Average handover time	SFT	Minutes	20	Jun-26	37	✗			Special Cause Concerning - Above Upper Control Limit
Average LoS	Group			Jun-26	7.6				Common Cause Variation
Average LoS	GWH			Jun-26	6.8				Common Cause Variation
Average LoS	RUH			Jun-26	9.2				Common Cause Variation
Average LoS	SFT			Jun-26	7.1				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
SHMI	GWH	Summary Hospital-level Mortality Indicator		Feb-26	100.3%				Special Cause Improving - Run Below Mean
SHMI	RUH	Summary Hospital-level Mortality Indicator		Feb-26	89.3%				Special Cause Improving - Below Lower Control Limit
SHMI	SFT	Summary Hospital-level Mortality Indicator		Feb-26	91.9%				Special Cause Improving - Two Out of Three Low
Pressure Ulcers per 1000 beddays	Group	Category 2/3/4, excluding specialist areas		Jun-26	1.4				Common Cause Variation
Pressure Ulcers per 1000 beddays	GWH	Category 2/3/4, excluding specialist areas		Jun-26	0.4				Common Cause Variation
Pressure Ulcers per 1000 beddays	RUH	Category 2/3/4, excluding specialist areas		Jun-26	0.7				Special Cause Concerning - Two Out of Three High
Pressure Ulcers per 1000 beddays	SFT	Category 2/3/4, excluding specialist areas		Jun-26	3.8				Common Cause Variation
Care Hours per Patient Day (CHPPD)	Group			Jun-26	8.8				Common Cause Variation
Care Hours per Patient Day (CHPPD)	GWH			Jun-26	9.3				Common Cause Variation
Care Hours per Patient Day (CHPPD)	RUH			Jun-26	8.4				Common Cause Variation
Care Hours per Patient Day (CHPPD)	SFT			Jun-26	7.7				Common Cause Variation
Falls per 1000 bed days	Group			Jun-26	6.5				Common Cause Variation
Falls per 1000 bed days	GWH			Jun-26	4.8				Special Cause Improving - Run Below Mean
Falls per 1000 bed days	RUH			Jun-26	7.7				Common Cause Variation
Falls per 1000 bed days	SFT		7.0	Jun-26	7.7	X			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%	Jun-26	4.3%	✓			Special Cause Concerning - Above Upper Control Limit
Vacancy Rate	RUH		4.0%	Jun-26	-1.1%	✓			Special Cause Improving - Below Lower Control Limit
Vacancy Rate	SFT		5.0%	Jun-26	0.6%	✓			Special Cause Concerning - Above Upper Control Limit
% Voluntary Turnover	Group			May-26	7.03%				Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	GWH		13.00%	May-26	6.86%	✓			Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	RUH			May-26	5.18%				Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	SFT			May-26	9.72%				Special Cause Improving - Below Lower Control Limit
% Sickness	Group			May-26					
% Sickness	GWH		4.00%	May-26	4.38%	✗			Common Cause Variation
% Sickness	RUH		4.70%	May-26	5.16%	✗			Special Cause Improving - Decreasing Run
% Sickness	SFT		3.00%	May-26	3.90%	✗			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
Neonatal Deaths per 1000 Births	Group			Jun-26	1.1				Common Cause Variation
Neonatal Deaths per 1000 Births	GWH			Jun-26	0.0				Special Cause Improving - Below Lower Control Limit
Neonatal Deaths per 1000 Births	RUH			Jun-26	2.6				Special Cause Concerning - Two Out of Three High
Neonatal Deaths per 1000 Births	SFT			Jun-26	0.0				Special Cause Improving - Below Lower Control Limit
Stillbirths per 1000 Births	Group			Jun-26	2.2				Common Cause Variation
Stillbirths per 1000 Births	GWH			Jun-26	0.0				Common Cause Variation
Stillbirths per 1000 Births	RUH			Jun-26	2.6				Common Cause Variation
Stillbirths per 1000 Births	SFT			Jun-26	5.6				Special Cause Concerning - Run Above Mean

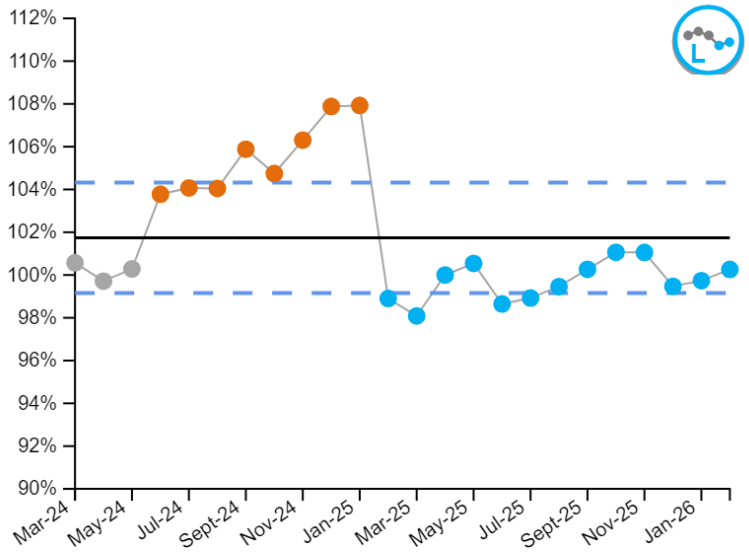
BSW Group Scorecard

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	Group			Jun-26	12.04				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	GWH			Jun-26	6.77				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	RUH			Jun-26	0.00				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	SFT			Jun-26	5.27				
Average Daily Number of Patients in Corridor Care within ED	Group			Jun-26	52.70				
Average Daily Number of Patients in Corridor Care within ED	GWH			Jun-26	23.00				
Average Daily Number of Patients in Corridor Care within ED	RUH			Jun-26	19.57				
Average Daily Number of Patients in Corridor Care within ED	SFT			Jun-26	10.14				

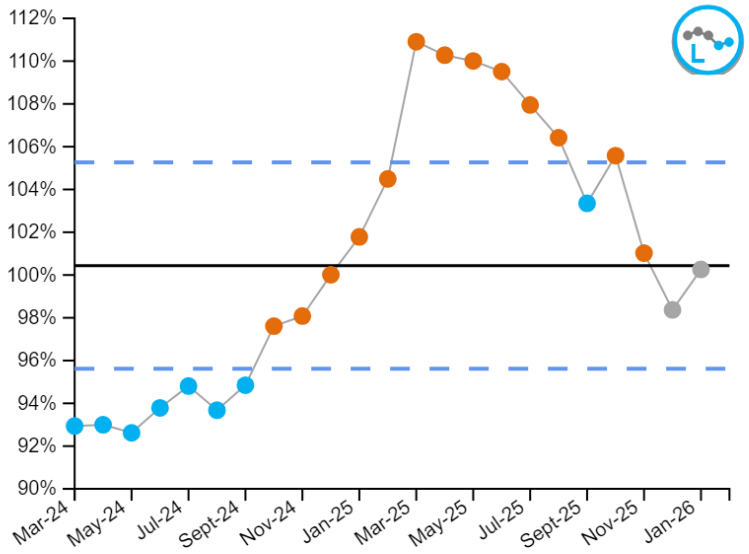
SHMI

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

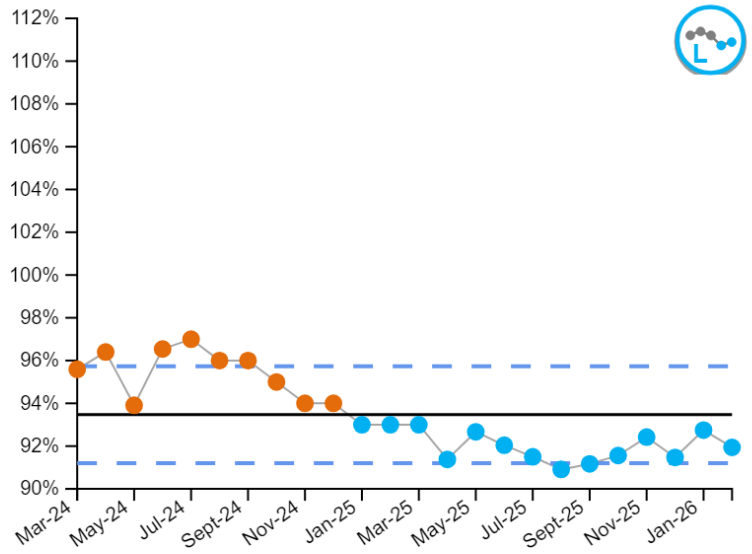
SHMI - GWH



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		Feb-26	100.3%				Special Cause Improving - Run Below Mean
SHMI	RUH	Summary Hospital-level Mortality Indicator		Feb-26	89.3%				Special Cause Improving - Below Lower Control Limit
SHMI	SFT	Summary Hospital-level Mortality Indicator		Feb-26	91.9%				Special Cause Improving - Two Out of Three Low

Understanding Performance

Each of the 3 Acute Trust's SHMI remain statistically within the expected range according to data published by NHSE.

RUH – The latest SHMI data publication covers the period from 1 March 2025 to 28 February 2026. This shows the trust to be 'as expected'. No concerns have been identified through other mortality surveillance processes. The RUH is no longer identified on the national SHMI report as having a high percentage of invalid codes.

GWH - The latest SHMI data publication covers the period Jan 2025 to Dec 2025. This shows the Trust to be 'As Expected'.

SFT – The SHMI is also statistically 'As Expected,' and is below the mean average. There have been a consistent downward (positive) trajectory over the past 12-18 months.

Countermeasures

Collectively, a series of development sessions to review current Power-Bi capabilities and opportunities were recently established to help align internal data reporting and methodologies.

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 2 trusts continue to work together to support the implementation and launch this through sharing learning and experience

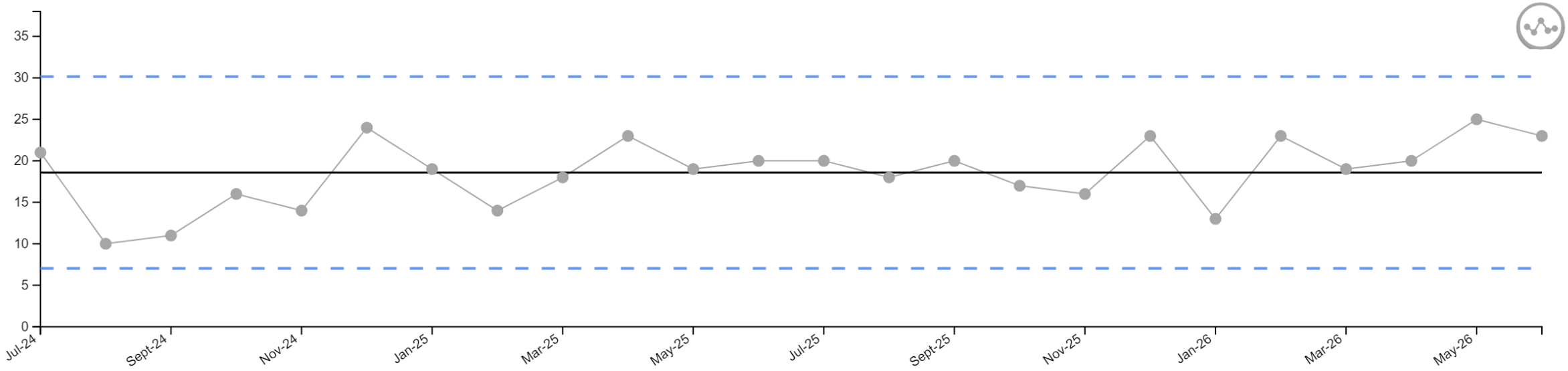
Risks and Mitigation

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 might transition into a single cluster mortality group as BSW ICB are now in a cluster with Somerset and Dorset. Local mortality leads are to be consulted on this.

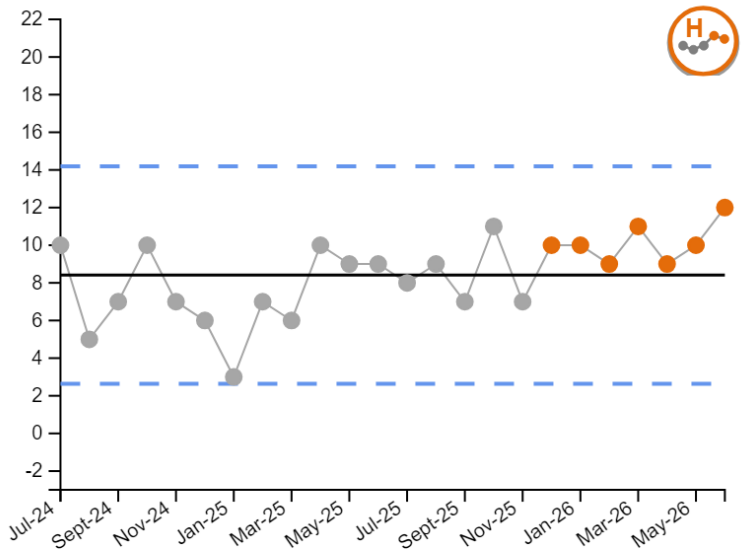
The SHMI data published by NHS Digital will continue to be reviewed regularly by each of the hospital mortality teams, and this will help to mitigate the withdraw from our reporting of HSMR+ (which was previously generated by Dr Foster). The combination of improving our internal reporting, development 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

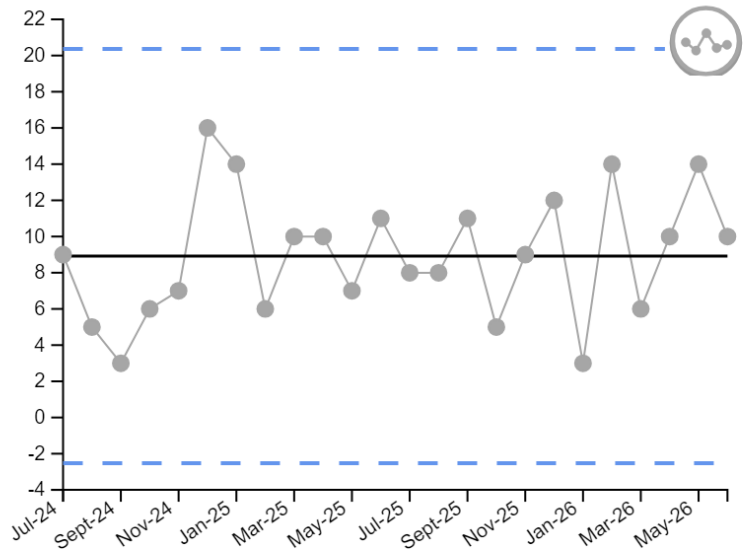
Ecoli - Group



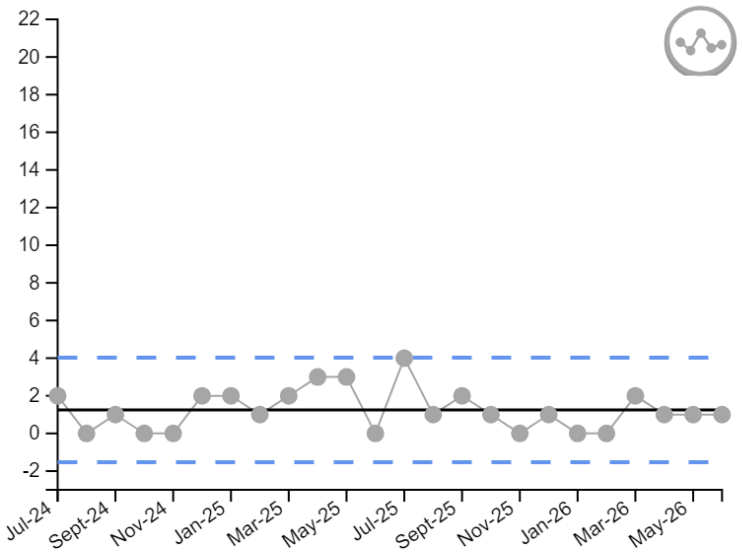
Ecoli - GWH



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			Jun-26	23				Common Cause Variation
Ecoli	GWH			Jun-26	12			H	Special Cause Concerning - Run Above Mean
Ecoli	RUH			Jun-26	10				Common Cause Variation
Ecoli	SFT			Jun-26	1				Common Cause Variation

Understanding Performance

Group: E. coli bloodstream infections remain above trajectory and the South West average across the Group, with performance primarily influenced by higher case numbers at GWH and RUH. Although variation persists between organisations, the overall position remains consistent with common cause variation.
GWH: E. coli bloodstream infections increased by three cases in month. Whilst variation remains within expected limits overall, UTI's remain the leading primary source of infection , however reviews have identified emerging theme skin, soft tissue infections, wounds and ulcers as a recurring contributory factor. Further work is underway to better understand causation and identify opportunities for targeted improvement.
SFT: There has been one Hospital Onset Healthcare Associated (HOHA) reportable *E.coli* bloodstream infection (BSIs), the same as last month.
RUH: Urinary tract sources remain the leading contributor to E coli infections and linked to acute infection onset.

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: Existing IPC workstreams continue, including catheter care, hand hygiene, antimicrobial stewardship, and cleaning and decontamination of patient care equipment.
Collaborative work with Tissue Viability colleagues is being strengthened to review the emerging theme around skin, wound and ulcer-related sources of infection and identify additional preventative action.
SFT: Catheter care improvement remains a priority through targeted education and support delivered by 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. Improving blood culture and sepsis management. Target patients with diarrhoea illnesses to prevent dehydration by ensuring optimum fluid management.

Risks and Mitigation

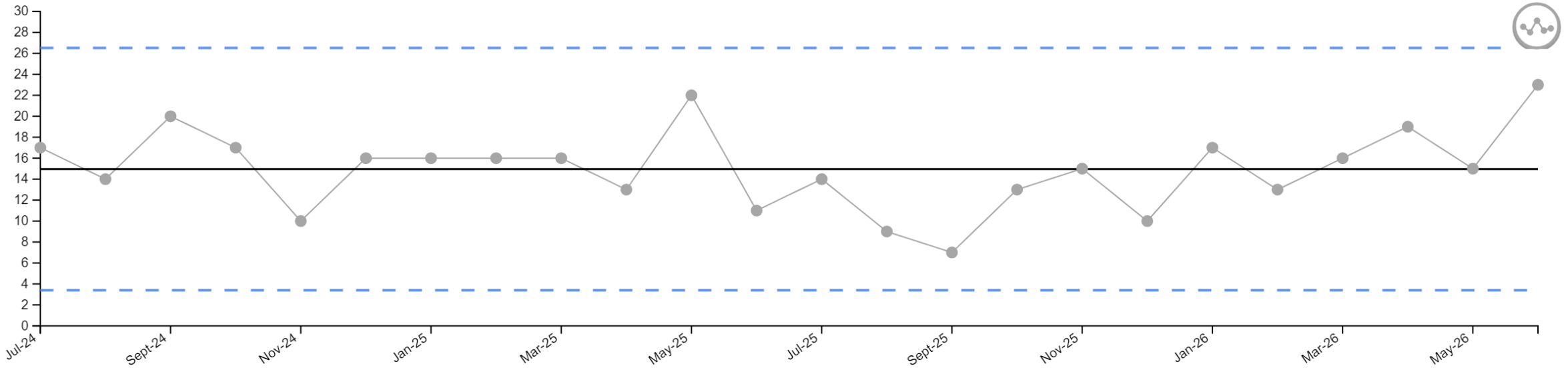
GWH: The Trust remains above the South West regional average for E. coli bloodstream infections. There is a risk that underlying contributory factors associated with skin integrity and wound management continue to drive infection rates. This is being mitigated through enhanced case review, multidisciplinary oversight and continued monitoring through IPC governance structures.

SFT: The Trust continues to undertake catheter management audits, with timely interventions implemented to address identified gaps and strengthen the quality and consistency of care.

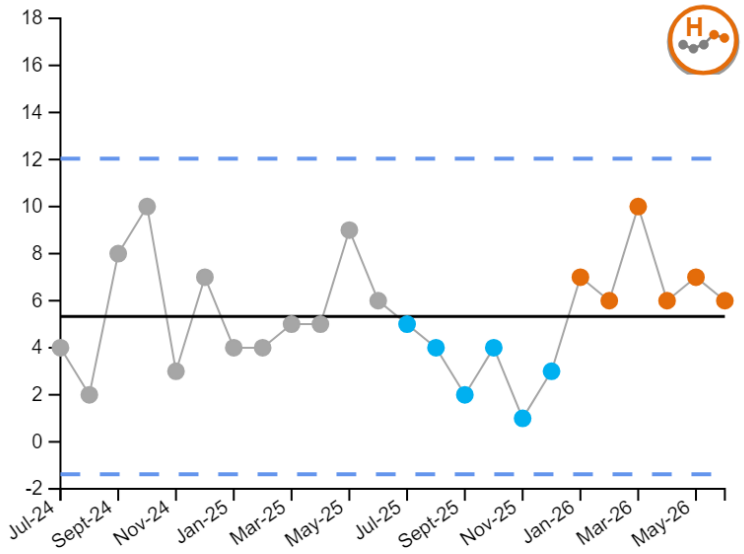
RUH: E. coli numbers continue to rise, despite hydration interventions. Further interventions to include community partners via the BSW IPC collaborative to drive effective UTI management pathways and UTI prevention.

Cdiff

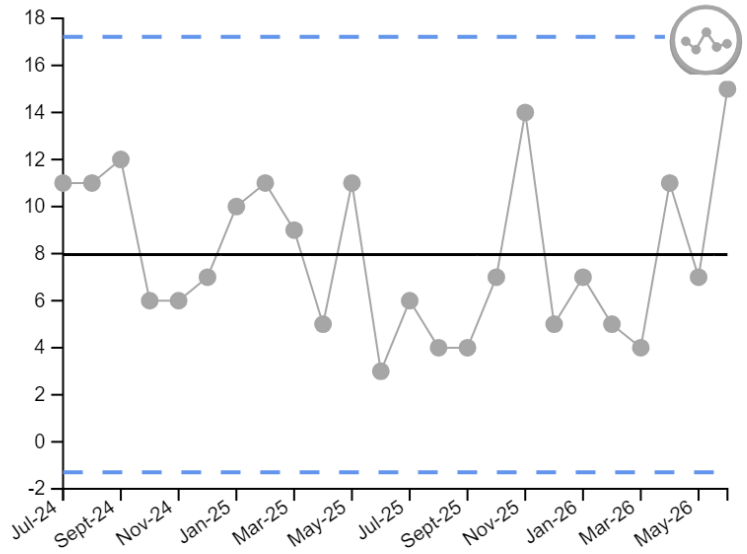
Cdiff - Group



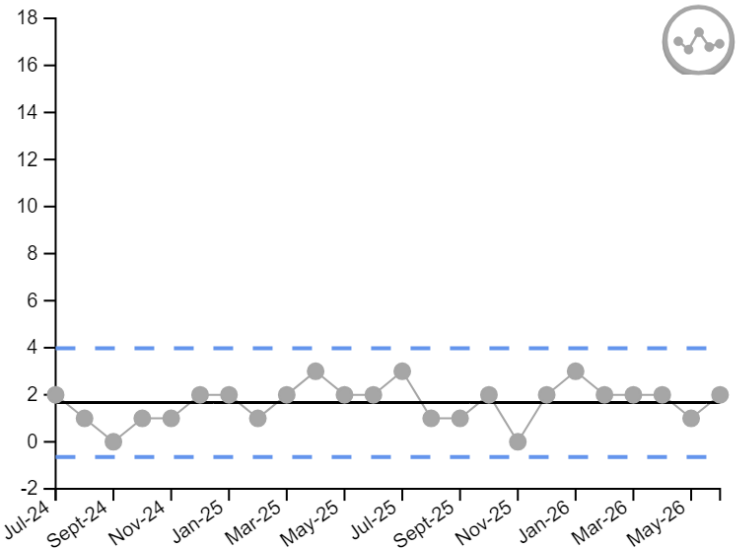
Cdiff - GWH



Cdiff - RUH



Cdiff - SFT



Cdiff

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
Cdiff	Group			Jun-26	23				Common Cause Variation
Cdiff	GWH			Jun-26	6			H	Special Cause Concerning - Run Above Mean
Cdiff	RUH			Jun-26	15				Common Cause Variation
Cdiff	SFT			Jun-26	2				Common Cause Variation

Understanding Performance

Group: C. difficile performance continues to demonstrate month-on-month variation across the Group, with higher case numbers reported at RUH and lower, stable levels at GWH and SFT. Overall variation remains consistent with common cause and no single recurring source has been identified across the Group.
GWH: C. difficile cases reduced in month and remain below the South West regional average. Whilst month-to-month variation continues to be seen, overall performance remains stable with no emerging themes or deterioration identified.
SFT: Two hospital-onset healthcare-associated (HOHA) C. difficile cases reported in June, consistent with the previous two months and remaining within expected common cause variation.
RUH: There has been a notable increase in infection rates, 15 cases in June; with no clear underlying cause identified at this stage. Further analysis has not identified any specific causation.

Countermeasures

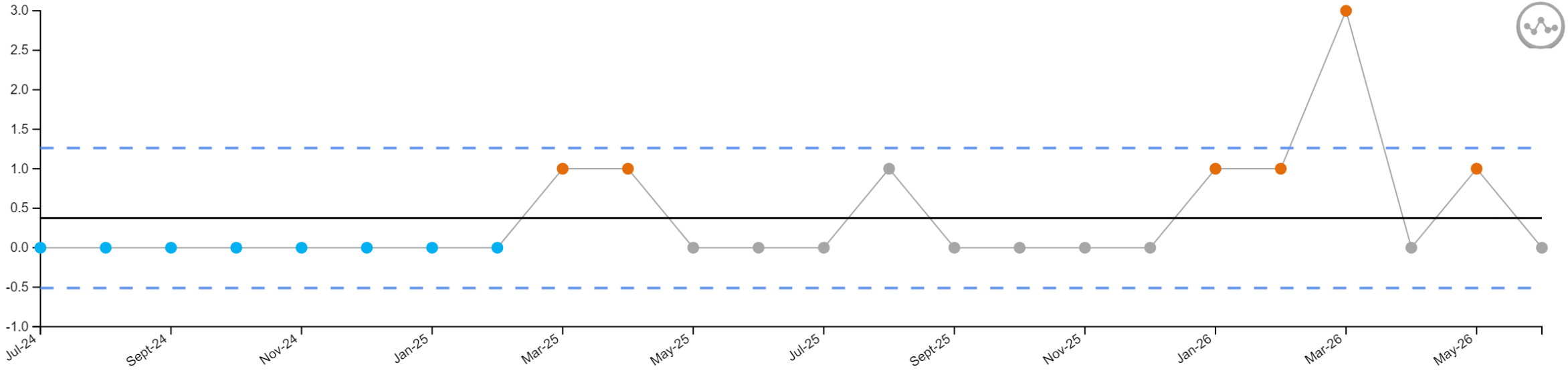
Group: BSW-wide IPC and antimicrobial stewardship workstreams continue to support improvement through optimised prescribing, enhanced environmental cleanliness, case review, and shared organisational learning. Trusts continue to strengthen surveillance, multidisciplinary review processes and local action plans to identify themes and drive reduction in infection rates.
GWH: IPC improvement work continues to focus on antimicrobial stewardship, hand hygiene, environmental cleanliness, and the cleaning and decontamination of patient care equipment. These actions are supported through established infection prevention workstreams and ongoing surveillance of all cases.
SFT: Reviews of C. difficile cases continue, identifying any lapses in care, with divisions monitored through action plans and regular reporting to the IPC Working Group. This is supported by ongoing multidisciplinary C. difficile virtual ward rounds led by the Infection Control Doctor to strengthen oversight, learning and improvement.
RUH: This has triggered periods of increase incidence when the criteria is met. IPC reviews continue to identify co morbidities and patient vulnerabilities with co-infection. Typing has not identified any evidence of cross infection. Commode cleanliness spot checks have demonstrated high standards.

Risks and Mitigation

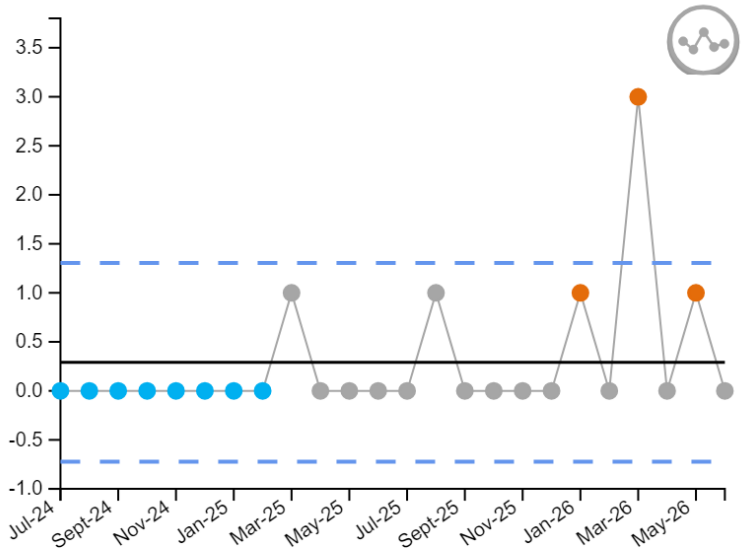
GWH: There remains a risk of ongoing variation associated with patient complexity and healthcare-associated infection factors. This is being mitigated through routine case review, IPC oversight, antimicrobial stewardship, and continued monitoring through Trust governance processes.
SFT: Risks relating to increased reportable HCAIs, delays in investigations and action plan completion, and inconsistent IPC improvement are closely monitored through divisional and IPC governance processes, with mitigations including enhanced oversight, action plan monitoring, and escalation of overdue investigations to support timely learning and continuous improvement in patient outcomes.
RUH: The high number of C.difficile cases at the start of Q1 is of concern, with no specific causative risk identified. Cases have been distributed across the wards, no cross infection identified though typing. The impact of HOCL vapour cleaning as a discharge clean is currently under review.

MRSA

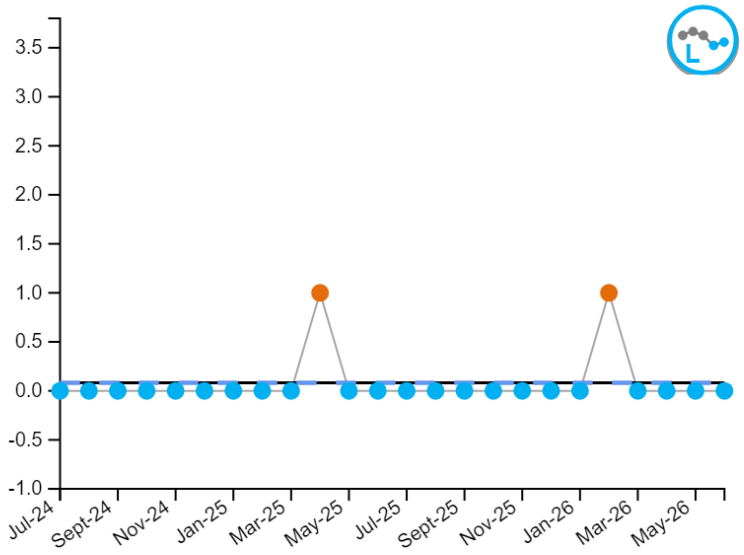
MRSA - Group



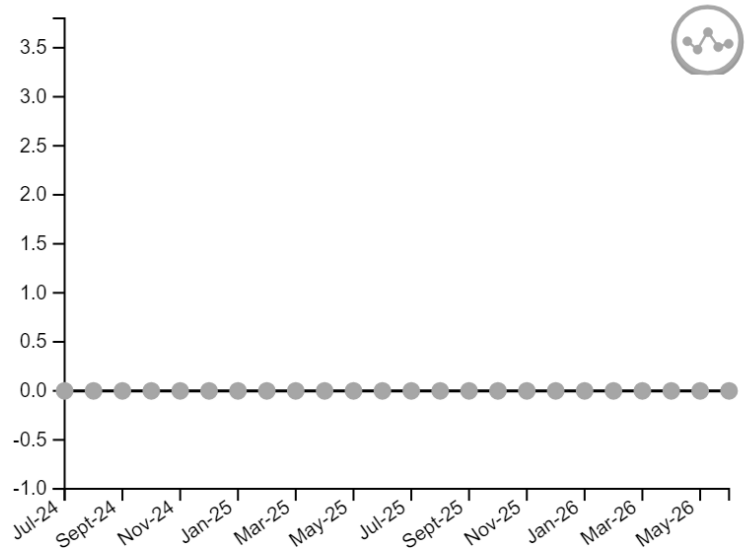
MRSA - GWH



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			Jun-26	0				Common Cause Variation
MRSA	GWH			Jun-26	0				Common Cause Variation
MRSA	RUH			Jun-26	0				Special Cause Improving - Below Lower Control Limit
MRSA	SFT			Jun-26	0				Common Cause Variation

Understanding Performance

Group: No MRSA cases reported across the Group at the beginning of the reporting year.

GWH: There was no healthcare associated methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia reported during June 2026.

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

RUH: There was no healthcare associated MRSA bacteraemia reported during June 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 where required to identify learning and maintain good practice.

SFT: Continued monitoring and escalation of cases.

RUH: Workstreams continue to focus MRSA high risk screening on admission, reducing the inappropriate use of gloves and empower clinical staff in departments to select the correct PPE. Improving blood culture and sepsis management.

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.

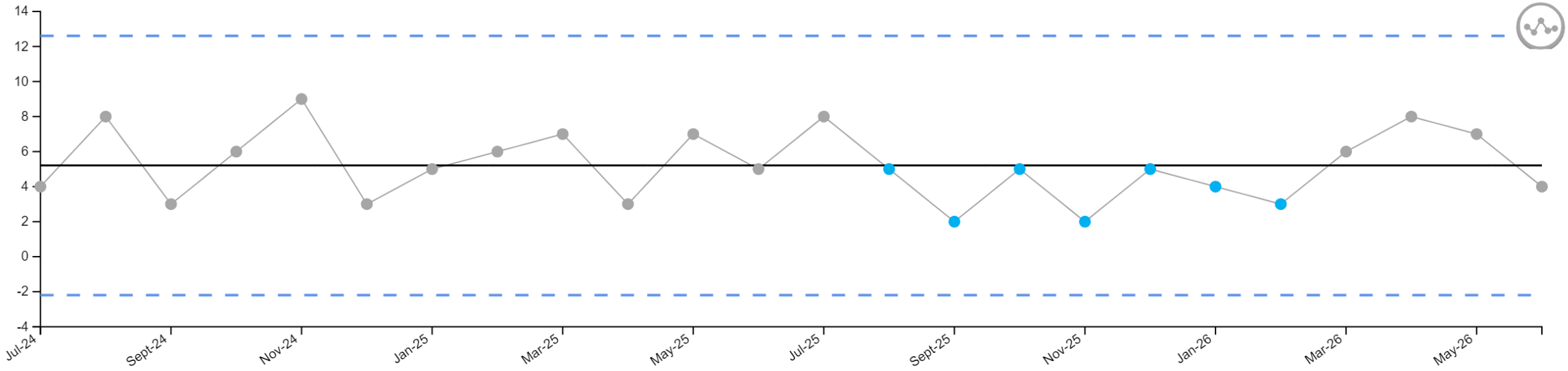
GWH: The Trust continues to maintain vigilance, monitoring and staff awareness activities to minimise the risk of healthcare-associated infection and sustain current performance.

SFT: Targeted IPC audits, peer reviews, ward visits and staff education continue to provide assurance that controls are in place to maintain current performance and support continuous improvement.

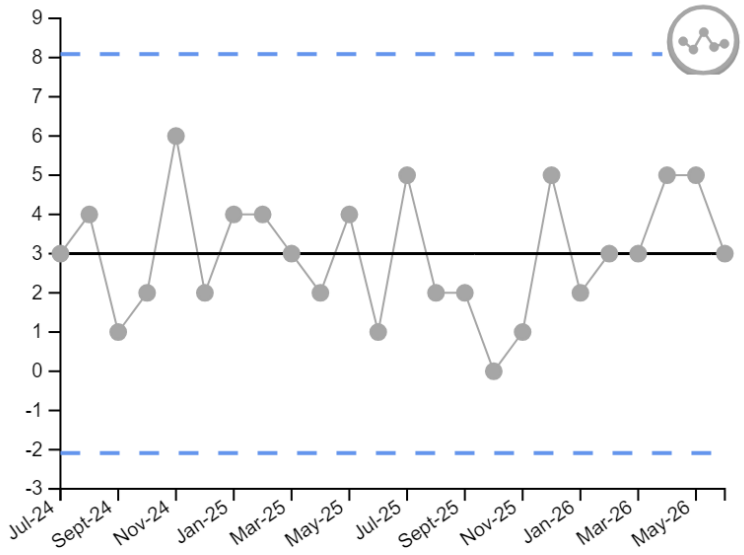
RUH: IPC & the QI team are jointly leading the delivery of six core quality standards, designed to provide a holistic and system-wide impact on patient outcomes.

MSSA

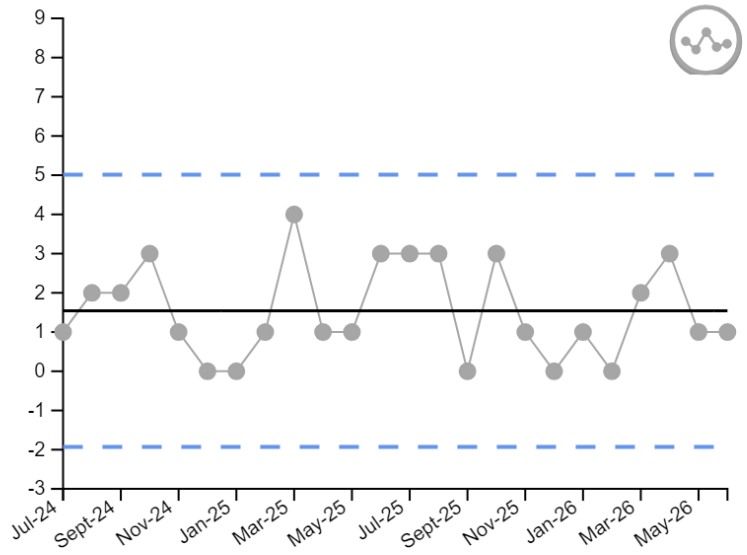
MSSA - Group



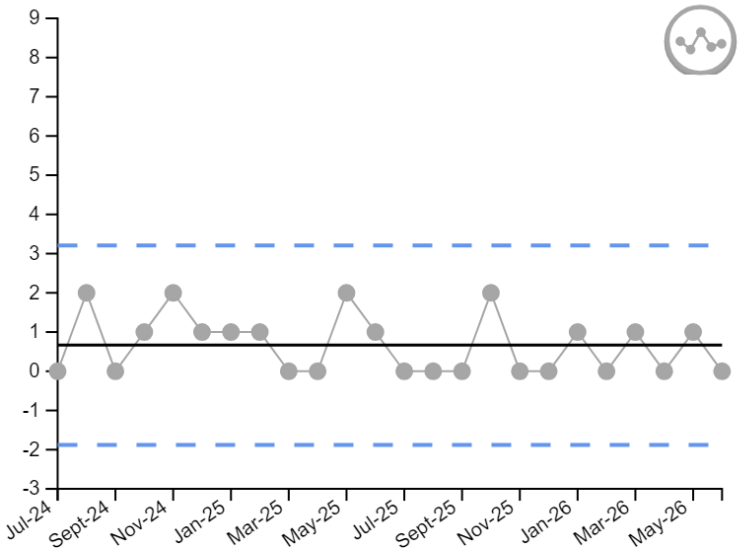
MSSA - GWH



MSSA - RUH



MSSA - SFT



MSSA

Metric	Trust	Metric Description	Local Year-End Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
MSSA	Group			Jun-26	4				Common Cause Variation
MSSA	GWH			Jun-26	3				Common Cause Variation
MSSA	RUH			Jun-26	1				Common Cause Variation
MSSA	SFT			Jun-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 June 2026. Overall variation remains within expected limits and is consistent with common cause variation.

GWH: MSSA bloodstream infections reduced in June 2026to 3.

SFT: There was 0 MSSA reported in June 2026.

RUH: There was 1 MSSA infection reported during June 2026, 5 cases reported to date.

Countermeasures

Group: IPC teams continue to undertake case review and shared learning to identify common themes and improvement opportunities. Group-wide focus remains on catheter and vascular access care, hand hygiene, antimicrobial stewardship, and the cleaning and decontamination of patient care equipment.

GWH: Learning from recent cases continues to inform improvement work, with a focus on catheter care, hand hygiene, antimicrobial stewardship and the cleaning and decontamination of patient care equipment.

SFT: To continue to monitor and report. All cases reviewed with ward teams and IPC for learning opportunities.

RUH: A quality improvement project has commenced 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

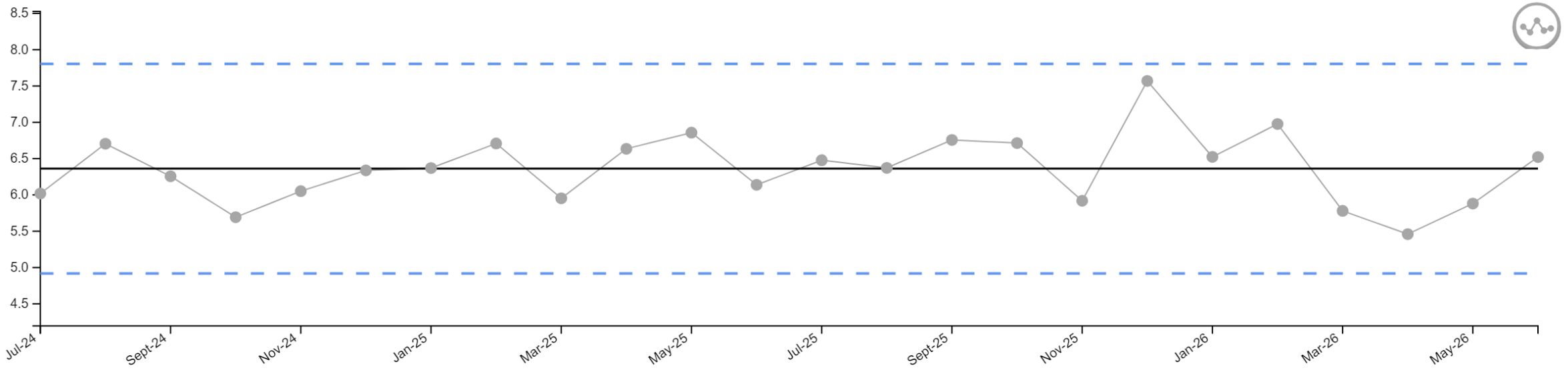
GWH: Mitigations through established IPC workstreams, ongoing case reviews, compliance monitoring and continued focus on key infection prevention measures to reduce future cases.

SFT: Ongoing IPC audits, peer review activity, and targeted education provide continued assurance that preventative controls remain effective and performance is being sustained.

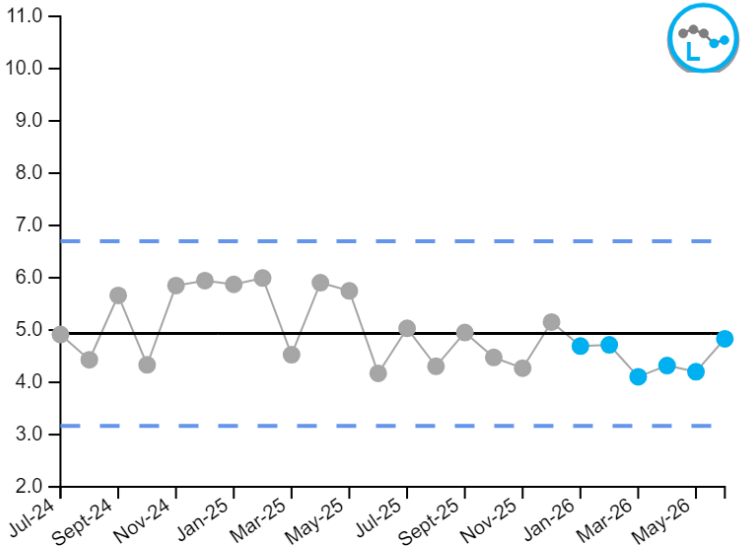
RUH: A programme of ongoing mitigation is in place which includes compliance audits and monitoring to support improvement.

Falls per 1000 bed days

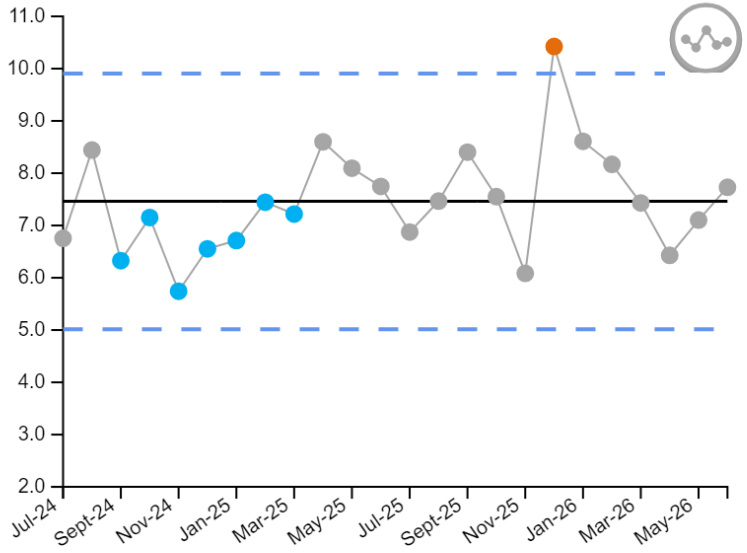
Falls per 1000 bed days - Group



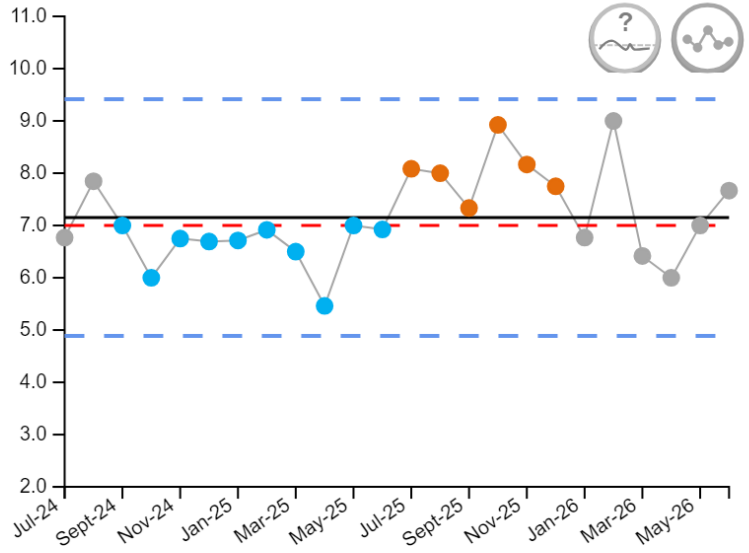
Falls per 1000 bed days - GWH



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			Jun-26	6.5				Common Cause Variation
Falls per 1000 bed days	GWH			Jun-26	4.8				Special Cause Improving - Run Below Mean
Falls per 1000 bed days	RUH			Jun-26	7.7				Common Cause Variation
Falls per 1000 bed days	SFT		7.0	Jun-26	7.7	X			Common Cause Variation

Understanding Performance

Group: Falls performance remains better than the national average across the Group, with overall variation consistent with common cause. However, there is a higher rate observed at RUH, which is being monitored to understand local drivers and opportunities for improvement.

GWH: There was an increase in month with 88 reported in June compared to 78 falls in May 2026, with no falls resulting in moderate harm or above. However, falls performance overall continues to improve, with a sustained reduction over time.

SFT: Falls rose slightly in June to 7.7 / 1000 bed days and is now just above the Trust target of 7/1000 bed days.

RUH: Falls per 1,000 bed days in June were below the National Audit for inpatient falls (NAIF) benchmark of 6.6 at 6.1.This is different to the data reported for the Group IPR at 7.7 falls per 1,000 bed days. This is due to issues in inclusion criteria for the indicator. This is being investigated with BIU to ensure consistency of reporting across the group.

Countermeasures

GWH: Falls incidents continue to be reviewed through a weekly multidisciplinary panel, enabling learning to be identified and shared across teams. There is focus on increasing meaningful activity for enhanced care patients and improving handover processes to ensure staff are clear on individual patients' mobility needs.

SFT: Falls reduction measures have been reviewed and strengthened across all wards. Following a slight deterioration associated with sustained operational pressures, performance is now showing encouraging improvement in response to targeted interventions.

RUH: Improvement projects regarding Lying and standing blood pressure in place in several wards.
Improvement project commenced with Adult Inpatient therapy team to improve patient multifactorial assessment post fall .
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

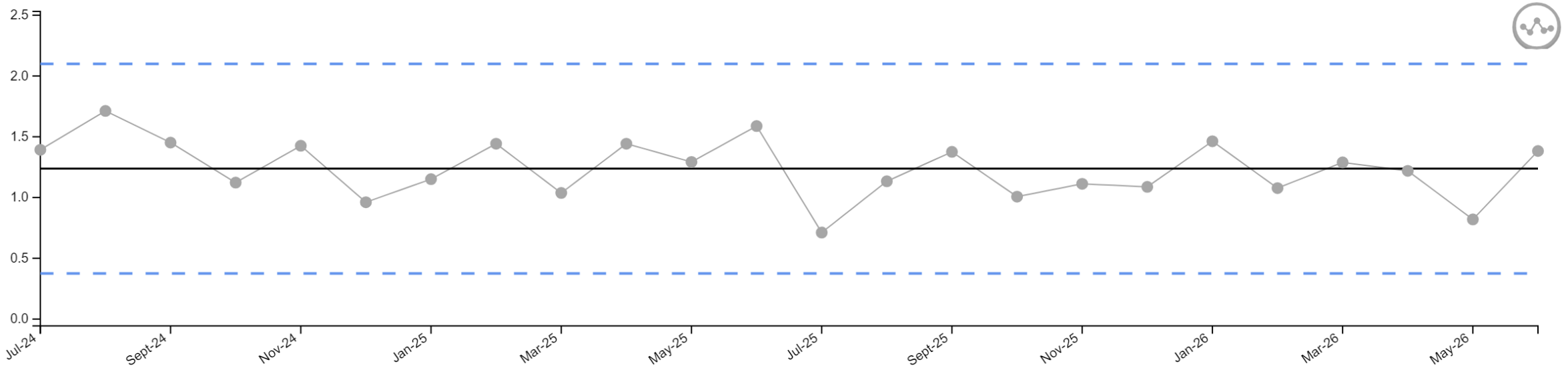
GWH: Work is progressing with the deconditioning programme to reduce risk of falls.

SFT: Staffing and patient safety are monitored at least three times daily, with risk mitigation measures continually reviewed and refreshed. While the use of escalation beds, increased patient acuity, and a focus on maintaining mobility may be associated with higher fall numbers, the incidence of falls leading to moderate or greater harm continues to remain low.

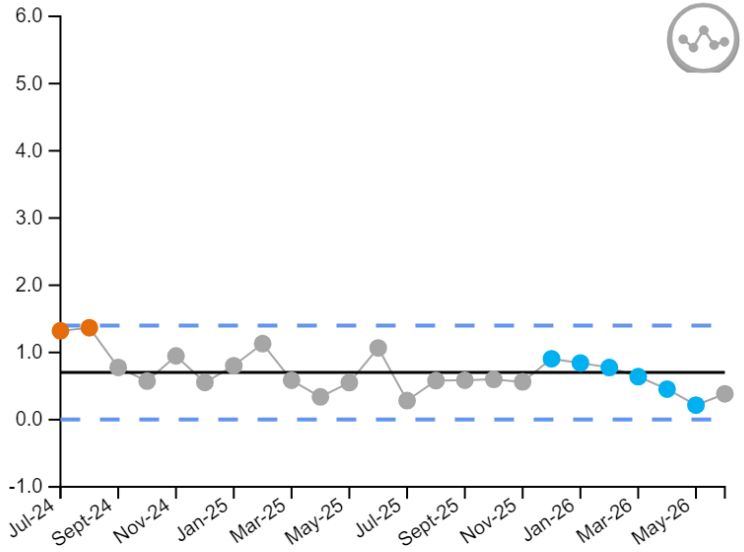
RUH: Lying and standing blood pressure compliance had been reducing, but the past 5 months has shown a steady increase. There is a risk to compliance if focused work is reduced or stopped. Improvement work is progressing aligned with the Enhanced Theraputic Observations of care workstream. There will be a temporary reduction in the falls prevention central resource due to a vacancy in the Quality Improvement team from the end of August.

Pressure Ulcers per 1000 beddays

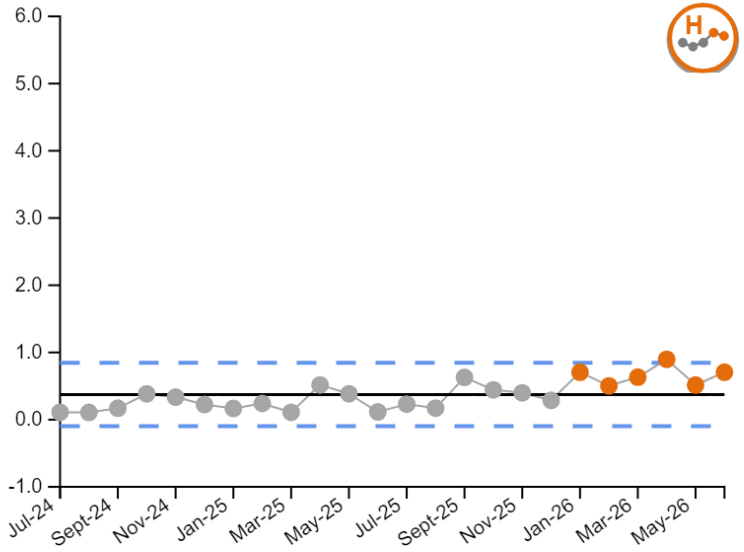
Pressure Ulcers per 1000 beddays - Group



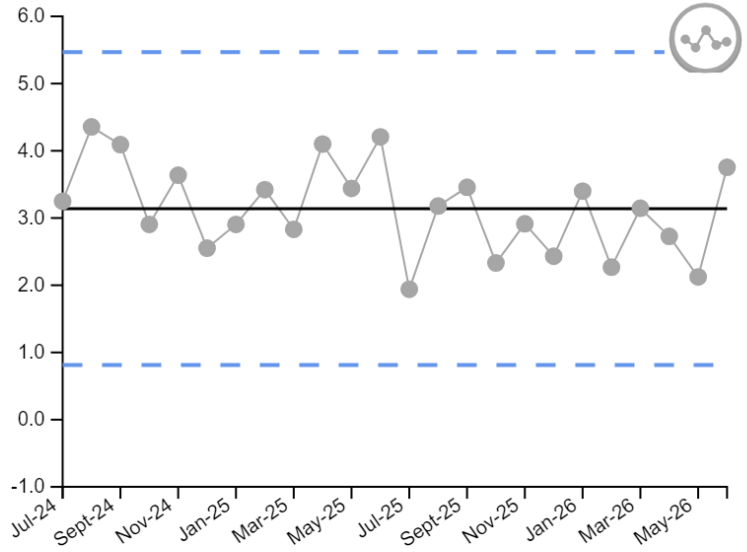
Pressure Ulcers per 1000 beddays - GWH



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		Jun-26	1.4				Common Cause Variation
Pressure Ulcers per 1000 beddays	GWH	Category 2/3/4, excluding specialist areas		Jun-26	0.4				Common Cause Variation
Pressure Ulcers per 1000 beddays	RUH	Category 2/3/4, excluding specialist areas		Jun-26	0.7			H	Special Cause Concerning - Two Out of Three High
Pressure Ulcers per 1000 beddays	SFT	Category 2/3/4, excluding specialist areas		Jun-26	3.8				Common Cause Variation

Understanding Performance

Group: Pressure ulcer rates remain low across the Group overall, although variation continues between organisations. GWH maintained low rates and remains below its planned reduction trajectory, RUH reported a low rate with some emerging variation, while SFT saw an increase in hospital-acquired pressure ulcers during the month.

GWH: GWH reported 0.4 pressure ulcers per 1,000 bed days in June 2026, with the overall cumulative rate remaining below the Trust's planned reduction trajectory. There were 2 cases of device related skin pressure damage.

SFT: The Trust reported an increase in hospital-acquired pressure ulcers in June with the rate rising from 2.07 to 3.79 per 1,000 occupied bed days. Increases were seen across both Surgical and Medical services, while medical device-related pressure ulcers reduced from four to one. Moisture Associated Skin Damage (MASD) also increased, with 62 incidents reported across 59 patients.

RUH: For June 2026, the RUH reported 0.7 pressure ulcers per 1,000 bed days and 0.18 medical device related pressure ulcers.

Countermeasures

Group: BSW-wide approach continues to be focusing on early identification of at-risk patients, consistent assessment, reporting and shared learning. Across the Group, improvement activity includes strengthening risk assessments, prevention bundles, staff education, MASD management and device-related pressure damage prevention.

GWH: Teams are strengthening how to identify and manage Moisture-Associated Skin Damage (MASD), while improving the quality and timeliness of risk assessments for pressure ulcers.

SFT: Trust is progressing several pressure ulcer prevention initiatives, including a trial of a new patient information leaflet, a review of the aSSKINg PSR form, reduction in the use of procedure pads for incontinence care, rollout of new continence products in September, and a review of mattress and bedframe products.

RUH: Targeted countermeasures are in place, led by the Tissue Viability Improvement Group. The Pressure Ulcer task and finish group are using quality improvement methodologies including listening exercises with staff to understand the barriers for providing preventative measures.

Risks and Mitigation

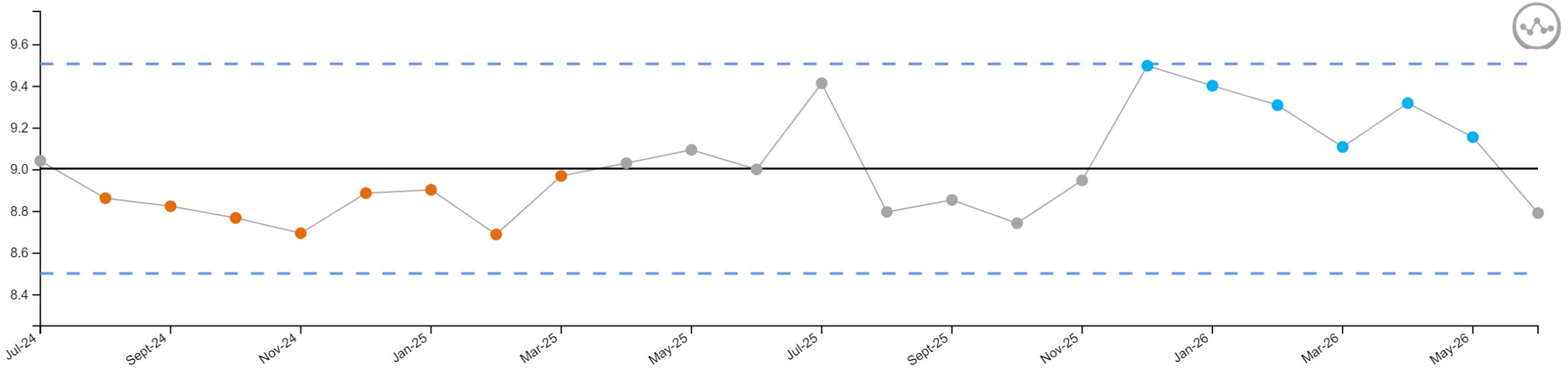
GWH: Focus on ensuring consistent, accurate assessments so patients receive the right care as early as possible. There is a drive to align pressure ulcer training as a mandatory module, alongside ward-based bitesize training.

SFT: Increased MASD and pressure ulcer incidence was associated with extreme heat conditions and prolonged patient stays in the Emergency Department during the Trust Critical Incident. Targeted pressure ulcer prevention programme with education from the Tissue Viability team is ongoing to mitigate impact.

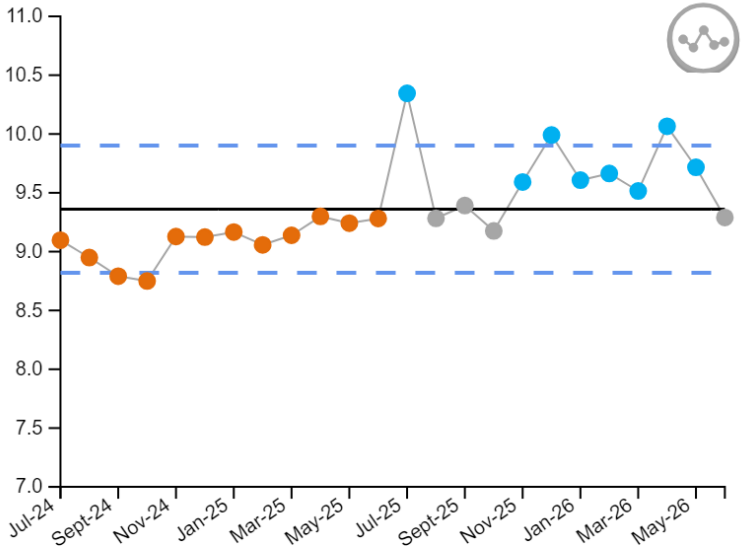
RUH: There is a risk that the lack of timely skin bundle assessments will impact on the ability to reduce avoidable pressure ulcers. The Tissue Viability Improvement Group monitors compliance with the matrons who work with the clinical area to implement improvements.

Care Hours per Patient Day (CHPPD)

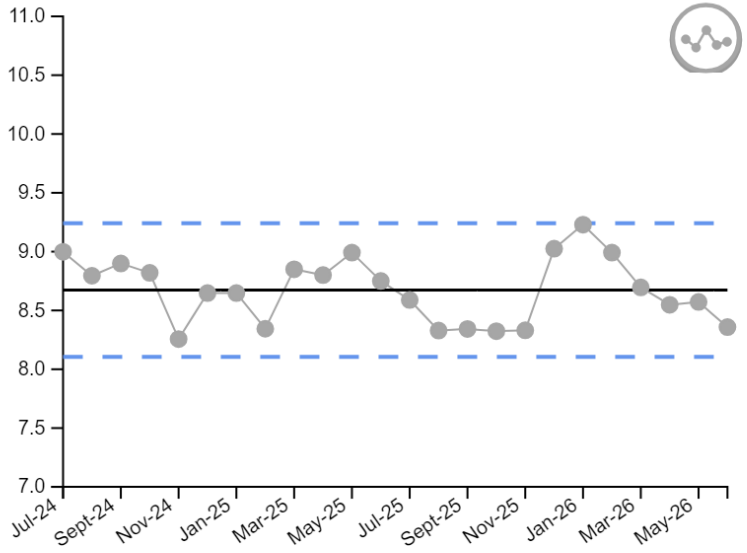
Care Hours per Patient Day (CHPPD) - Group



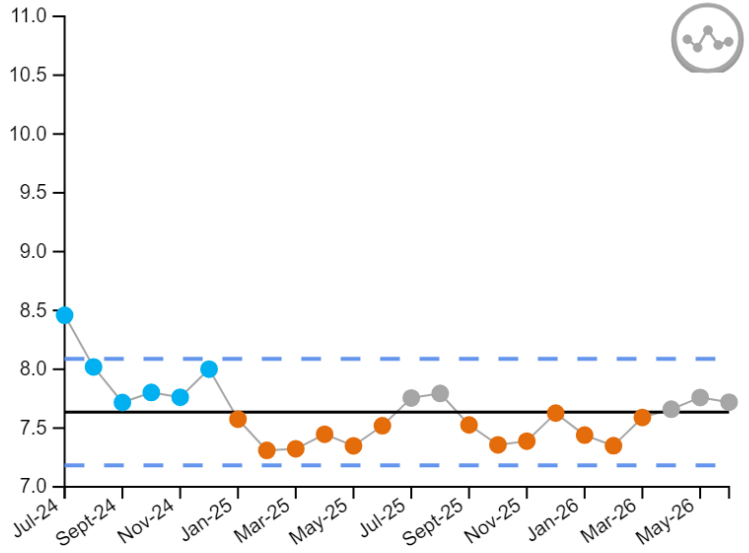
Care Hours per Patient Day (CHPPD) - GWH



Care Hours per Patient Day (CHPPD) - RUH



Care Hours per Patient Day (CHPPD) - SFT



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			Jun-26	8.8				Common Cause Variation
Care Hours per Patient Day (CHPPD)	GWH			Jun-26	9.3				Common Cause Variation
Care Hours per Patient Day (CHPPD)	RUH			Jun-26	8.4				Common Cause Variation
Care Hours per Patient Day (CHPPD)	SFT			Jun-26	7.7				Common Cause Variation

Understanding Performance

GWH: CHPPD remains above planned levels, largely driven by increased Health Care Support Worker deployment to support Enhanced Therapeutic Observation and Care (ETOC) requirements and additional escalation capacity.

SFT: CHPPD was 7.7, reflecting increased bed occupancy and ongoing use of boarding spaces and escalation beds. Demand for Enhanced Therapeutic Observation and Care (ETOC) remained high at 1,705 hours, with some shifts unfilled despite bank and agency support. Off-framework agency use remained limited at 16 shifts, predominantly within ICU, reflecting continued workforce pressures.

RUH: Slight reduction in the month of June at 8.4 CHPPD rather than 8.6 in May 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 established escalation processes continue across all organisations to ensure workforce resources are aligned to patient acuity and dependency. Ongoing focus remains on optimising workforce deployment, supporting enhanced care requirements and maintaining safe staffing levels during periods of sustained operational pressure.

SFT: Enhanced governance of staffing continues through three-times-daily staffing reviews, weekly safe staffing meetings, and monthly Safer Staffing oversight, providing robust scrutiny of workforce capacity, staff unavailability, roster performance, temporary staffing usage, and associated risks, with agreed mitigations monitored across all divisions.

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.

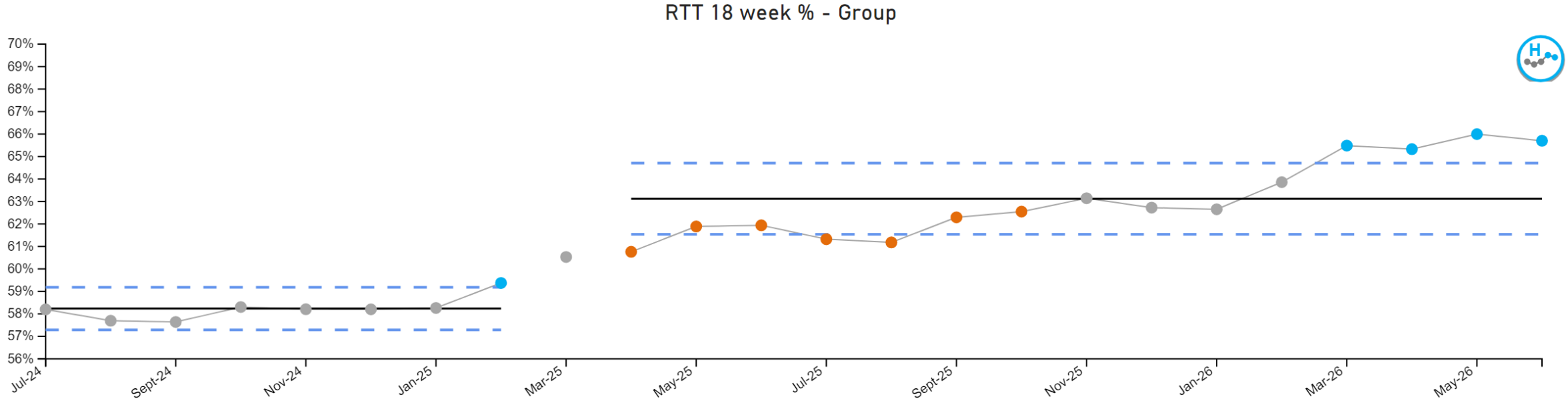
Risks and Mitigation

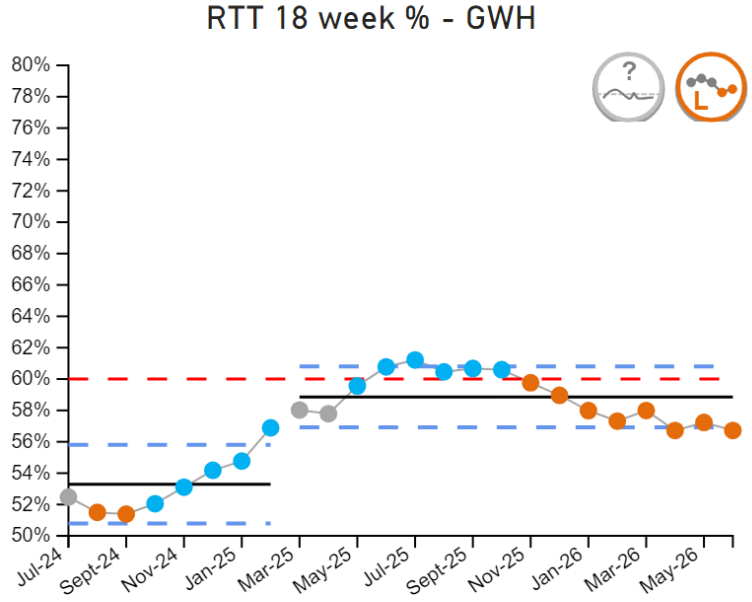
Group: Additional escalation capacity and increased enhanced care requirements continue to place pressure on workforce resources and CHPPD. This is mitigated through routine staffing oversight, triangulation of quality indicators, professional judgement and proactive workforce management to maintain safe patient care across the Group.
GWH: Sustained demand for enhanced care and escalation beds continues to place pressure on workforce resources. This is mitigated through daily safe staffing reviews, professional judgement and proactive workforce management.

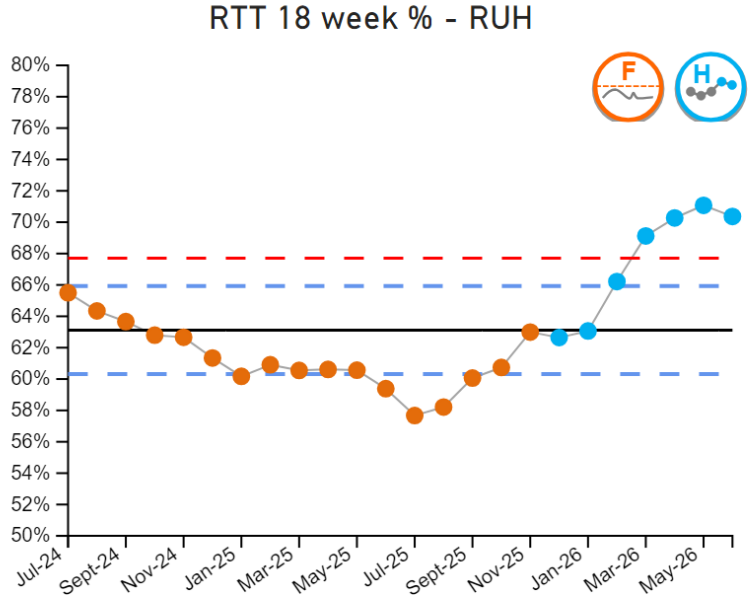
SFT: High levels of short-term sickness absence continue to impact staffing resilience, requiring enhanced oversight and mitigation through redeployment of available staff, with associated risks to leadership, education, and operational priorities. Demand for ETOC, including RMN provision, remains a financial and operational pressure, with ongoing work to strengthen governance.

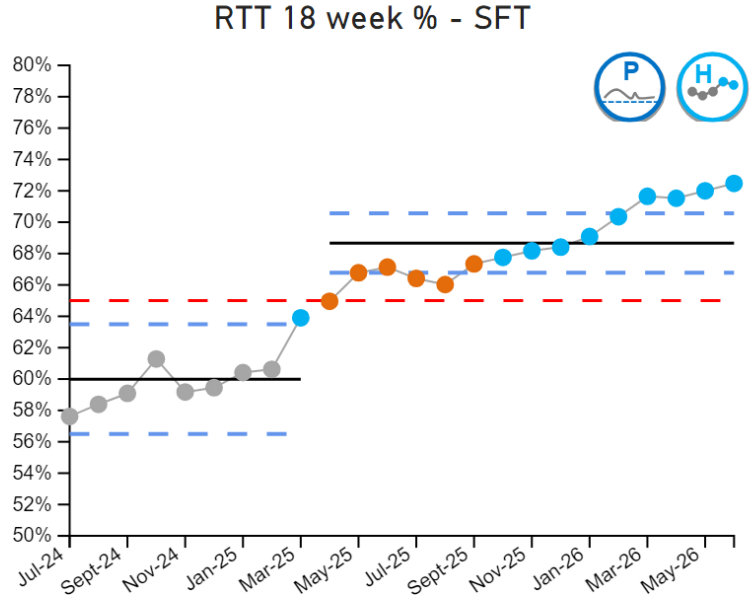
RUH: The risks identified from SafeCare in June show continued raised levels of short-term absence, alongside existing vacancy and the operational need for additional escalation capacity, which is reviewed at the twice daily safer staffing meetings chaired by a senior nurse.

RTT 18 week %


RTT 18 week % - Group
H
70%
69%
68%
67%
66%
65%
64%
63%
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59%
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57%
56%
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Sept-24
Nov-24
Jan-25
Mar-25
May-25
Jul-25
Sept-25
Nov-25
Jan-26
Mar-26
May-26


RTT 18 week % - GWH
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76%
74%
72%
70%
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66%
64%
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56%
54%
52%
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May-25
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Nov-25
Jan-26
Mar-26
May-26


RTT 18 week % - RUH
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74%
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66%
64%
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Jul-24
Sept-24
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Nov-25
Jan-26
Mar-26
May-26


RTT 18 week % - SFT
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76%
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Jul-24
Sept-24
Nov-24
Jan-25
Mar-25
May-25
Jul-25
Sept-25
Nov-25
Jan-26
Mar-26
May-26

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			Jun-26	65.7%			H	Special Cause Improving - Above Upper Control Limit
RTT 18 week %	GWH		60.0%	Jun-26	56.7%	✗	?	L	Special Cause Concerning - Below Lower Control Limit
RTT 18 week %	RUH		67.7%	Jun-26	70.4%	✓	F	H	Special Cause Improving - Above Upper Control Limit
RTT 18 week %	SFT		65.0%	Jun-26	72.5%	✓	P	H	Special Cause Improving - Above Upper Control Limit

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
June performance was mixed: RUH and SFT remained ahead of trajectory, while GWH stayed below plan.

GWH 56.7%, down 0.4% and below plan. The waiting list fell by 1,092 to 42,881, but 52-week waits rose by 17 to 1,091. Dermatology, Ophthalmology and ENT improved during Q1.

RUH 70.4%, ahead of trajectory but 0.7% lower month on month. The largest over-18-week cohorts remain General Surgery, Oral Surgery, ENT, Cardiology and Neurology.

SFT 72.5%, ahead of plan and on track for March 2027. The waiting list reduced to 29,733, while 52-week waits rose to 84 and two patients remained over 65 weeks.

Countermeasures

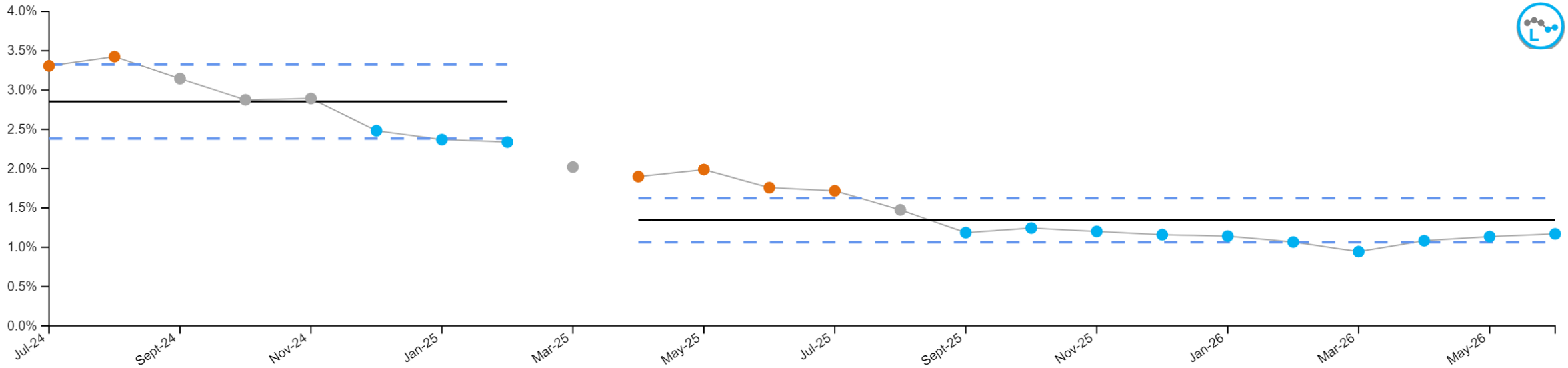
- **Group** continued adoption of the RTT toolkit and approach. Approach to planning for elective care for 27/28 now written up to ensure robust plans developed for coming years.
- **RUH and SFT** remain ahead of trajectory, so existing countermeasures will continue. RUH is targeting the largest over-18-week cohorts through locum and consultant recruitment and additional radiology capacity. SFT is using Patient Led Validation and additional clinical capacity to sustain improvement.
- **GWH** remains challenged by pathway data quality and a persistent capacity gaps although has a clear recovery plan based on the approach used in RUH. Positive feedback has been received from region based on recent updates. Recovery actions focus on targeted validation of pathways, weekly trajectory oversight, specialty-owned demand and capacity plans, improved outpatient processes and additional capacity from Q2.

Risks and Mitigation

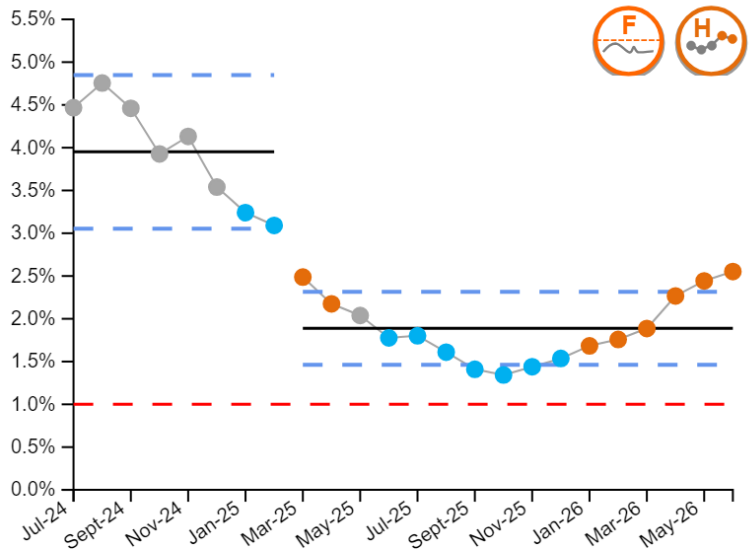
- Risk: increasing elective demand across group. Mitigation: Elective Coordination Centre being mobilised during Q4 to ensure maximise use of IS. In addition, demand management schemes being piloted in ENT and Gastro. Gynae and Derm transformation programmes being drafted for 2027 implementation.
- Risk: increasing elective demand. Mitigation: all hospitals implement Advice and Refer to ensure only appropriate referrals receive in person appointments.
- Risk: GWH remains below trajectory. Mitigation: continue targeted validation, remove duplicate or inappropriate clocks and track specialty trajectories weekly.

RTT % Over 52 Weeks

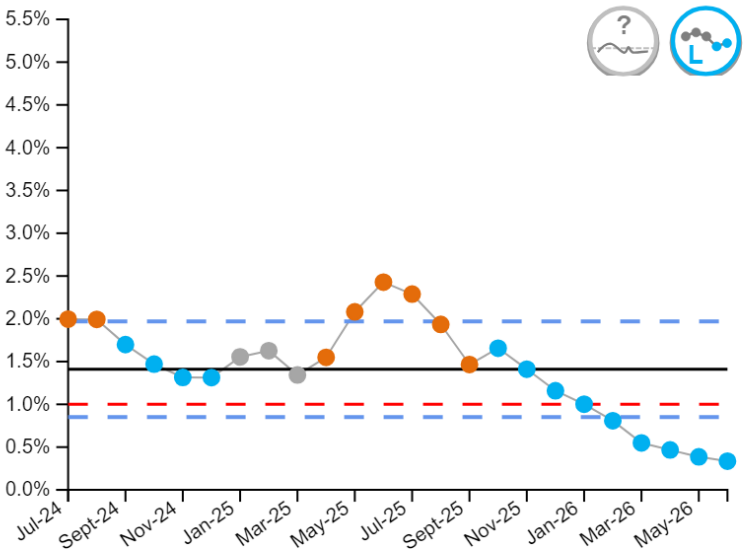
RTT % Over 52 Weeks - Group



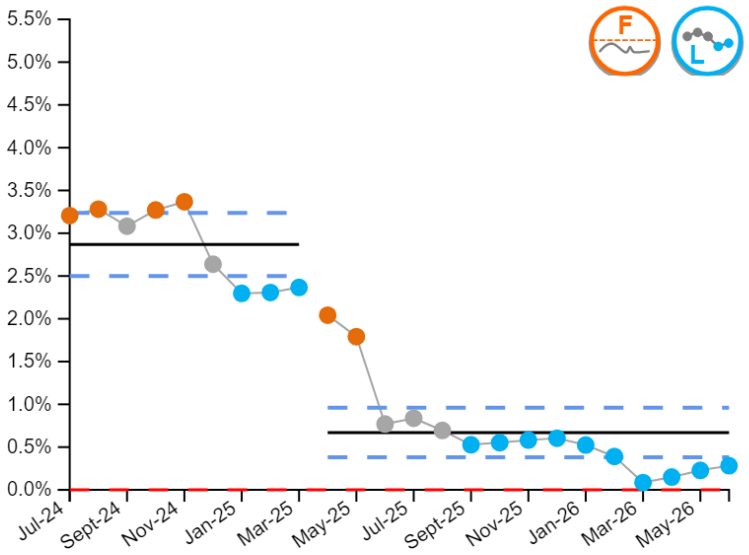
RTT % Over 52 Weeks - GWH



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			Jun-26	1.2%				Special Cause Improving - Run Below Mean
RTT % Over 52 Weeks	GWH		1.0%	Jun-26	2.6%	✗			Special Cause Concerning - Increasing Run
RTT % Over 52 Weeks	RUH		1.0%	Jun-26	0.3%	✓			Special Cause Improving - Decreasing Run
RTT % Over 52 Weeks	SFT		0.0%	Jun-26	0.3%	✗			Special Cause Improving - Below Lower Control Limit

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
June 52-week performance was mixed: GWH and SFT increased, while RUH reduced its long-wait cohort.

GWH reported 1,091 patients over 52 weeks, up 17 in month and above the plan of 361. Nine patients remained over 65 weeks, although this was three fewer than May.

RUH reduced the 52-week cohort from 155 to 133, equivalent to 0.34% of the waiting list. Pain reduced from 43 to 36, while General Surgery increased from 22 to 32.

SFT increased to 84 patients over 52 weeks, representing 0.28% of the waiting list. The rise was mainly attributable to diagnostic pathway stages and reporting delays; two patients were over 65 weeks.

Countermeasures

Group is progressing use of consistent RTT toolkit approach alongside mutual aid where feasible. Specific work underway to understand the Orthopaedic capacity gap at GWH and the level of support needed from Sulis Orthopaedic Centre.

GWH is using the corporate long-wait PTL, daily specialty review and closure of outstanding booking tasks to accelerate clearance. Targeted validation and additional Q2 capacity are focused on the cohorts with greatest impact.

RUH continues weekly long-wait PTL oversight against its internal stretch ambition of zero 52-week waits by September. Actions include additional General Surgery consultant capacity, a Pain locum and maximising ENT theatre lists.

SFT is extending Patient Led Validation and launching the Patient not Present programme, supported by additional clinical capacity where required, to reduce avoidable pathways and long waits.

Risks and Mitigation

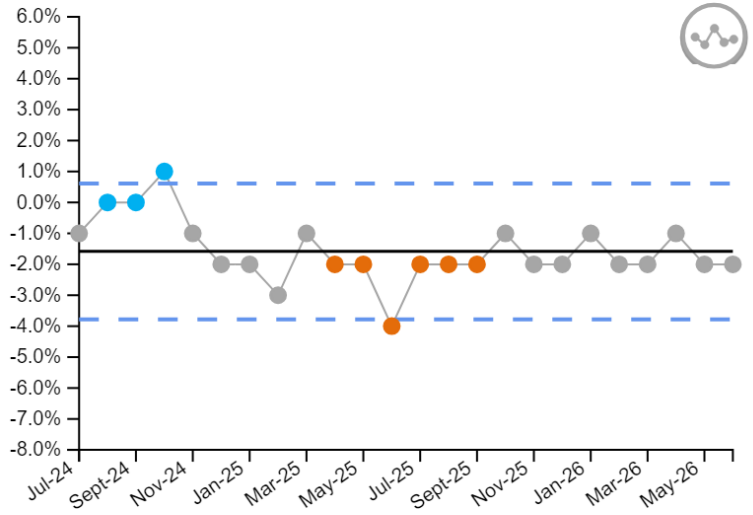
- Risk: GWH remains significantly above plan and its 52-week cohort is still rising. Mitigation: targeted long-wait validation, daily PTL control and divisional tracking of capacity and trajectory.
- Risk: RUH faces General Surgery, ENT and Pain capacity constraints. Mitigation: deploy additional consultant, locum, theatre and radiology capacity to the highest-risk cohorts. Track recovery actions via specialty-specific recovery meetings.
- Risk: SFT diagnostic, reporting and clinical-capacity delays may create further long waits. Mitigation: strengthen pathway validation and add capacity where necessary, with close oversight of the 52- and 65-week cohorts.

RTT wait times top versus bottom quintile of social deprivation

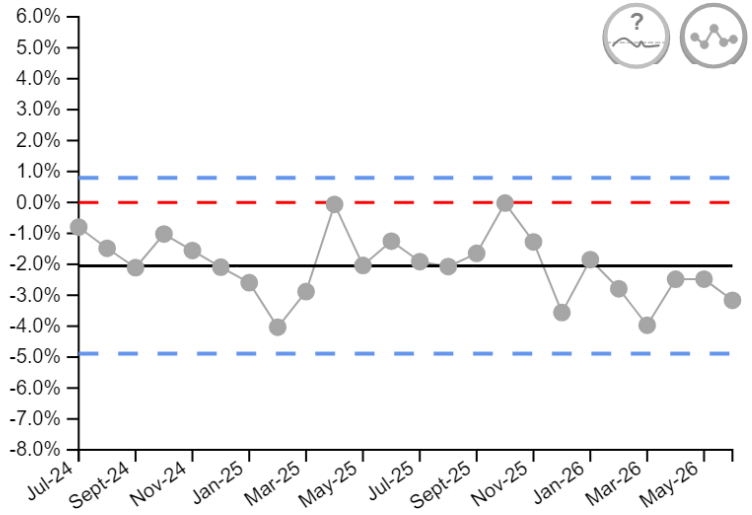
Please note that the RTT social deprivation metric cannot be aggregated across multiple trusts.

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.

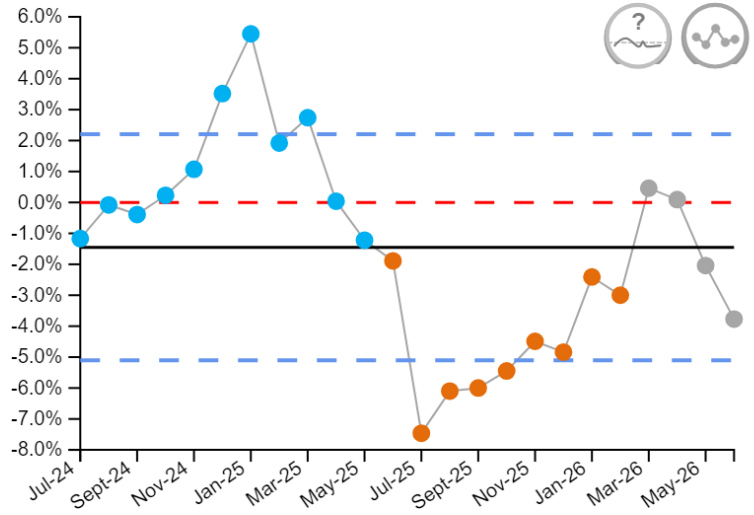
RTT wait times top versus bottom quintile of social deprivation - GWH



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			Jun-26	-2.0%				Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	RUH		0.0%	Jun-26	-3.2%	X			Common Cause Variation
RTT wait times top versus bottom quintile of social deprivation	SFT		0.0%	Jun-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 shows limited variation in RTT performance between the top and bottom quintiles of social deprivation for each of the 3 acute Trusts. There has been consistent and sustained improvements in the performance data for SFT since July '25, which brings all 3 Trusts close to the mean average, but slightly short of the 0% variation target. Each with common cause variation.

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 met in May and 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.

Other actions being taken:

SFT: Refreshing A3 with Public Health input; 2 BSW-funded paediatrics and cancer projects to reduce inequalities; Wiltshire workshop to focus priorities and partnership working aligned to BSW inequalities strategy.

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.

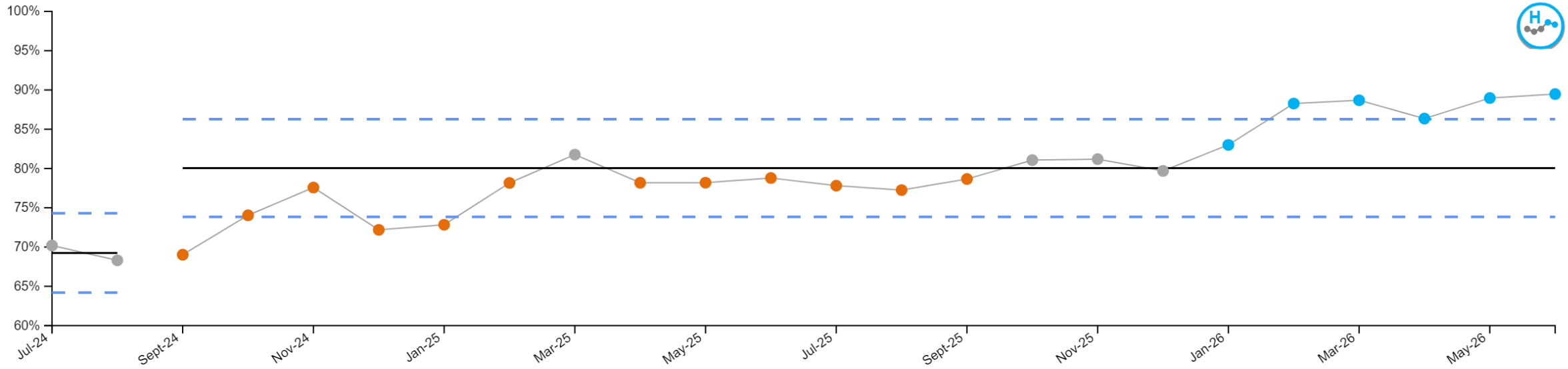
SFT: The Ops HI Group feeds into the wider Wiltshire Health Inequalities Group (WHIG). Additional groups operate in BANES (meeting bi-monthly) and Swindon (established summer 2025).
GWH: An internal Inclusion and Health Inequalities Sub-Committee meets bi-monthly. The Health Inequalities Lead also attends 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:

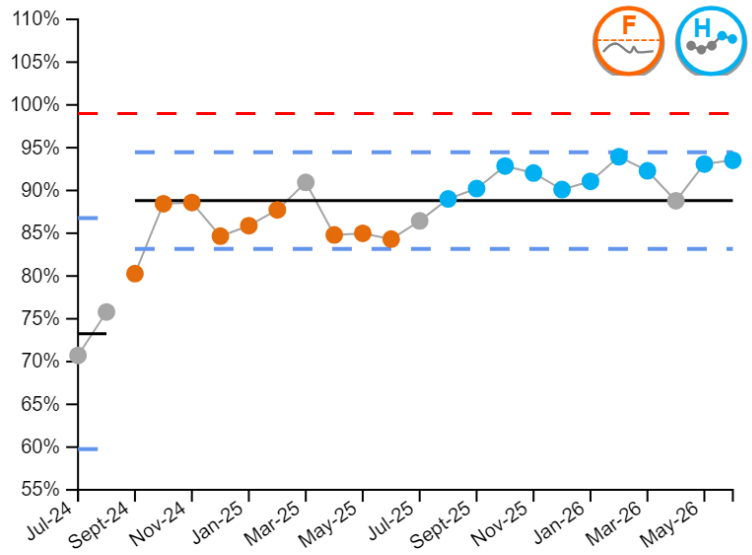
- Joint BI and EPR working groups.
- Shared templates, frameworks, and reporting approaches.
- Common education and awareness resources.
- Regular collaborative meetings and Board-level engagement to maintain oversight and accountability.

DM01 Performance

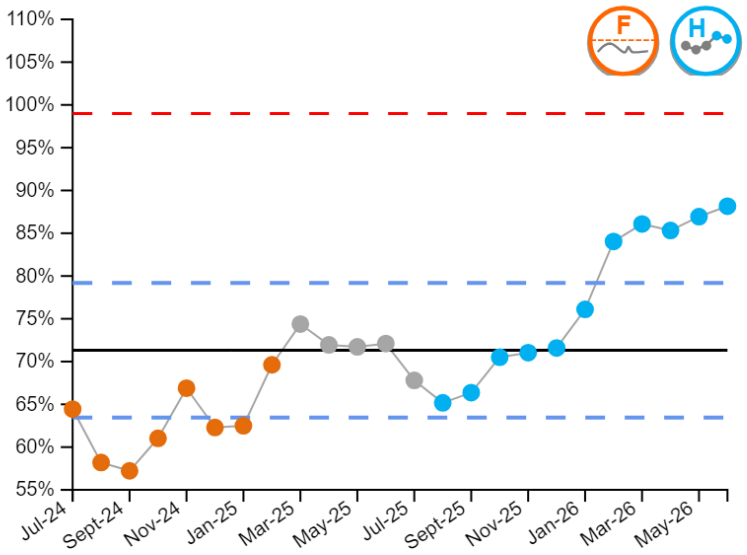
DM01 Performance - Group



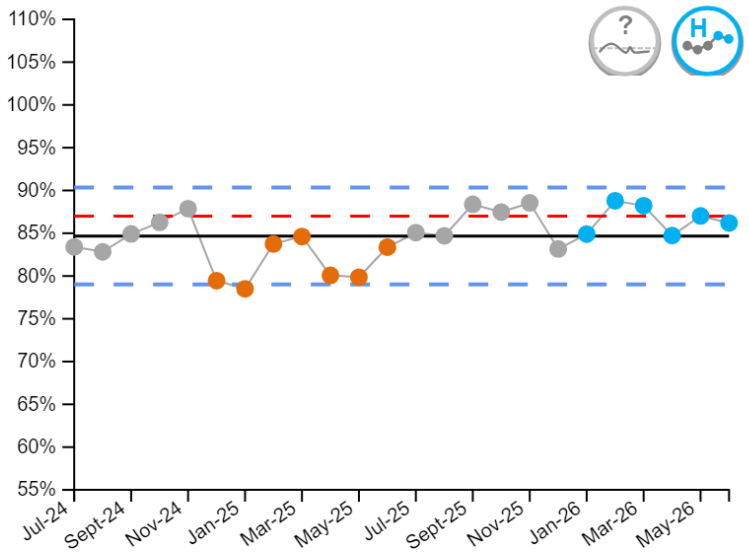
DM01 Performance - GWH



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			Jun-26	89.5%				Special Cause Improving - Above Upper Control Limit
DM01 Performance	GWH		99.0%	Jun-26	93.5%	X			Special Cause Improving - Two Out of Three High
DM01 Performance	RUH		99.0%	Jun-26	88.2%	X			Special Cause Improving - Above Upper Control Limit
DM01 Performance	SFT		87.0%	Jun-26	86.2%	X			Special Cause Improving - Run Above Mean

Understanding Performance

Group
Group DM01 performance was 89.5% in June. Pressure being experienced in endoscopy, audiology and other high-demand diagnostic pathways.

GWH reported 93.5%, the strongest position in the Group. Recovery continued from the April dip; residual pressures remain in Audiology, Respiratory Sleep Studies, Endoscopy and long-wait Cystoscopy.

RUH reported 88.2%. Recovery work remains focused on endoscopy, DEXA, audiology, and ultrasound, with capacity aligned across RUH and Sulis CDC.

SFT reported 86.2%. Audiology workforce constraints remain the principal concern, while the earlier MRI provision issue has been resolved.

Countermeasures

System
- BSW Community Diagnostic Centre activity was above contract. CDC utilisation and delivery remain under monthly Diagnostic Delivery Group review.
- Group projects on Gastro, ENT/Audiology and Cardiology pathways aim to maximise CDC use and reduce referrals
- A group diagnostic proposal is progressing that aims to improve sonographer training and supply.

GWH. Sustain endoscopy and ultrasound recovery, with focused management of Cystoscopy and other long waits.

RUH. Continue endoscopy, DEXA and ultrasound recovery across RUH and Sulis CDC capacity.

SFT. Continue audiology recruitment and sustain radiology delivery following restoration of MRI provision.

Risks and Mitigation

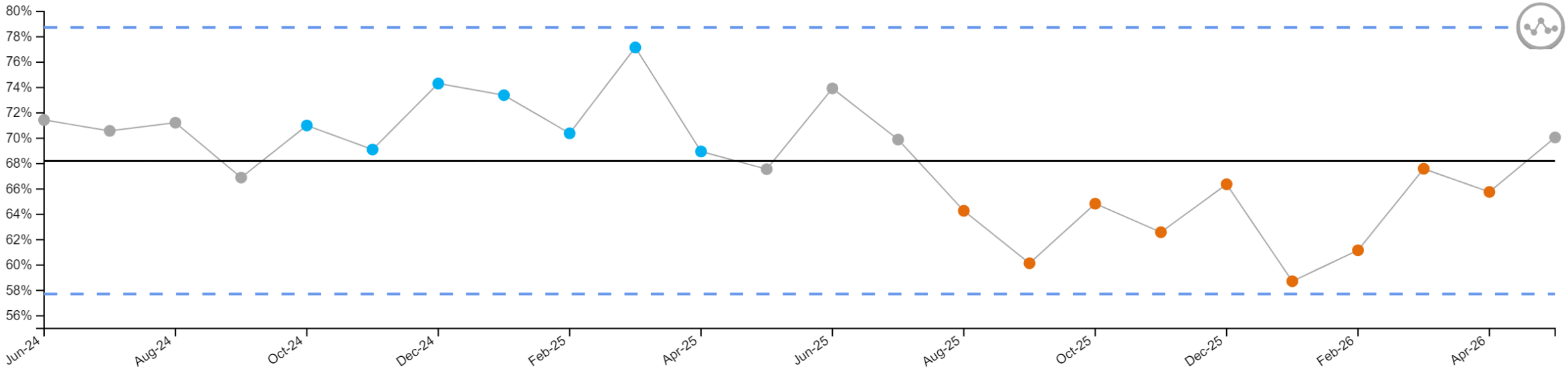
- Risk: CDC revenue may not fully support planned capacity, particularly at Sulis. Mitigation: maintain regional escalation and align available capacity to the highest-impact modalities and pathways.

- Risk: workforce gaps in sonography, audiology and endoscopy may constrain recovery. Mitigation: develop the system workforce plan, expand training capacity and progress the funded pathway programmes.

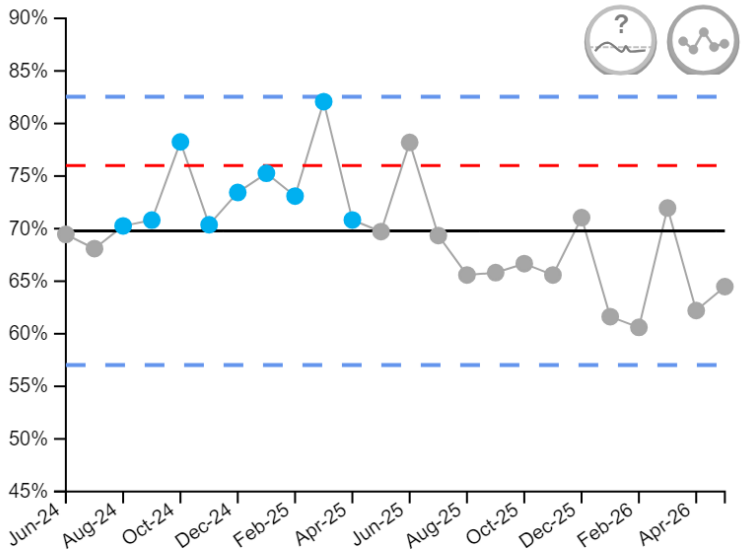
- Risk: long waits remain concentrated in specific modalities. Mitigation: use modality-level tracking, targeted validation and focused backlog clearance while monitoring delivery through the Diagnostic Delivery Group.

Cancer 62 Day Performance

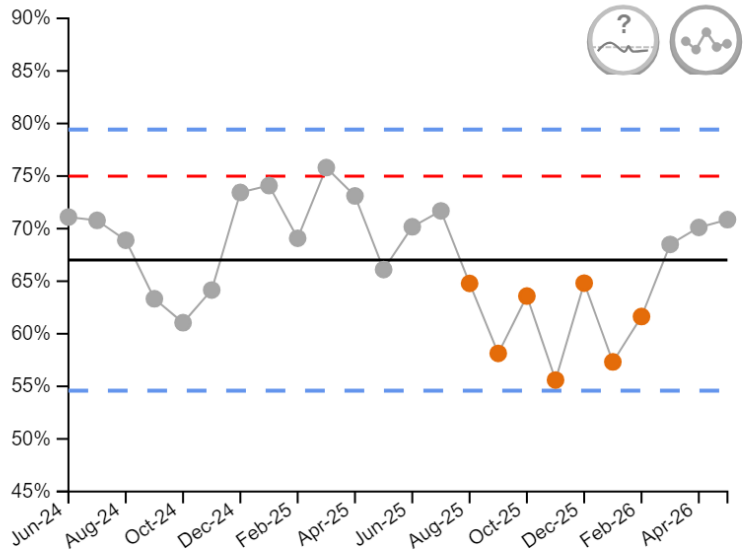
Cancer 62 Day Performance - Group



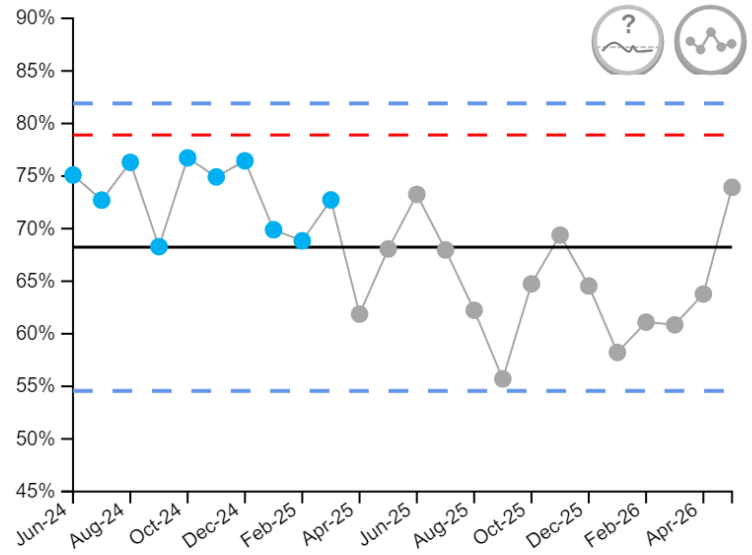
Cancer 62 Day Performance - GWH



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			May-26	70.1%				Common Cause Variation
Cancer 62 Day Performance	GWH		76.0%	May-26	64.5%	X			Common Cause Variation
Cancer 62 Day Performance	RUH		75.0%	May-26	70.9%	X			Common Cause Variation
Cancer 62 Day Performance	SFT		78.9%	May-26	73.9%	X			Common Cause Variation

Understanding Performance

Group
Group 62-day performance was 70.1% in May, improving overall but remaining below the national standard; SFT achieved the 75% standard.

GWH reported 64.5%. The largest breach cohorts were Urology, Colorectal, Skin and Breast, driven by diagnostic, outpatient and treatment capacity delays.

RUH reported 70.9%, below trajectory. Colorectal recovered to 64%, while Breast, Lung, Upper GI and Urology remained affected by diagnostic and pathway delays.

SFT improved to 75.1%, achieving the standard and its strongest result since December 2024. The backlog reduced to 76; Lower GI and Urology remained the largest breach areas.

Countermeasures

System
Tele-dermatology rollout and Cancer Alliance capacity support continue, alongside pathway improvement and diagnostic-capacity action across BSW.

GWH. Maintain weekly PTL review; improve radiology reporting, Breast outpatient capacity and Dermatology/Plastics capacity.

RUH. Complete long-wait pathway reviews, expand biopsy and outpatient capacity, and address prostate MRI and diagnostic delays through recruitment and pathway redesign.

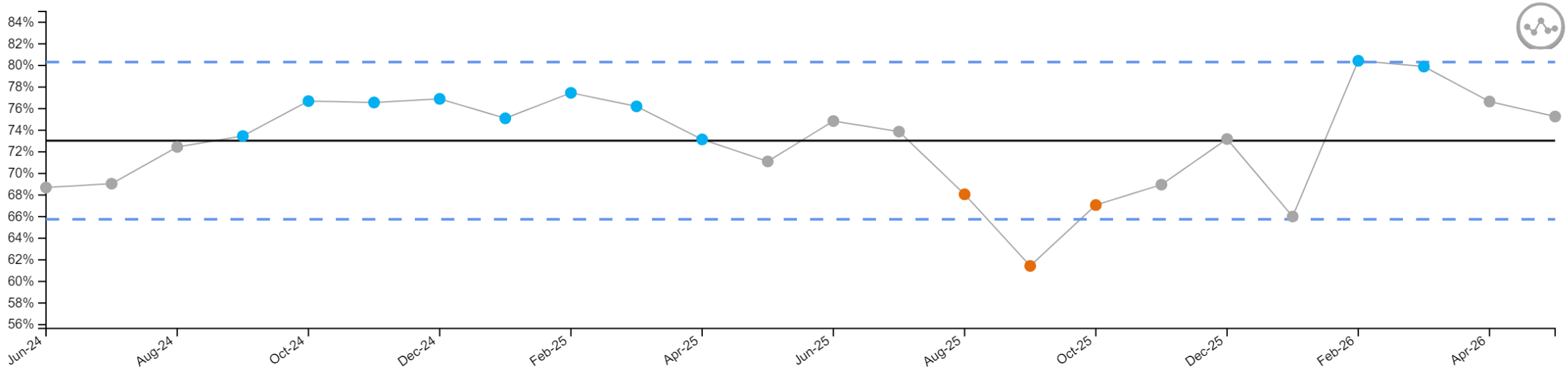
SFT. Deliver the Cancer Improvement Group recovery plan, align timed pathways to national best practice and strengthen PTL control through Cancer 360.

Risks and Mitigation

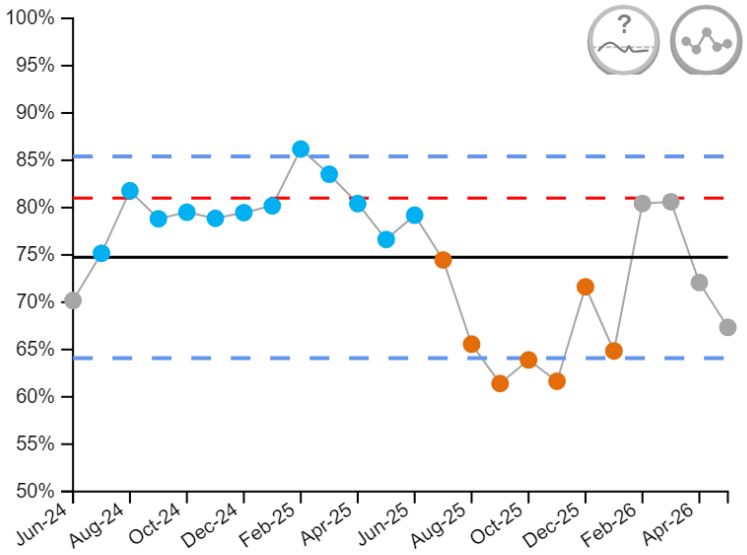
- Risk: rising referrals and diagnostic demand may outstrip capacity. Mitigation: targeted capacity, insourcing and workforce plans focused on the highest-breach pathways.
- Risk: Urology, Colorectal and Breast pathways remain vulnerable to imaging, biopsy and outpatient delays. Mitigation: pathway-level recovery plans, recruitment and additional diagnostic capacity.
- Risk: SFT delivery depends on 28-day performance, SACT capacity and clearing long-wait Skin patients. Mitigation: CIG oversight, escalation protocols and operational capacity plans.

Cancer 28 Day Performance

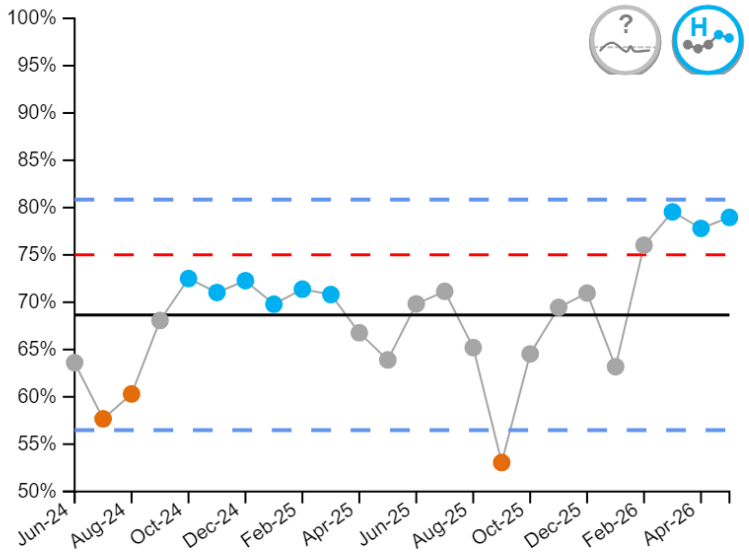
Cancer 28 Day Performance - Group



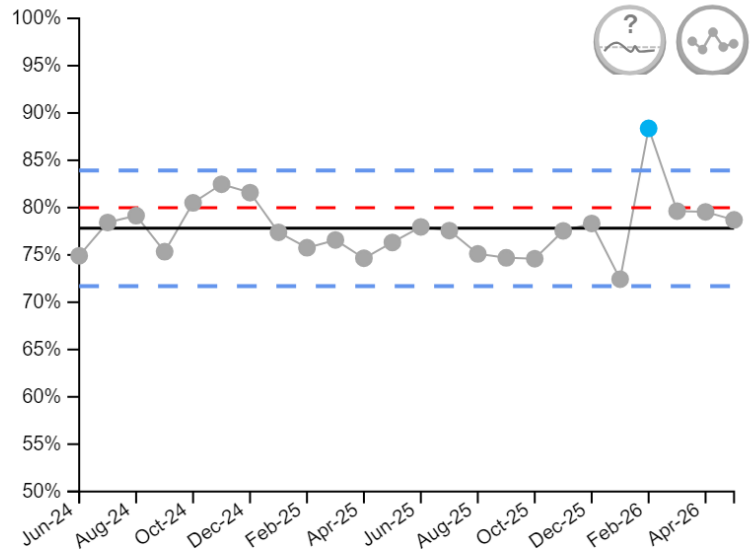
Cancer 28 Day Performance - GWH



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			May-26	75.3%				Common Cause Variation
Cancer 28 Day Performance	GWH		81.0%	May-26	67.3%	✗			Common Cause Variation
Cancer 28 Day Performance	RUH		75.0%	May-26	79.0%	✓		H	Special Cause Improving - Two Out of Three High
Cancer 28 Day Performance	SFT		80.0%	May-26	78.7%	✗			Common Cause Variation

Understanding Performance

Group
Group 28-day Faster Diagnosis performance was 75.3% in May. Performance remained below standard, with common pressures in outpatient, diagnostic and reporting capacity.

GWH reported 67.3%. Outpatient capacity caused 54.2% of breaches; Colorectal, Skin and Breast were the largest pathway contributors, with additional pathology and radiology reporting delays.

RUH reported 79.0%. Breast fell following radiologist sickness; Colorectal improved to 64%, while demand pressures continued in Gynaecology, Skin and Urology.

SFT reported 78.7%. Lower GI, Urology and Haematology remained below standard; diagnostic and histopathology turnaround and tertiary access continued to affect performance.

Countermeasures

System
- Cancer Alliance funding and CDC capacity continue to support recovery, with tele-dermatology and timed-pathway improvement focused on shared pressure areas.
- Provider plans prioritise Breast, Colorectal, Skin, Urology and diagnostic turnaround to accelerate communication of diagnosis.

GWH. Increase outpatient capacity and reduce reporting delays, with recovery plans targeted to Colorectal, Skin, Breast and Gynaecology.

RUH. Use Breast one-stop WLIs, colorectal pathway redesign, additional Gynaecology capacity, tele-dermatology and Urology MRI/consultant capacity.

SFT. Standardise timed pathways and booking processes, improve Bowel Screening management and strengthen pathway ownership through Cancer 360.

Risks and Mitigation

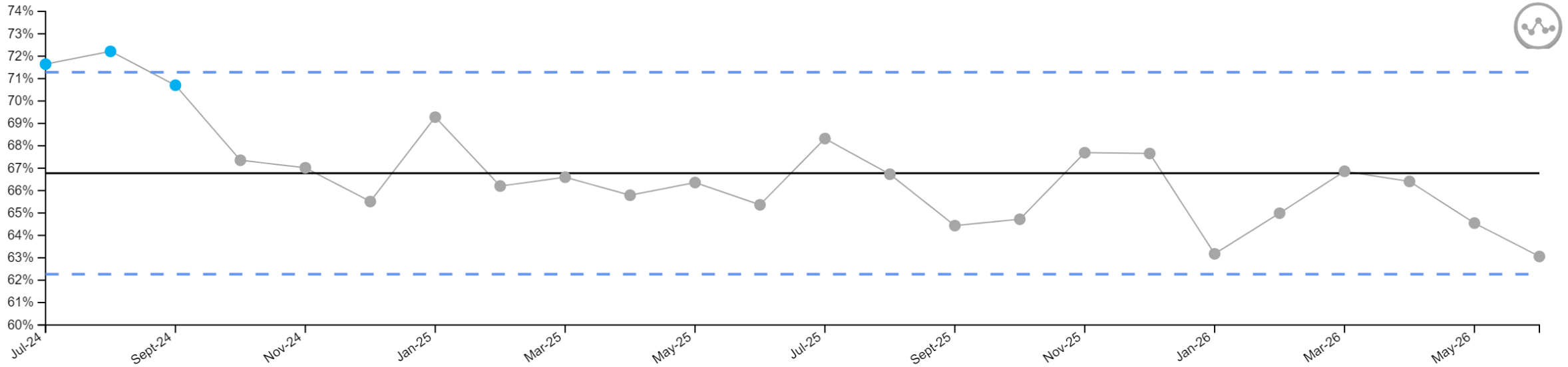
- Risk: demand growth may exceed outpatient and diagnostic capacity. Mitigation: Cancer Alliance support, CDC expansion, insourcing and targeted waiting-list initiatives.

- Risk: Dermatology, Colorectal and Urology pathways remain exposed to capacity and reporting delays. Mitigation: tele-dermatology, pathway redesign and additional diagnostic and clinical capacity.

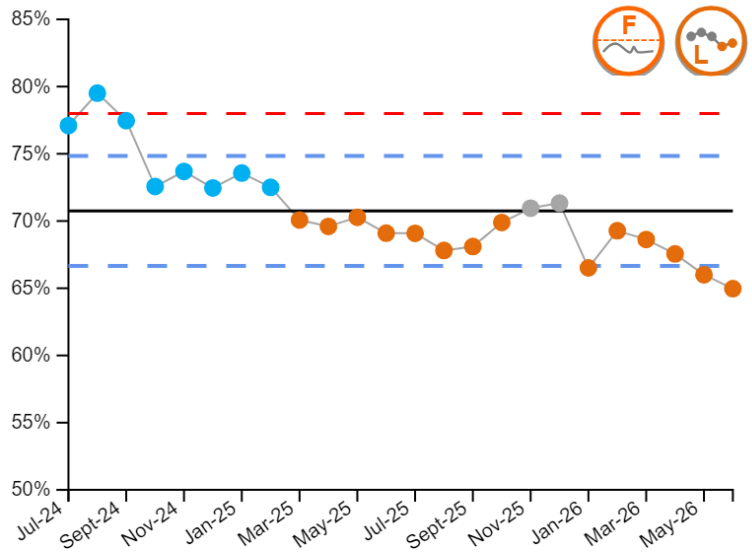
- Risk: patient choice, tertiary diagnostics and variable PTL management may delay diagnosis. Mitigation: clear escalation ownership, Cancer 360 oversight and national timed-pathway standards.

ED 4 Hour Performance

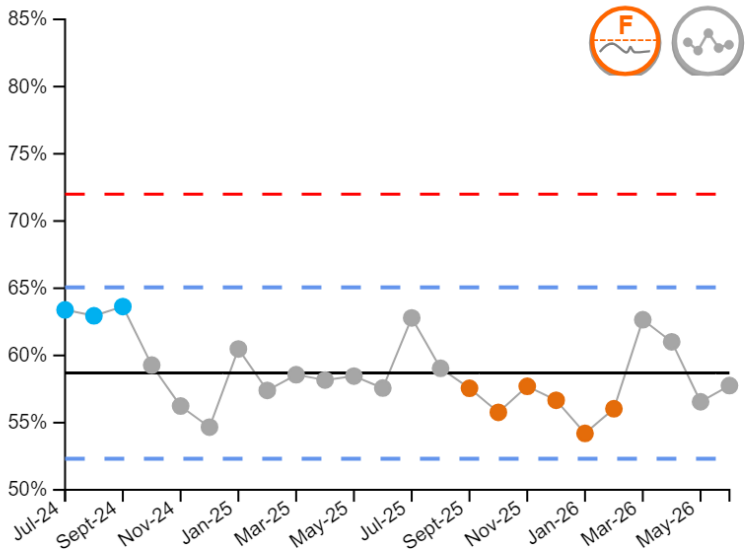
ED 4 Hour Performance - Group



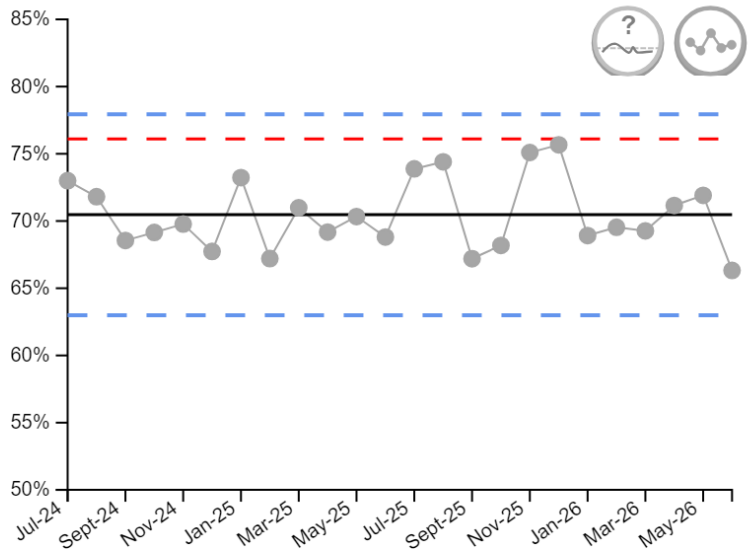
ED 4 Hour Performance - GWH



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		Jun-26	63.1%				Common Cause Variation
ED 4 Hour Performance	GWH	All Types	78.0%	Jun-26	65.0%	X	F	L	Special Cause Concerning - Below Lower Control Limit
ED 4 Hour Performance	RUH	All Types	72.0%	Jun-26	57.8%	X	F		Common Cause Variation
ED 4 Hour Performance	SFT	All Types	76.1%	Jun-26	66.3%	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 25/26 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

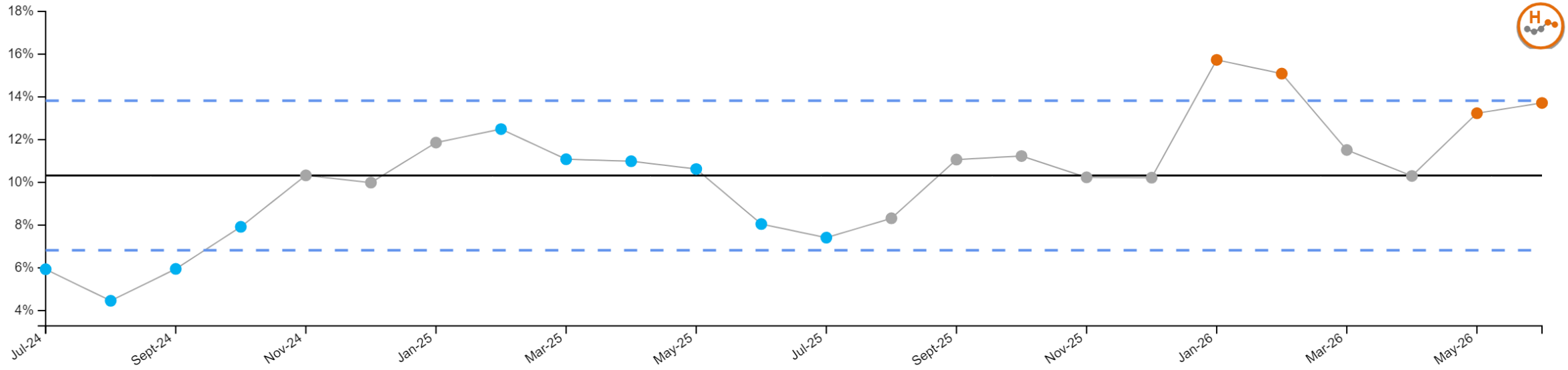
- Each organisation has an improvement plan that focuses on ED process improvements incorporating actions to increase SDEC capacity to avoid attendance at ED. RUH have a refreshed plan focusing on ED.
- There is a system wide care coordination (Care Co) function that is key to ensuring only appropriate 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

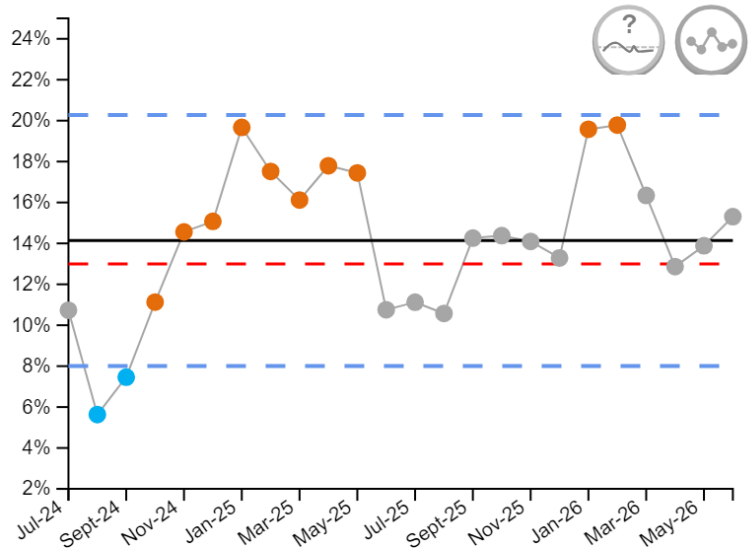
R – lack of community capacity leading to delays in discharge
M – ongoing demand profiling across the system to ensure the correct capacity is in place to meet demand
R – the ability for internal and system responses to keep with the pace of change needed
M- trust and system oversight of challenges with 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

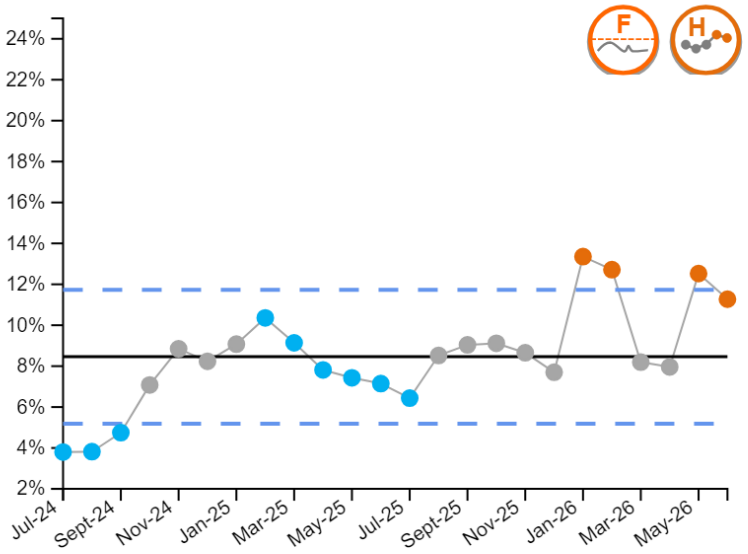
ED 12 Hour Performance - Group



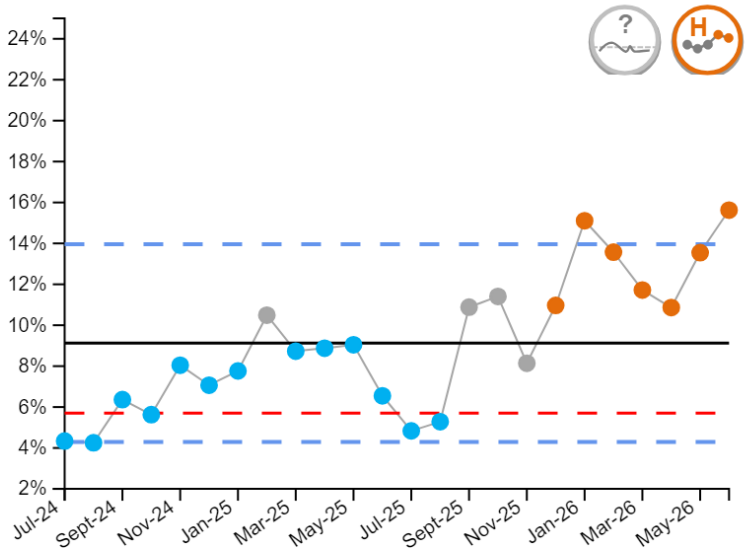
ED 12 Hour Performance - GWH



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		Jun-26	13.7%			H	Special Cause Concerning - Two Out of Three High
ED 12 Hour Performance	GWH	Type 1 and Type 2 attendances	13.0%	Jun-26	15.3%	X	?		Common Cause Variation
ED 12 Hour Performance	RUH	Type 1 and Type 2 attendances	0.0%	Jun-26	11.3%	X	F	H	Special Cause Concerning - Two Out of Three High
ED 12 Hour Performance	SFT	Type 1 and Type 2 attendances	5.7%	Jun-26	15.6%	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

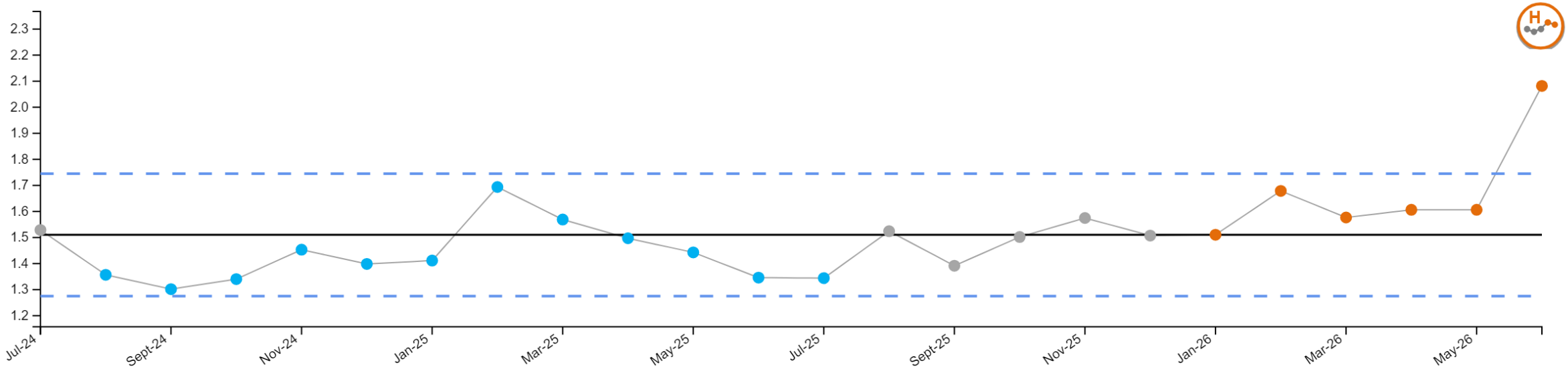
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- There is refocused UEC reset being planned to support system improvement.
- System wide groups are in place to support delivery of alternatives to ED conveyance
- Ongoing improvements in SWASFT to improve see and treat and hear and treat numbers.UEC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

Risks and Mitigation

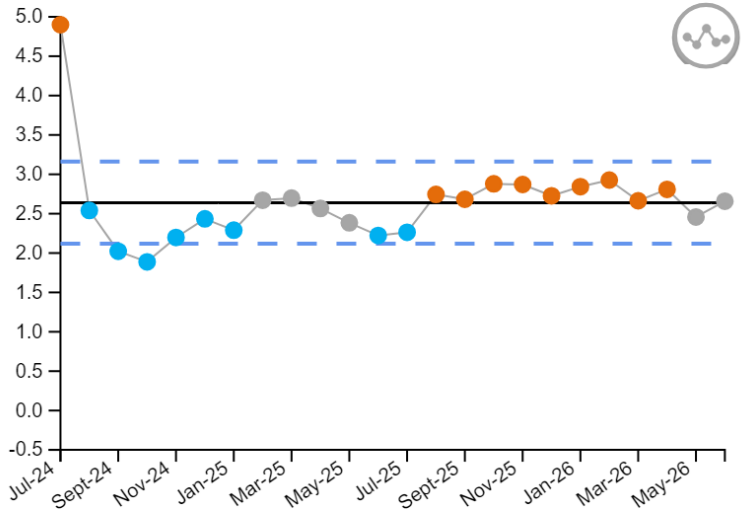
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- System wide groups are in place to support delivery of alternatives to ED conveyance
- Ongoing improvements in SWASFT to improve see and treat and hear and treat numbers.
- Front door event with Health Hero and key stakeholders in Care co in May 2026.
- Winter Debrief held in April with key learning to be shared and actions taken.

Average days between discharge ready date and discharge date

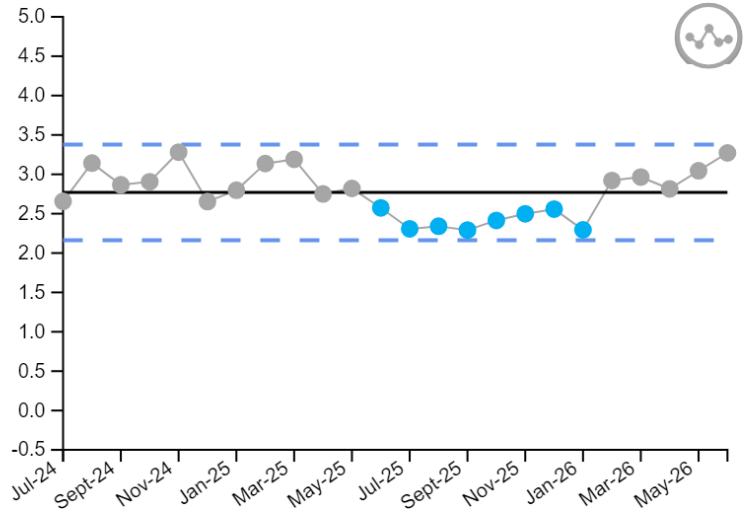
Average days between discharge ready date and discharge date - Group



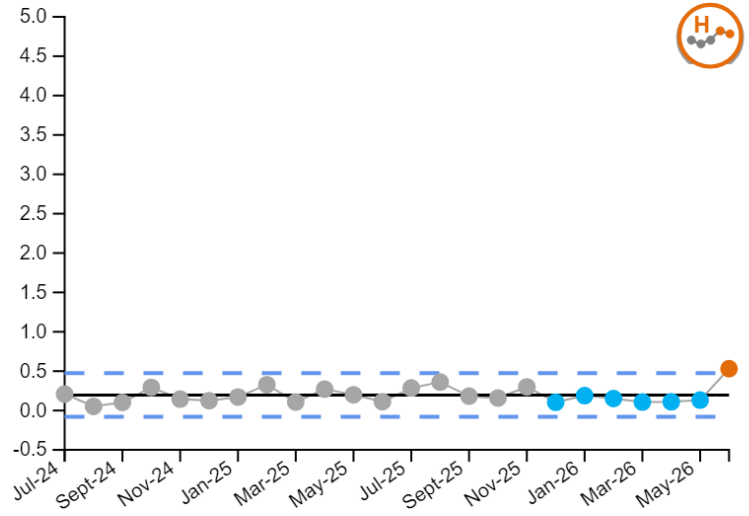
Average days between discharge ready date and discharge date - GWH



Average days between discharge ready date and discharge date - RUH



Average days between discharge ready date and discharge date - SFT



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			Jun-26	2.1			H	Special Cause Concerning - Above Upper Control Limit
Average days between discharge ready date and discharge date	GWH			Jun-26	2.7				Common Cause Variation
Average days between discharge ready date and discharge date	RUH			Jun-26	3.3				Common Cause Variation
Average days between discharge ready date and discharge date	SFT			Jun-26	0.5			H	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

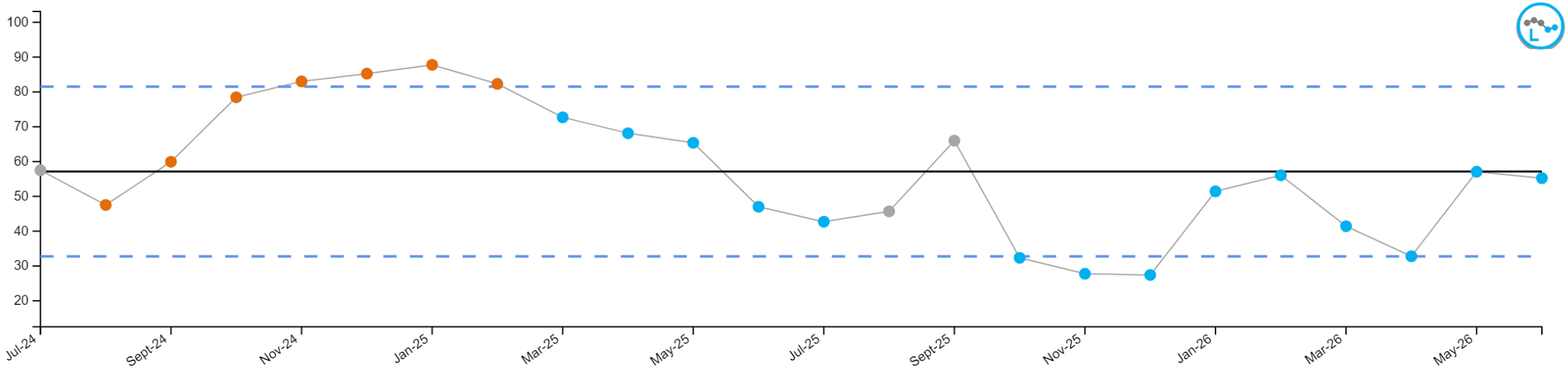
- There is significant work ongoing in each organisation to reduce delays in discharging patients due to hospital reasons
- Internal improvement plans across all three trusts have actions and activities relating to reducing delays in P0 discharges and those that are more complex that have hospital actions
- 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

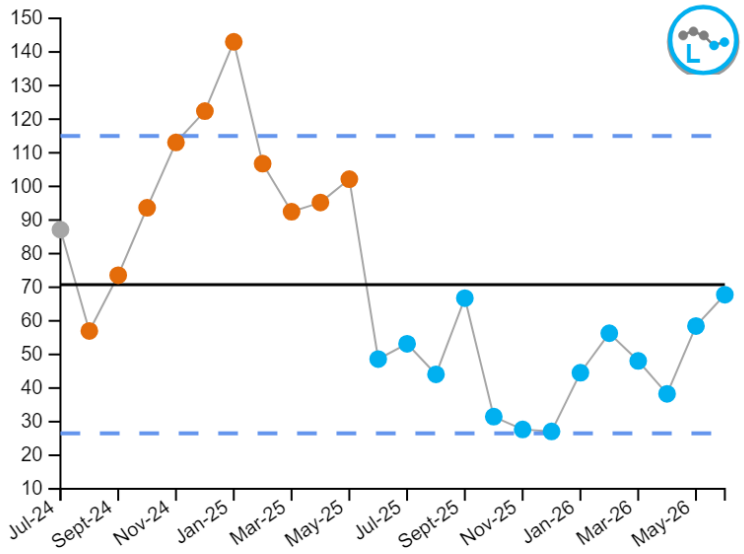
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Average handover time

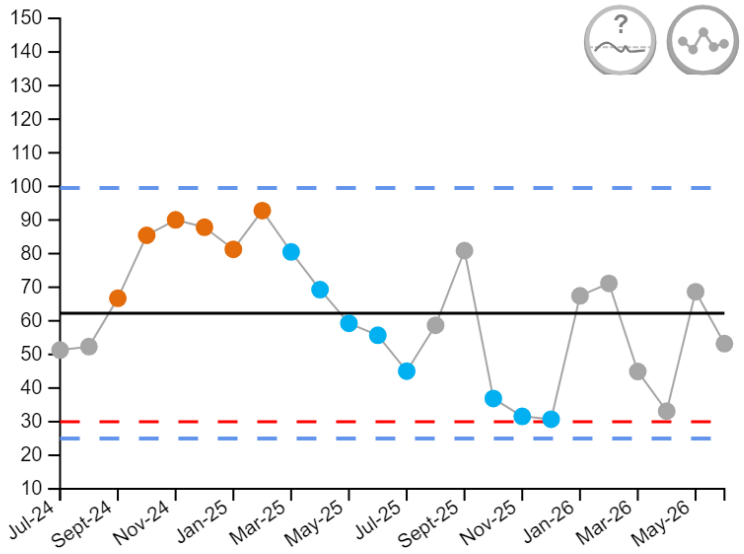
Average handover time - Group



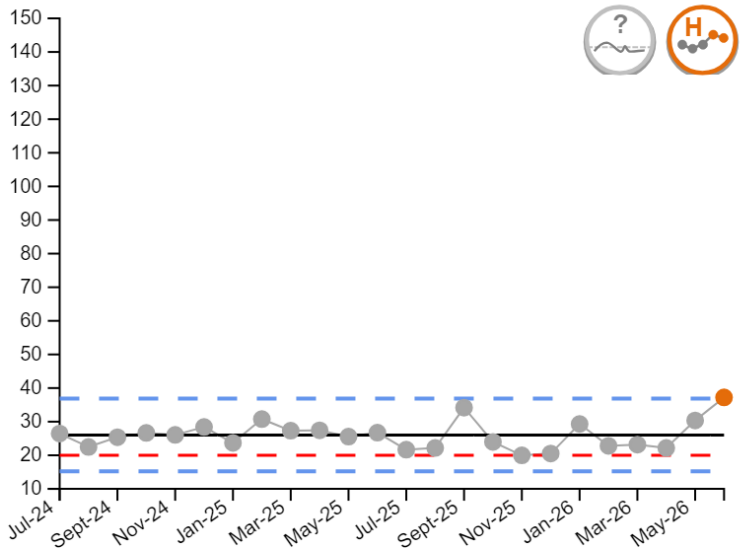
Average handover time - GWH



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		Jun-26	55				Special Cause Improving - Run Below Mean
Average handover time	GWH	Minutes		Jun-26	68				Special Cause Improving - Run Below Mean
Average handover time	RUH	Minutes	30	Jun-26	53	X			Common Cause Variation
Average handover time	SFT	Minutes	20	Jun-26	37	X			Special Cause Concerning - Above Upper Control Limit

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			Jun-26	52.70				
Average Daily Number of Patients in Corridor Care within ED	GWH			Jun-26	23.00				
Average Daily Number of Patients in Corridor Care within ED	RUH			Jun-26	19.57				
Average Daily Number of Patients in Corridor Care within ED	SFT			Jun-26	10.14				

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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Increased system demand and W45 has impacted on ambulance conveyance to EDs.
Further developments in reporting to be undertaken.

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			Jun-26	12.04				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	GWH			Jun-26	6.77				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	RUH			Jun-26	0.00				
Average Daily Number of Corridor Care Beds Occupied (Adults and Paeds)	SFT			Jun-26	5.27				

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

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

Countermeasures

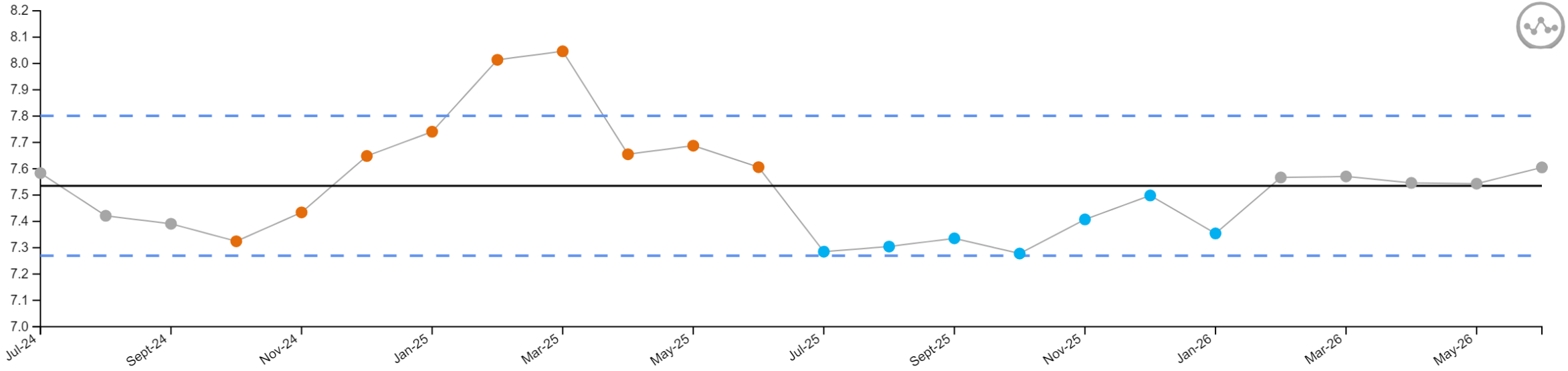
In March 2026 NHSE published new guidance that outlined the additional actions that are required to eliminate corridor care. This is a system challenge that relates to poor flow out of the back door of the Emergency Depts and can also result in extra beds being placed in wards and other areas that are 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.
RUH have very few areas to board in and in March no corridor care outside of the ED.

Risks and Mitigation

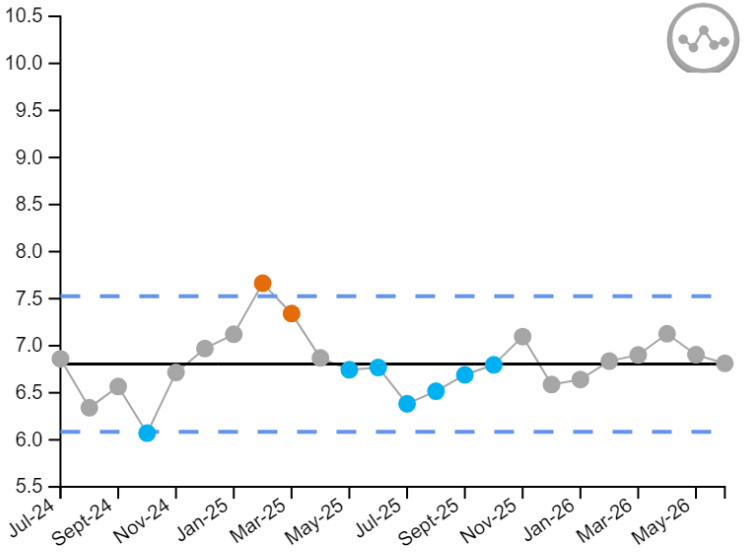
R: no reduction in system demand **M**: demand and capacity modelling requested via system to ensure that there is adequate capacity to support good flow
R: non delivery of internal actions **M:** ongoing review of plans and monthly UEC boards in place, oversight via IPR and executive structures
R: Non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

Average LoS

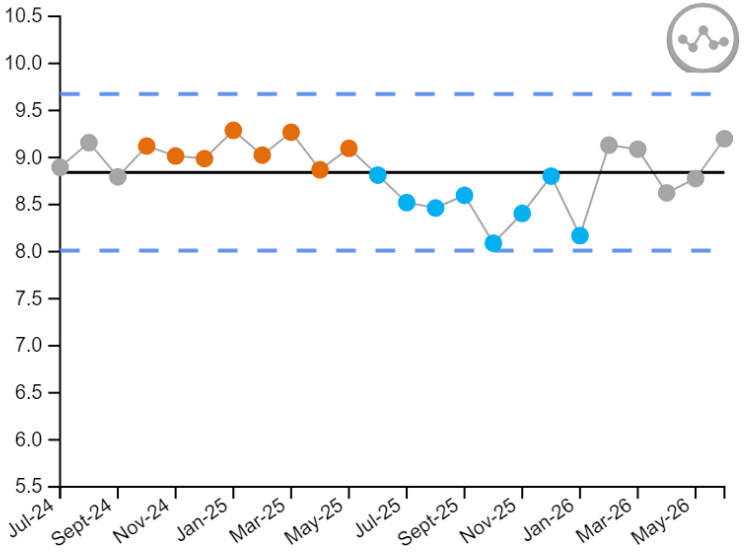
Average LoS - Group



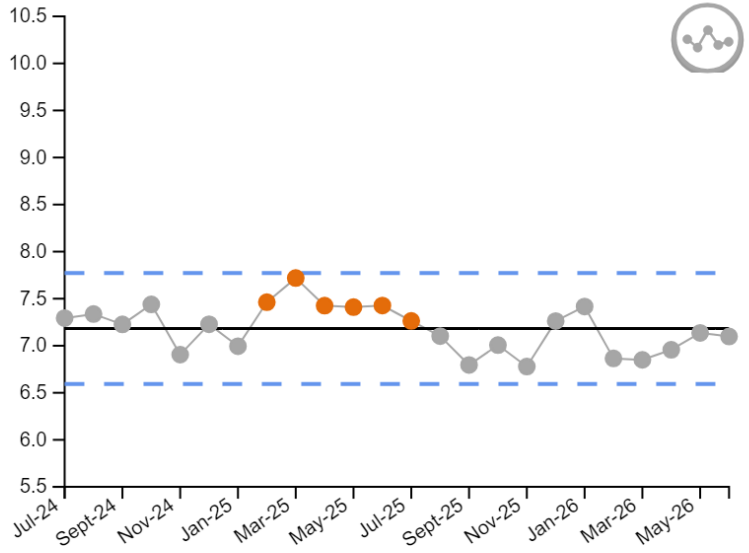
Average LoS - GWH



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			Jun-26	7.6				Common Cause Variation
Average LoS	GWH			Jun-26	6.8				Common Cause Variation
Average LoS	RUH			Jun-26	9.2				Common Cause Variation
Average LoS	SFT			Jun-26	7.1				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

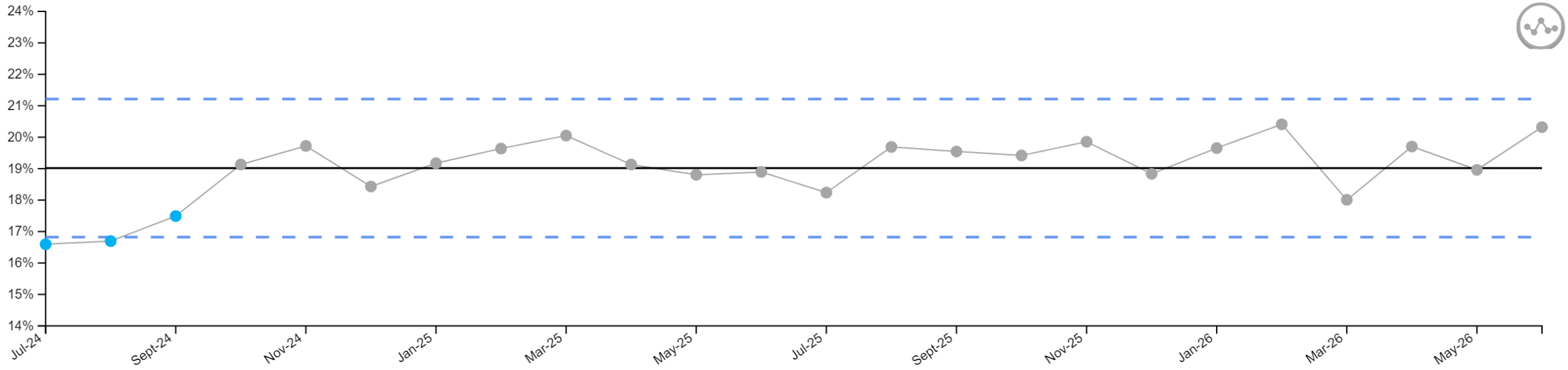
- Internal flow improvements across all three trusts as part of UEC improvement plans– including ward process improvements and referral process improvements to reduce delays across all internal elements of the pathways
- Engagement with clinicians across specialties across all three acutes to improve 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

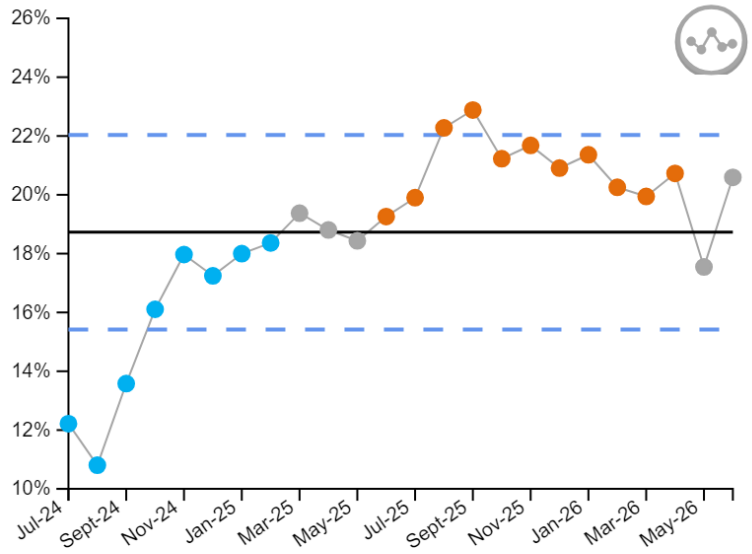
- R - Inability to deliver improvement programmes at the pace required to see improvement
- M - oversight at trust and Delivery group in place to identify where there are challenges to delivery and unblock any issues, ongoing go and see approach by execs at trust level to support delivery, clear objectives 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

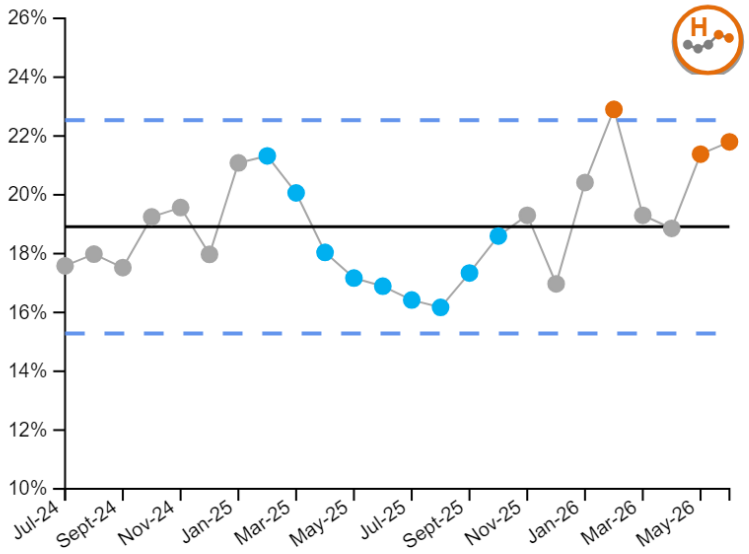
% of NCTR - Group



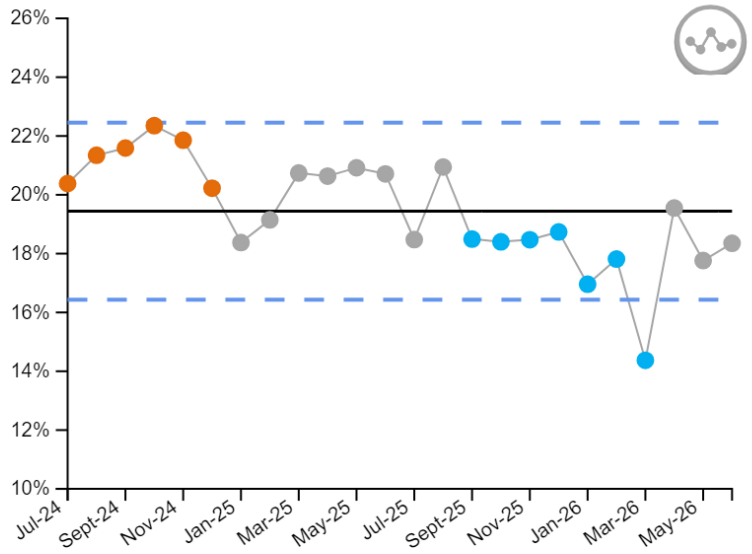
% of NCTR - GWH



% 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			Jun-26	20.3%				Common Cause Variation
% of NCTR	GWH			Jun-26	20.6%				Common Cause Variation
% of NCTR	RUH			Jun-26	21.8%			H	Special Cause Concerning - Two Out of Three High
% of NCTR	SFT			Jun-26	18.4%				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.

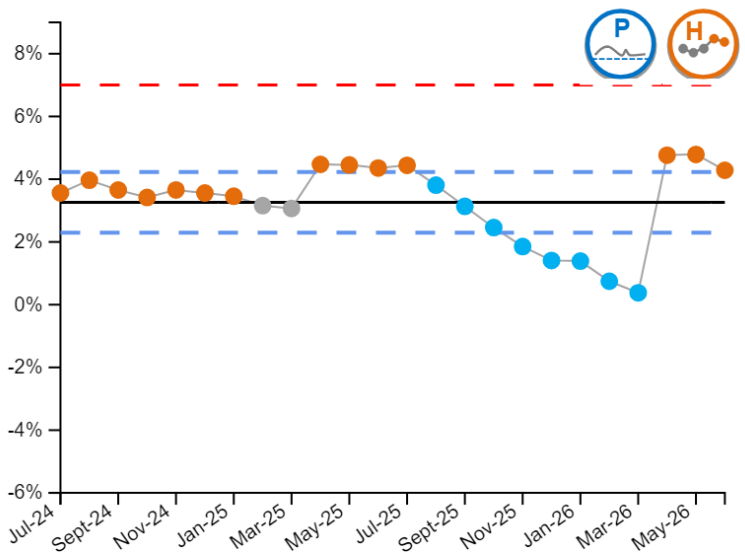
R: due to non-reduction in NCTR acute trusts will be unable to reduce beds in line with recovery plan.

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

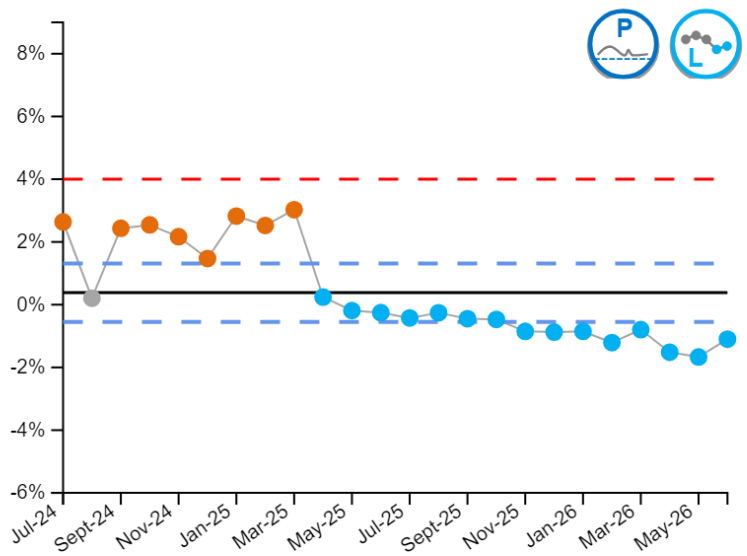
Vacancy Rate

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.

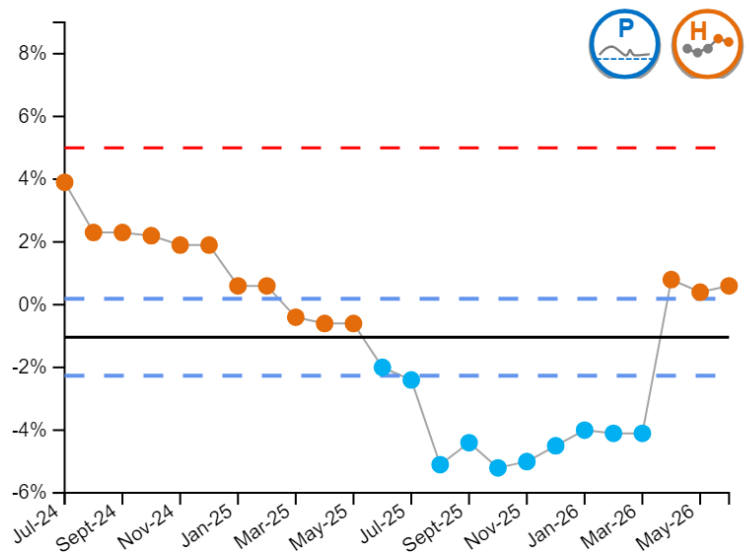
Vacancy Rate - GWH



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	Group			Jun-26					
Vacancy Rate	GWH		7.0%	Jun-26	4.3%	✓			Special Cause Concerning - Above Upper Control Limit
Vacancy Rate	RUH		4.0%	Jun-26	-1.1%	✓			Special Cause Improving - Below Lower Control Limit
Vacancy Rate	SFT		5.0%	Jun-26	0.6%	✓			Special Cause Concerning - Above Upper Control Limit

Understanding Performance

GWH: May vacancy position is **249wte** (budget/ledger basis). 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

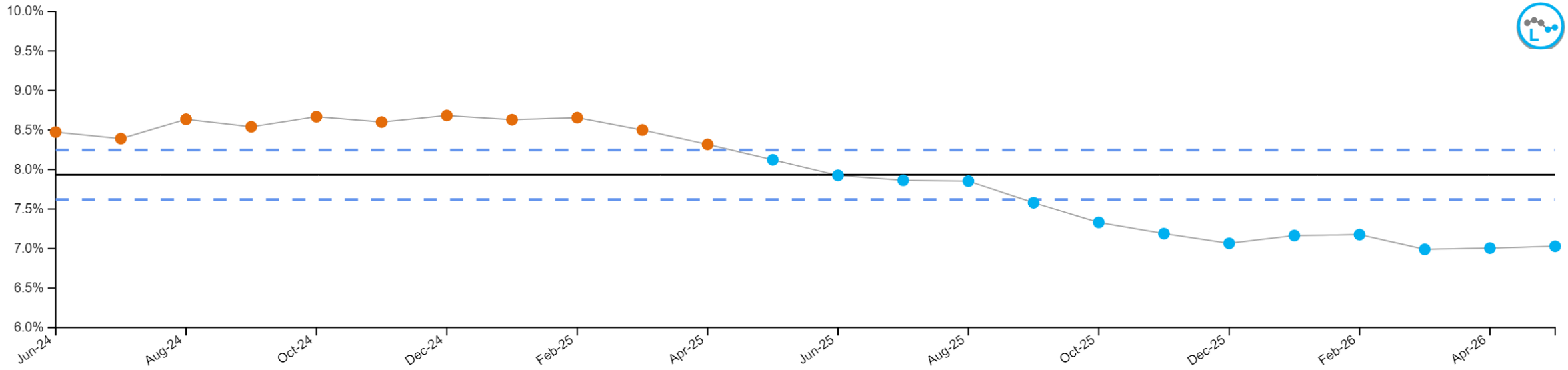
Standardise vacancy and establishment reporting methodology across all Trusts for consideration at GLT.

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

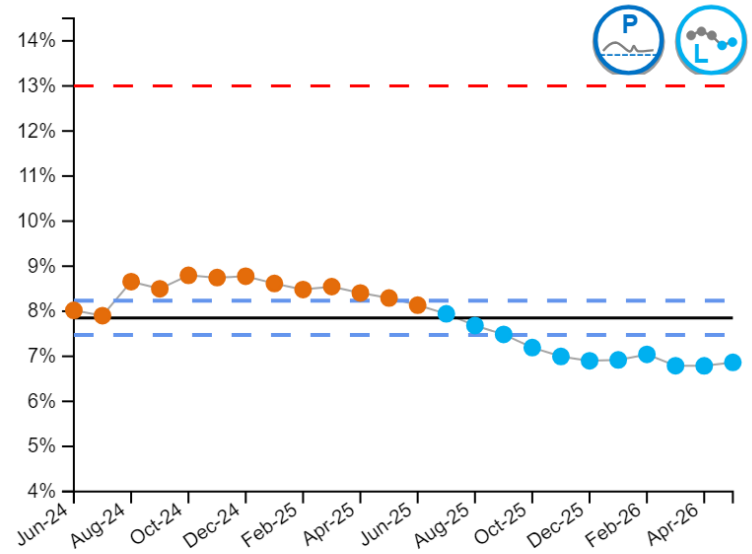
Risks and Mitigation

% Voluntary Turnover

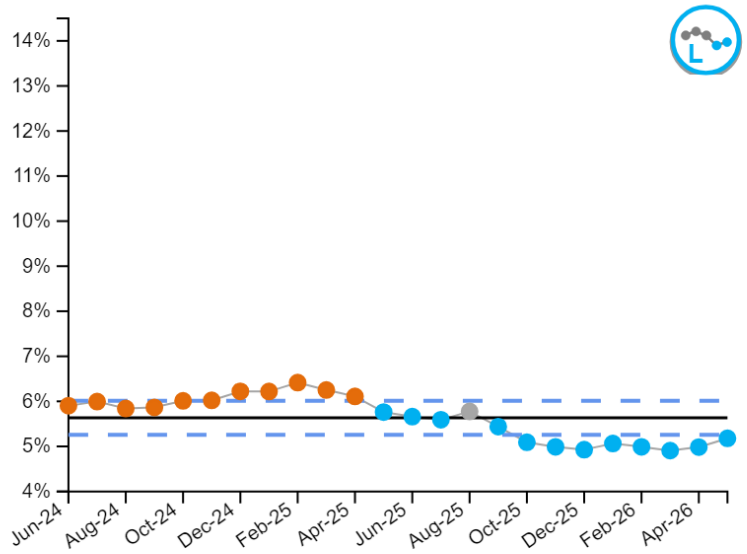
% Voluntary Turnover - Group



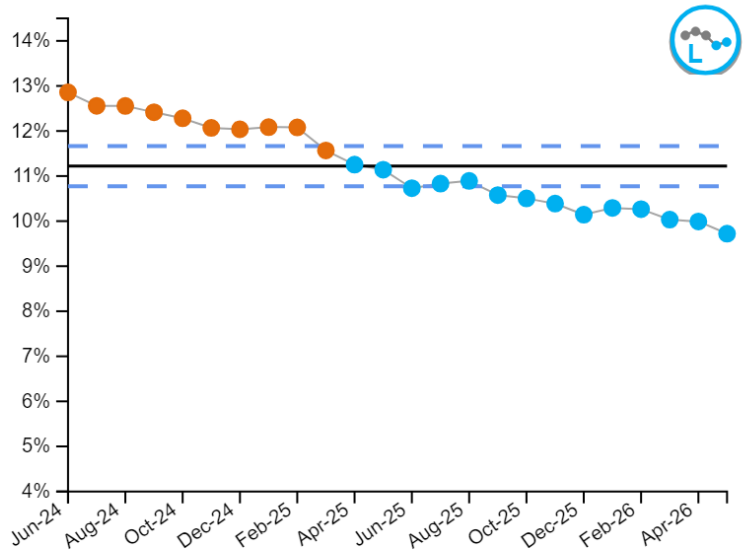
% Voluntary Turnover - GWH



% 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			May-26	7.03%				Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	GWH		13.00%	May-26	6.86%	✓			Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	RUH			May-26	5.18%				Special Cause Improving - Below Lower Control Limit
% Voluntary Turnover	SFT			May-26	9.72%				Special Cause Improving - Below Lower Control Limit

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

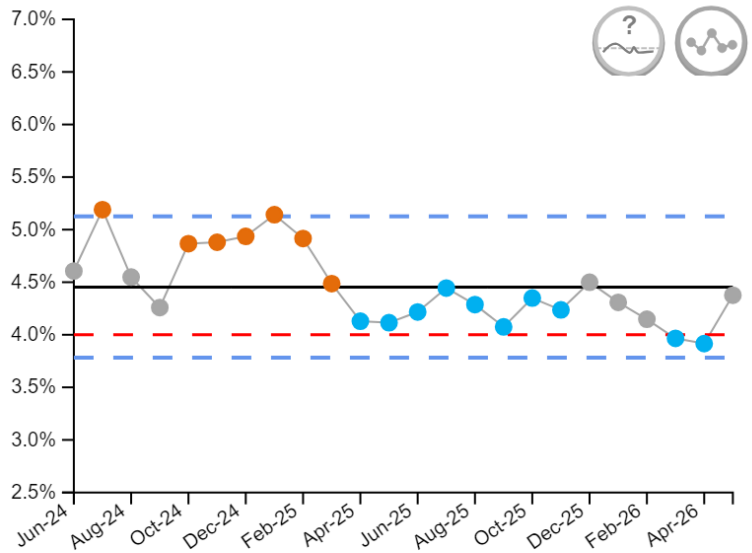
As identified across all turnover metrics, low levels of turnover can negatively impact Trust performance.

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

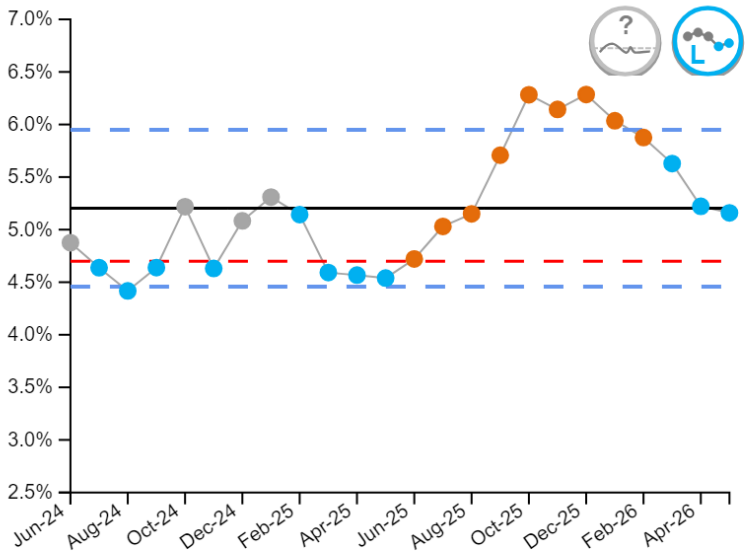
% Sickness

% Sickness - Group

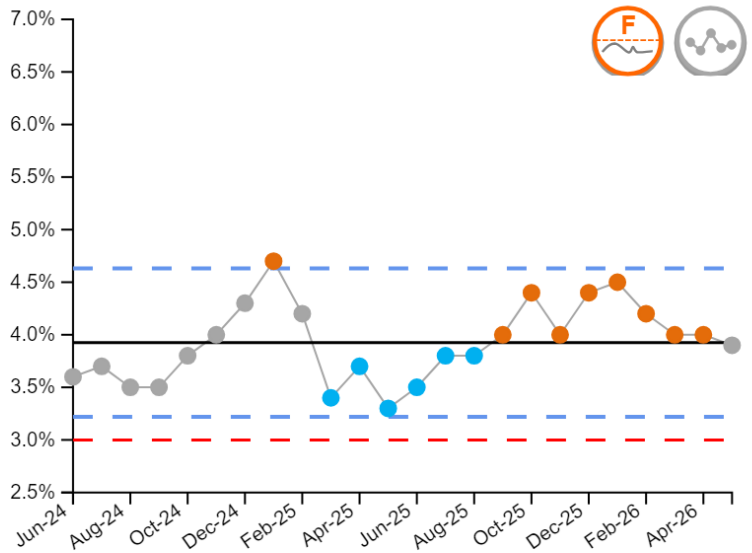
% Sickness - GWH



% 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			May-26					
% Sickness	GWH		4.00%	May-26	4.38%	X			Common Cause Variation
% Sickness	RUH		4.70%	May-26	5.16%	X			Special Cause Improving - Decreasing Run
% Sickness	SFT		3.00%	May-26	3.90%	X			Common Cause Variation

Understanding Performance

Sickness Absence Rates – April

RUH reports the highest sickness absence rate at 5.22% significantly above the group average, however improvement over the last 5 months and a reduction from 5.6% last month

GWH has the lowest rate at 3.92%, while SFT is currently at 4%.

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

BSW Hospitals Group Board

Agenda item	4.3.1
Report title	BSW Group Briefing Paper – NHSE 10-Point Plan for Maternity & Neonatal Services
Date of meeting	3rd September 2026
Sponsor	Angie Ansell – Interim Chief Nursing officer Jason Lugg – Chief Nursing Officer Luisa Goddard – Chief Nursing Officer
Prepared by	Vicki Marston Director of Midwifery & Neonatal Services
Approval Process: (where has this paper been reviewed and approved)	Care Organisation's Quality & Safety 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
R8	Reducing Avoidable Harm
R4	Transforming Models of Care
R9	Improving staff satisfaction

KEY MESSAGES

The Board are asked to receive the briefing Paper for the NHSE 10-point plan for Maternity and Neonatal Services which was sent to Trusts in July 2026. The Board are asked to note the initial briefing and actions required.

In response to Publication of Baroness Amos' independent investigation into Maternity and Neonatal Services in England and Donna Ockenden's review into Maternity and Neonatal Services, NHSE created a 10-Point Plan for Maternity and Neonatal Services that must form the initial work to be completed in response to the two reports.

The 10-point plan is a set of urgent actions in response to the recommendations in both reports that Trusts and the wider system are expected to prioritise.

The urgent actions will support, and report into, the National Maternity and Neonatal Taskforce as it develops the National Action Plan, which will be published in December.

NHSE have asked Trusts to submit the standardised national reporting template to their NHS Region at two points:

- Baseline Assessment: 25th September 2026
- Progress Update: 31st December 2026

Both submissions must be approved by the Group Board and Boards are asked to provide visible ownership and scrutiny of delivery, ensuring actions are progressing at pace, risks are managed appropriately and any significant concerns are escalated. A virtual extraordinary Board meeting is proposed c 21st September to review the baseline assessment.

The Directors of Midwifery are completing the 10-point plan reporting template along with the supporting evidence to meet the submission date. This will be alongside the Triage benchmarking tool.

RECOMMENDATION

The Group Board is asked to:

1. Note the 10-Point Plan and the associated national expectations for Maternity and Neonatal Services to comply with, published by NHSE in response to Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England and Donna Ockendens review into Nottingham University Hospital Maternity Services.
2. Note that the Group's Maternity and Neonatal Services are currently benchmarking their position against the requirements of the 10-Point Plan and completing the National Implementation Tool to support formal compliance assessment and reporting.
3. Receive a further update on the Group's compliance assessment, identified gaps and proposed implementation actions in line with national reporting expectations.
4. Continue to support robust Board oversight of Maternity and Neonatal safety, quality, workforce, inequalities and patient experience improvements.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix 1	NHSE letter 12th August 2026 Maternity and Neonatal 10 point plan assurance process [Refer Reading Room]
Appendix 2	Briefing paper on the NHSE 10-point plan for Maternity and Neonatal Services

Appendix 2

Briefing Paper of NHSE 10-Point Plan for Maternity and Neonatal Services

1.0 Purpose

To provide an overview of NHS England's **NHSE 10-Point Plan for Maternity and Neonatal Services** which has been set out in response to the publication of Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England and Donna Ockenden's review into Maternity and Neonatal Services at Nottingham University Hospital, including the urgent actions that all Trusts and systems are expected to prioritise.

2.0 Background

On 1 July 2026, NHS England published its response to Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England. NHS England described the findings as a significant moment requiring collective leadership and urgent action to address the failings and harm experienced by women, babies and families and to improve maternity and neonatal care.

NHS England states that the findings of the Amos Investigation and Donna Ockenden's review highlight the need for immediate action and have informed the development of a national **10 Point Plan for Maternity and Neonatal Services**. These urgent actions will support and inform the work of the National Maternity and Neonatal Taskforce, which is developing a National Action Plan, due to be published in December 2026.

Alongside the publication of the report, the Government announced:

- £10.6 million in 2026/27 to support recruitment of newly qualified midwives.
- The creation of the UK's first Maternity and Neonatal Commissioner.
- An additional £41 million to improve the safety and quality of Maternity and Neonatal estate infrastructure.

3.0 Information

NHS England Urgent Actions for Trusts

1. Listening to women and their families by rolling out Martha's Rule

- Commence roll out of Martha's Rule across all Maternity and Neonatal Services in 2026/27.
- Building on the learning and insights from the recent pilot, this next phase will support implementation in all antenatal, intrapartum and postnatal inpatient maternity and obstetric settings, including maternity triage and assessment units, and neonatal settings.
- Implementation will be led by the National Martha's Rule Programme Team, working closely with patient safety collaboratives to provide coordinated local support, webinars, guidance and advice. They will contact provider organisations in the coming weeks to confirm expectations, resources and timelines.

2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit data that are acted upon at Board level

- All Trusts should implement a monthly cycle of collecting and analysing real-time patient outcomes and experience data at their Public Boards, using locally meaningful measures like the friends and family test, selected elements of PREM (when available) and insights from Maternity and Neonatal Voices Partnerships (MNVPs). This should include regularly listening to women, families and neonatal parents at different points in the pathway, publishing data and patient commentary for full transparency, and ensuring a clear focus on the experiences of people from minority backgrounds. This will ensure the voices and experiences of women and families are heard, scrutinised and acted upon by Boards.

- As part of this, Trusts should also reinvigorate clinical audits focusing on key and relevant recommendations identified in the Ockenden and Amos reviews in a focused and effective way, and act on the findings.

- The aim is to support this approach through National webinars.

3. Dual board-level accountability between Medical Directors and Chief Nursing Officers for Maternity and Neonatal Care

- All Trusts must establish clear joint accountability at Board level for Maternity and Neonatal Services, with Medical Directors and Chief Nurses holding shared responsibility for oversight, performance and improvement. This must include consistent Medical Director engagement alongside the Chief Nurse, and parity between obstetric, midwifery, neonatal and operational leadership. Directors of Midwifery and Clinical Directors leading Maternity and Neonatal Services should attend Boards when Maternity or Neonatal matters are discussed.

- This should also be implemented across all levels in the NHS including at system, Regional, and NHS England Boards to eliminate siloed working and strengthen system-wide leadership.

4. "Amos into action" staff listening exercise

- Following the listening conversation undertaken by Baroness Amos to understand the nature of the issues in Maternity and Neonatal Services, NHS England will launch a full, open conversation with NHS staff and leaders to identify how the recommendations can be implemented across the system.

- It will explore and help address the role of culture, attitudes, approaches to practice and ways of working – bringing staff into the single largest national conversation about what Trusts and individual clinicians need to do differently to implement both the letter and spirit of the Amos recommendations. This will be done in a way that aligns to, rather than duplicates, the work of the taskforce and will report findings into it. It will focus on how we implement Baroness Amos's findings from the listening exercise and the findings of the Ockenden review of Nottingham University Hospitals NHS Trust (NUH).

5. Addressing inequalities in Maternity and Neonatal outcomes

- We can now confirm the timeline for the national rollout of the Perinatal Equity and Anti-Discrimination Programme, which will be available to all Trusts by the end of 2026. The programme has been developed to support Maternity and Neonatal teams to tackle racism and discrimination, improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and support staff to work in environments free from discrimination and racism. All Boards must ensure that provision is in place to allow enough staff to be released to

complete the Perinatal Equity and Anti-Discrimination Programme, with full participation expected across multi-disciplinary teams.

- Boards must also regularly review and act on trends identified by their inequalities data dashboards. All NHS Trusts providing Maternity services are responsible for fully implementing the Maternal Care Bundle by March 2027. This includes providing regular reports to the Trust Board on implementation.

6. Ensuring 24/7 safety and responsiveness of Maternity and Neonatal Services

- All Boards must take accountability for ensuring safe and effective service arrangements, including reviewing staffing to ensure 24/7 availability and responsiveness across key workforce groups.

- Boards must also review internal resource deployment and consider whether roles not directly supporting frontline delivery can be redirected to strengthen service provision. Trusts must ensure that, where specialist posts exist (including in bereavement care and infant feeding), other staff have the knowledge and skills to ensure that care is not compromised when the specialist midwives are not immediately available.

- Commissioners also hold responsibility for ensuring that their Maternity and Neonatal service model aligns to local demographic needs. Boards and Commissioners must address local gaps and eliminate siloed working to ensure services can consistently and safely respond to the needs of women, babies and families.

7. Trusts to review their homebirth services

- Trusts have a continuing responsibility to offer homebirth as a choice for women and are responsible for ensuring that they manage their workforce to enable this. In November 2025, the Chief Midwifery Officer for England asked Trusts to urgently review the safety and quality of their homebirth services.

- Trusts should ensure that this review has been undertaken and reported to their Board and that any safety concerns requiring urgent attention have been actioned. They should ensure that improvement plans are in place where necessary and that risks have been communicated to their regional NHS England team.

- NHS England is working with partners to develop homebirth standards and a homebirth framework, to support women's autonomy, choice and personalised care, and to help services provide safe homebirth care.

8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach

- Trust Boards should review how they are responding to patient safety incidents, complaints and concerns within Maternity and Neonatal Services, with openness, humanity and candour.

- We will work with Trusts, in alignment with the work of the National Taskforce, to develop a blueprint for how organisations and leaders can respond with more humanity and compassion when things go wrong with a patient's care.

9. Deliver safe and effective triage in Maternity Services

- All Trusts must commit to delivering safe and effective triage, starting by completing a board-level audit within 3 months, with a focus on ensuring that maternity triage services are consistently safe, responsive and appropriately resourced. This will be supported by new NHS England guidance, which will be published this week.

- This includes having dedicated midwifery staffing to answer calls and provide face-to-face assessments, separate from other services such as the labour ward. Services should also have enough clinical, antenatal and bed capacity, with clear escalation routes in place at all times, including overnight and at weekends.

- Boards should have clear oversight of triage quality and performance, supported by regular data on waiting times, assessment and review times, redeployment, delays and outcomes. Triage records should capture women's preferences, and services should use evidence-based standards, such as BSOTS, supported by rapid assessment training for triage midwives. This should enable Trusts to identify risks, address delays and provide women with timely, consistent and high-quality triage care.

- The outcomes of this audit should be reported to regions and the Department of Health and Social Care / NHS England. Within 12 months, Trusts must implement improvements in line with national triage guidance to ensure women have consistent access to high-quality, responsive triage across the NHS.

- National maternity triage principles and a supporting measurement framework will be provided to Trusts this week to reduce unwarranted variation, strengthen consistency in how concerns are assessed and escalated, and provide a clearer basis for local, Regional and National improvement.

10. Post death care

- All Trusts must implement actions set out in the system letter following the Fuller and NUH reviews, including responding to the Board Assurance Statement by 31 July and to the Human Tissue Authority requirement to review and assure completeness of incident records over the past 10 years.

- Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

4.0 Actions

The Directors of Midwifery are completing the 10 point plan reporting template along with the supporting evidence to meet the baseline assessment submission date of the 25th September 2026. This will be alongside the Triage benchmarking tool.

Progress against the baseline assessment and action plan will be reported through the Care Organisations Maternity and Neonatal Governance structures and Quality and Safety Committee. Progress updates will be provided to the Group Board, including any actions required to strengthen compliance with the national requirements.

5.0 Recommendations

The Board are asked to:

1. Note the 10-Point Plan and the associated national expectations for Maternity and Neonatal Services to comply with, published by NHSE in response to Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England and Donna Ockendens review into Nottingham University Hospital Maternity Services.
2. Note that the Group’s Maternity and Neonatal Services are currently benchmarking their position against the requirements of the 10-Point Plan and completing the National Implementation Tool to support formal compliance assessment and reporting.
3. Receive a further update on the Group's compliance assessment, identified gaps and proposed implementation actions in line with national reporting expectations.
4. Continue to support robust Board oversight of Maternity and Neonatal safety, quality, workforce, inequalities and patient experience improvements.

BSW Hospitals Group Board

Agenda item	4.3.2
Report title	Salisbury NHS Foundation Trust – Maternity & Neonatal Services Quality & Safety Report Quarter 1
Date of meeting	3rd September 2026
Sponsor	Angie Ansell, Interim Chief Nursing Officer
Prepared by	Vicki Marston Director of Midwifery & Neonatal Services
Approval Process: (where has this paper been reviewed and approved)	Maternity & Neonatal Assurance Committee 20th August 2026 Quality & Safety Committee 26th August 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 Maternity & Neonatal Quality and Safety Report for Q1 26/27 demonstrates the current position against local and nationally agreed measures to monitor maternity and neonatal safety. The purpose of this report is to inform the Board of present and emerging safety concerns within Maternity and Neonatal Services.

It will evidence current compliance with national reporting to include Care Quality Commission (CQC), Maternity Incentive Scheme (MIS) and all national workstreams. It will also demonstrate patient experience and feedback and learning, and triangulation of risk, concerns, outcomes and feedback to the service.

This report reflects data from **Quarter 1 26/27** with detail highlighted below:

- **Risk Register highlights**:
    - Highest risk is 'Harm to Women and Babies through lack of dedicated second Obstetric theatre' Risk ID:6412. At present current obstetric theatre capacity is insufficient to safely meet the increasing demand for its use. With reliance on a single dedicated maternity theatre, alongside an anaesthetic room frequently used as a second operating space despite not being designed for surgical procedures, significant risk is being held by Maternity and Neonatal Services, and the Trust.
- **Midwifery, Obstetric, Neonatal and Anaesthetic staffing:**
    - Non-Compliant for BAPM for Medical cover–progress static due to requirement for full paediatric workforce review, meaning staffing remains consistently at just 43% compliance to BAPM medical standards.
    - Midwifery staffing budget reflects Birthrate Plus establishment levels for Salisbury, and escalation plan in place for any times where staffing does not meet acuity to maintain safe staffing levels.
    - Obstetric attendance in 100% of clinical situations listed in the RCOG document when a consultant is required to attend in person surpasses the minimum MIS requirement of 80%.
    - Anaesthetic staffing 100% complaint to CNST SA A standard of demonstrate that a duty Anaesthetist is immediately available for the obstetric unit 24 hours a day.
- **Safety champions**
    - Executive and Non-Executive Safety Champion attendance at Safety Champion meetings and regular walkabouts in progress. You said/we did boards visible to

staff to ensure ward to board and board to ward cascade of information and oversight.

- Continued escalations include continued suspension of Obstetric outreach clinic at Tidworth due to IT capacity and risks related to lack of second Obstetric theatre and increases in demand not matching availability increasing the risk further.

- **PMRT**
  - In the last completed quarter (**Q1), SFT had 2 stillbirths** (excluding MTOP's). This is a total of 9 in the last 12 months, which equates to 3.96 per 1000 births in the last 12 months (national stillbirth rate 3.2/1000 births).
  - In the last quarter **(Q4), SFT had 0 neonatal deaths** >24 weeks. This is a total of 2 neonatal deaths >24 weeks in the last 12 months which equates to 1.06 per 1000 live births (national neonatal death rate 1.63/1000 live births).

RECOMMENDATION

The Group Board is asked to:

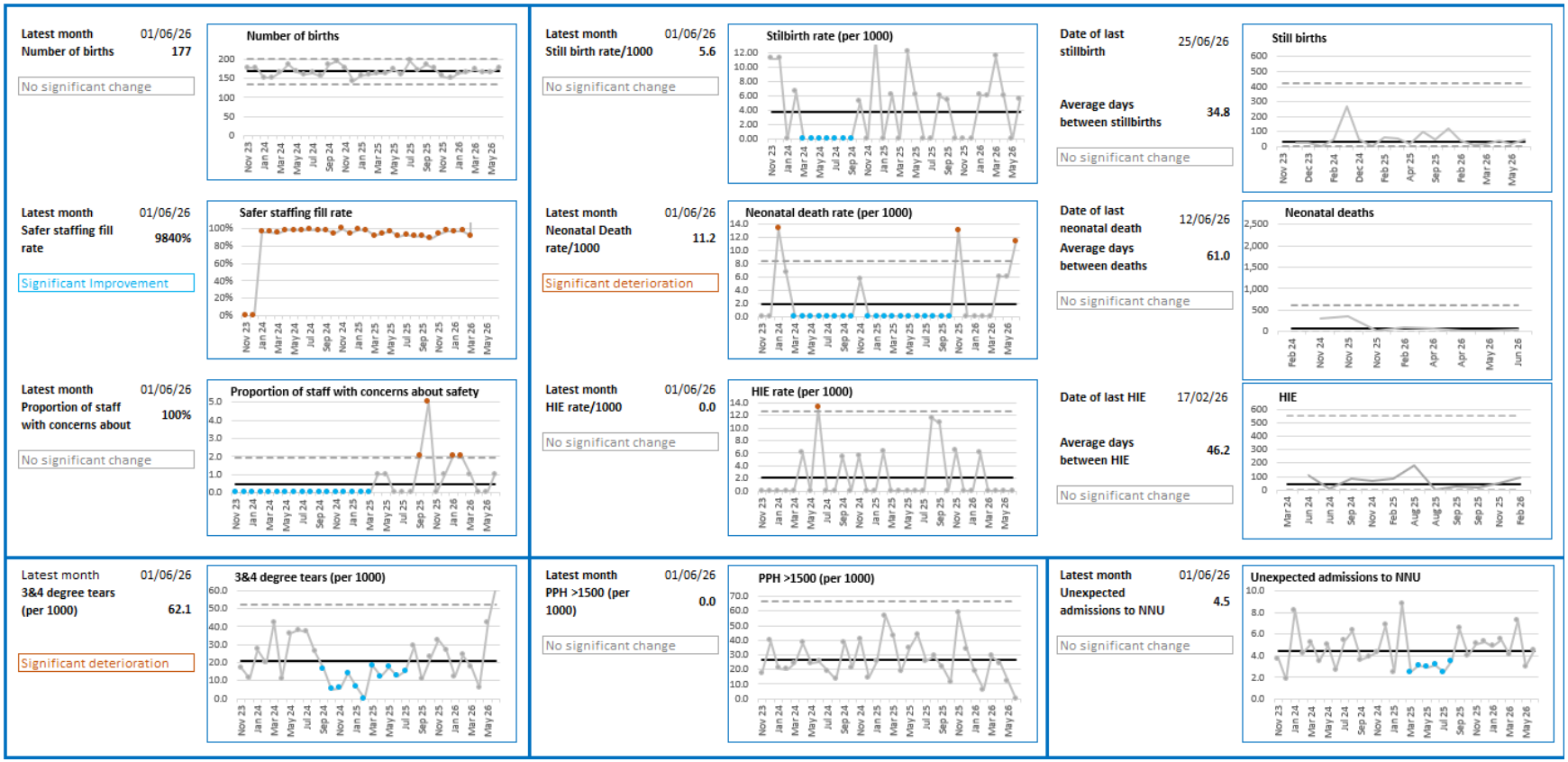
1. Note the contents of the report and SFT current position against metrics defined for Board oversight and review.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix 1	NHSE

Maternity and Neonatal Services Quality and Safety Report Q1 2026/27

MATERNITY DATA MEASURES: PERINATAL QUALITY SURVEILLANCE TOOL



Trust: **Salisbury NHS Foundation Trust Hospital**

CQC Maternity Inspection Ratings 2024	MATERNITY	SAFE	EFFECTIVE	CARING	WELL-LED	RESPONSIVE	
	Select Rating:	*Select Rating:*	*Select Rating:*	*Select Rating:*	*Select Rating:*	*Select Rating:*	
	Good	**Good**	**Good**	**Good**	**Good**	**Good**	

NHSE Maternity Safety Support Programme	No	SFT successfully exited the MSSP during Q3 2024/25

	2026/27											
	Jan	**Feb**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	✓	✓	✓	✓	✓	✓						
2. Findings of review of all cases eligible for referral to MNSI	✓	✓	✓	✓	✓	✓						
Report on: 2a. Number of incidents logged graded as moderate or above and what actions are being taken	✓	✓	✓	✓	✓	✓						
2b. Training compliance for all staff groups in maternity related to the core competency framework (CCF) and wider job essential training	Compliant	Compliant with MIS Yr 7	Compliant with MIS Yr 7	Compliant MIS yr 8	Compliant MIS yr8	Compliant MIS yr 8						
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	✓	✓	✓	✓	✓	✓						
3.Service User Voice Feedback	✓	✓	✓	✓	✓	✓						
4.Staff feedback from frontline champion and walk-abouts	✓	✓	✓	✓	✓	✓						
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	✓	✓	✓	✓	✓	✓						
6.Coroner Reg 28 made directly to Trust	n/a	n/a	n/a	n/a	n/a	n/a						
7.Progress in achievement of CNST 10	✓	✓	✓									

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	Reported annually
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours	Reported annually

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1. Report Overview

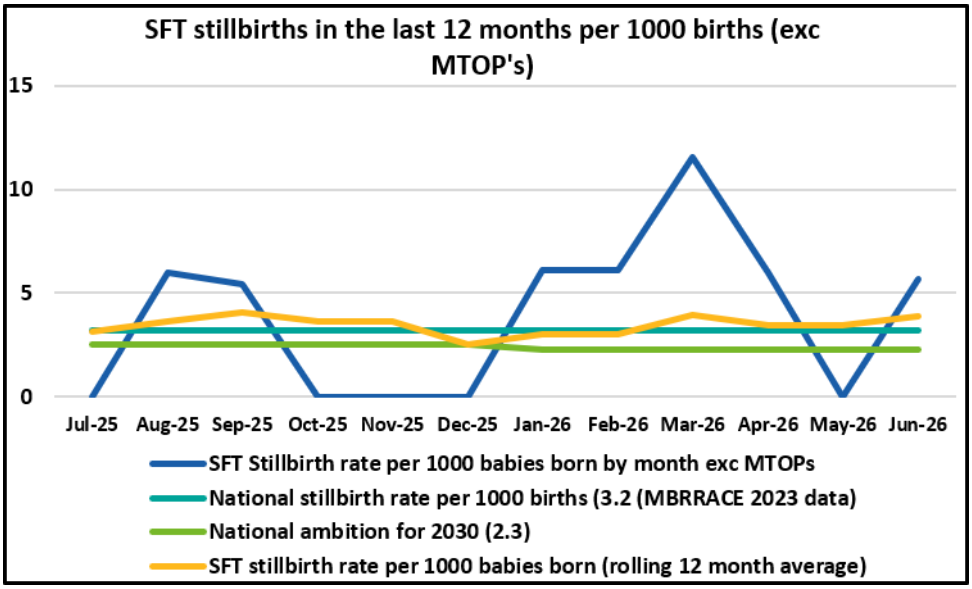
This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The information within the report reflects actions in line with Ockenden and progress made in response to any identified concerns at provider level. Monthly reports will also be shared with Trust Board and LMNS Board via the Perinatal Quality Surveillance Monthly slide set.

2. Perinatal Mortality Rate

The full report is contained in the appendices. The following is a summary of key highlights.

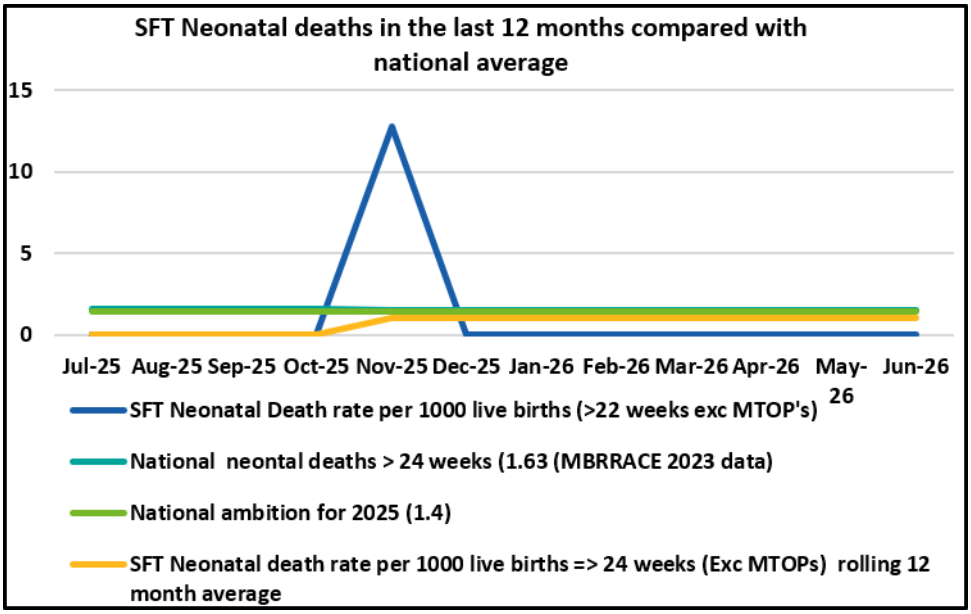
The graphs below demonstrate how Salisbury NHS Foundation Trust is performing against the national ambition.

Figure 1. Monthly Stillbirth rate (per 1000 births excluding MTOP's) for SFT over the last 12 months, compared with national rate and ambition.



In the last completed quarter (Q1), SFT had 2 stillbirths (Excluding MTOP's). This is a total of 9 in the last 12 months, this equates to 3.90 per 1000 births in the last 12 months and remains above the national stillbirth rate, which is 3.2 per 1000 births and the national ambition of 2.5 per 1000 births.

Figure 2. Monthly neonatal death rate per 1000 live births > 24 weeks for SFT compared with national rate.



In the last quarter (Q1), SFT had 0 neonatal deaths >24 weeks. This is a total of 2 neonatal deaths >24 weeks in the last 12 months which equates to 1.06 per 1000 live births and is below the national neonatal death rate of 1.63 per 1000 live births and below the national ambition rate of 1.4 per 1000 live births.

Historic PMRT cases with outstanding actions are detailed in the full report in the appendices. These have been discussed at Safety Champions meetings with the Executive and Non-Executive Safety champions and work is ongoing to progress these actions to close.

2.1 Perinatal Mortality Summary for the Quarter (Q1 26/27)

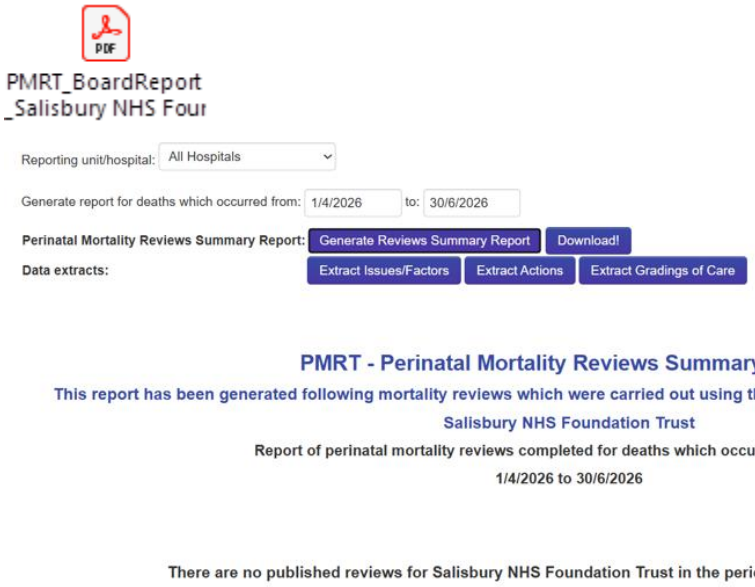
Figure 3. Perinatal Mortality summary

PMRT ID	Cause of Death	Issues/ Actions / learning
102697	Undetermined	Grading of B was given for antenatal care to acknowledge the parents feedback around birth options counselling. A discussion was undertaken with the staff involved- Completed. Issue- it is not clear from the notes if the couple were asked if they wish to take their baby home. This has been highlighted in the maternity newsletter- completed.

2.2 PMRT real time data monitoring tool

At Salisbury NHS Foundation Trust, authorised PMRT users generate reports that summarise the results from completed reviews over a period, within the PMRT for user-defined time periods. Reports are accessed directly from the national PMRT reporting portal. They are used as the basis for Trust Board reports and are discussed with Trust Maternity Safety Champions.

Report generated from the PMRT tool shows the 1 case from Q4 25/26 reviewed in Q1 26/27.



The snapshot above shows cases occurring in Q1 26/27 have not been reviewed at present.

2.3 Learning from PMRT reviews

There was 1 case reviewed under PMRT in Q1 26/27. Learning and progress against previous actions are detailed in the full report in the appendices.

3. Maternal deaths

There have been no maternal deaths during this quarter.

4. Maternity and Newborn Safety Investigations (MNSI) and Maternity Patient Safety Incident Investigation (PSII's)

4.1 Background

The National Maternity Safety Ambition, launched in November 2015, aims to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. This strategy was updated in November 2017 with a new national action plan called Safer Maternity Care, which set out additional measures to improve the rigour and quality of investigations into term stillbirths, serious brain injuries to babies and deaths of mothers and babies. The Secretary of State for Health asked HSIB (now MNSI) to carry out the work around maternity safety investigations outlined in the Safer Maternity Care action plan.

MNSI undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy.

Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.

Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause.

Severe brain injury diagnosed in the first seven days of life, when the baby:

- Was therapeutically cooled (active cooling only), or
- Was diagnosed with moderate to severe hypoxic ischemic encephalopathy (HIE), consisting of altered state of consciousness and at least one of the following:
    - Hypotonia
    - Abnormal reflexes
    - Absent or weak suck.
    - Clinical seizures

To meet the requirements against the 15 Immediate and Essential Actions (IEAs) in the Ockenden 2022 report, all SI's concerning maternity services adhere to the Trusts Patient Safety Incident Response (PSIRF) Policy and Plan.

4.2 CNST Maternity Incentive Scheme (MIS) year 8 compliance - Safety Action C

As part of the CNST MIS standards, Trusts are required to notify all eligible events vis the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR EN and

MNSI as soon as possible after the death/diagnosis.

For eligible events the Trust Board must be assured that:

- Relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews is provided to families in a format that is relevant and accessible NHS England » Accessible information standard (about MNSI and ENS) and,
- Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.

Maternity services are required to report this quarterly to Trust Board for oversight of evidence for Safety Action C.

During Q1, no cases were referred to MNSI.

Figure 4. Summary of MNSI and ENS cases for safety action 10 compliance in Q1.

MNSI case number	**Case accepted by MNSI**	**Families have received DOC 2 letter** (containing information explaining the role of MNSI and ENS in an accessible format)	**Duty of Candour (DoC) compliance**	**Case referred to ENS*** (if eligible)	**Claims reporting wizard completed*** (families informed of ENS involvement)
N/A	N/A	N/A	N/A	N/A	N/A

**From 6th October 2025 all eligible MBRRACE, PMRT, MNSI and ENS cases are notifiable through the 'Submit a Perinatal Event' (SPEN) portal.*

BadgerNet patient records are reviewed to identify any accessibility needs so that the Q&S team can arrange for information about MNSI and ENS to be provided in an accessible format.

Salisbury NHS Foundation Trust is currently compliant with all eligible standards for MIS CNST Year 8 (safety action C).

4.3 Investigation progress update (MNSI and PSII cases) for the last quarter (Q1)

On 8th January 2024, SFT transitioned to the national Patient Safety Incident Response Framework (PSIRF). The Trust Patient Safety Incident Response Plan (PSIRP) identifies local and nationally mandated PSII responses. Maternity Serious Incidents include both commissioned Patient Safety Incident Investigations (PSII's) and MNSI cases that have been accepted.

Figure 5. Investigation progress update

Investigation Type and Ref	MNSI Ref	Incident Summary	Date Investigation Commissioned	External Notifications / Other Investigations	Current Investigation Progress
Nil	N/A	N/A	N/A	N/A	N/A

4.4 Coroner Reg 28 made directly to Trust

There have been no coroner regulation 28's and actions being taken in the last quarter.

4.5 Maternity Patient Safety Incident Investigation (PSII) during Q1

During the last quarter, there were no new maternity PSII's commissioned. These are normally highlighted below for the last quarter.

Figure 6. Commissioned Maternity PSII's

DATIX	Incident Summary	Immediate learning identified
N/A	Nil PSII's commissioned in Q1.	N/A

All patient safety incidents, resulting in moderate harm or above, follow the Trust's Patient Safety Incident Response Plan (PSIRP) in terms of PSR methodology and supporting the statutory duty of candour process. This is detailed in section 11 of this report.

5. Midwifery Continuity of Care (MCOC)

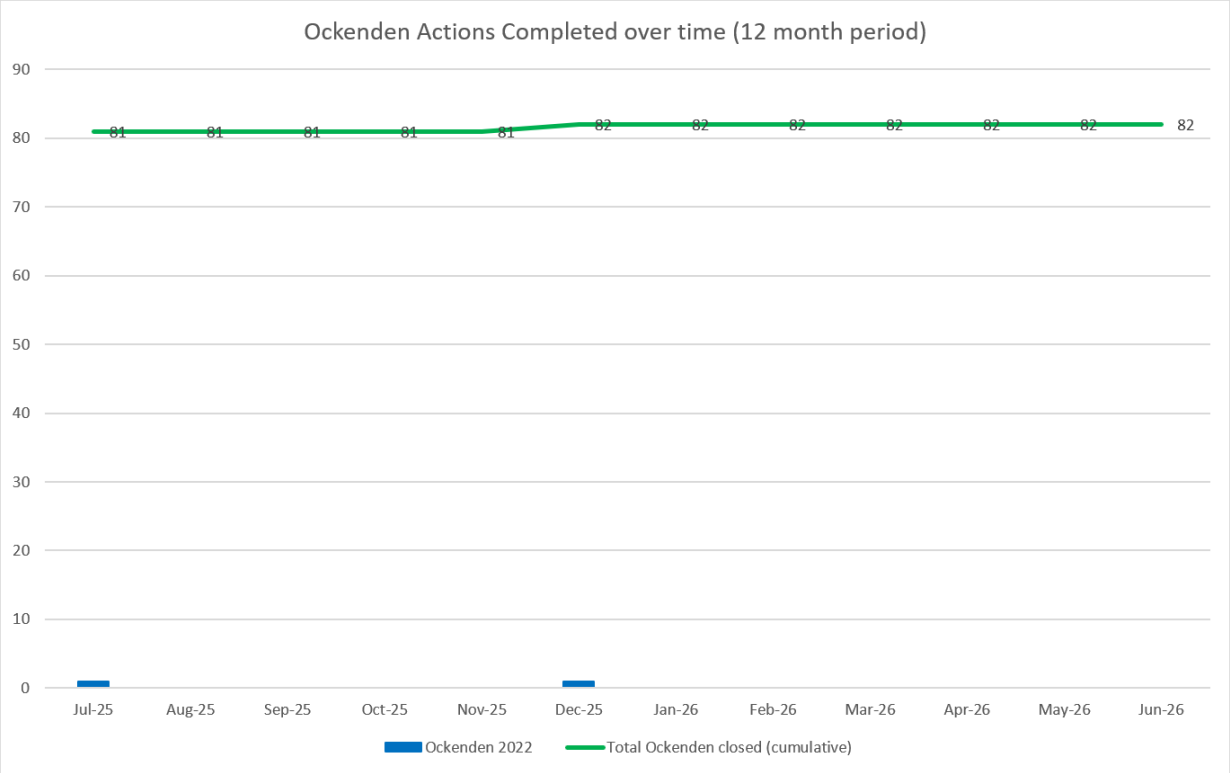
The Three-Year Maternity and Neonatal Delivery Plan state the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings. The delivery and roll out of midwifery continuity of carer, in line with the principles around safe staffing that NHS England set out in September 2022, should be considered.

At Salisbury NHS Foundation Trust, there are no midwifery continuity of carer teams presently. Due to historic midwifery vacancies and having a less experienced workforce, plans to implement this model are paused as per recommendation from NHSE and as advised, following the publication of the Ockenden report. When staffing and skill mix improves, significant consideration will be given to reviewing a team for continuity of care in line with national recommendations. As an interim measure there is now a Continuity of carer Maternity Support Worker working in the community to support women who are non-English speaking or have additional needs.

6. Ockenden 2022 updates

For the Ockenden Final Actions 2022, there are 15 essential actions, separated into 84 sub-actions. The multi-disciplinary Ockenden Working Group has been disbanded, and progress on this workstream is being driven through the Maternity Improvement Group who meet monthly. Current progress on immediate and essential actions is detailed in the table below.

Figure 7. Numbers of actions closed per month in Q1 against the total number of closed actions.



The key achievements and next steps to progress the closure of Ockenden 2022 IEAs are highlighted below:

- **Key achievements:** Key foundations in the implementation of pathways for women with complex care, learning from incidents, clinical governance and leadership and staff staffing levels.
- **Next steps for progression:** Ongoing work continues around a succession planning gap analysis and leadership development training and, working towards Neonatal staffing models becoming BAPM compliant.

Whilst over the years Salisbury maternity and neonatal services have made steady and meaningful progress toward delivering the 2022 Ockenden IEAs, 2 actions remain.
A proposal to Trust Board will be made to formally close Ockenden 2022 action plan, with 82 of the 84 sub-actions fully implemented and embedded into business-as-usual practice. It is proposed that the 2 outstanding actions are to be incorporated into the national service

priorities which aligned to the 3 Year delivery plan (3YDP) themes: listening to women and families, supporting the workforce, developing a safety culture, and strengthening standards and structures.

7. Three-Year Delivery Plan (3YDP)

Ongoing work continues around the 3YDP.

All actions are now either in progress or complete with evidence collated to demonstrate this, with 32 of the 44 actions now complete, with 3 pending closure at July's MNIG, the progress is demonstrated in the chart below.

Figure 8. Three-Year Delivery Plan overall performance by theme

Three-Year Maternity & Neonatal Single Delivery Plan Objective Detail		Number of actions under each heading rated			
		RED	AMBER	To Close	GREEN
1	Care that is personalised	0	0	0	4
2	Improve equity for mothers and babies	0	1	1	0
3	Work with service users to improve care	0	0	0	1
4	Grow our workforce	0	0	1	2
5	Value and retain our workforce	0	5	0	1
6	Invest in skills	0	1	0	2
7	Develop a positive safety culture	0	0	1	4
8	Learning and improving	0	0	0	6
9	Support and oversight	0	0	0	5
10	Standards to ensure best practice	0	0	0	4
11	Data to inform learning	0	0	0	2
12	Make better use of technology	0	2	0	1
	Total	0	9	3	32

8. Training compliance for all staff groups in Maternity related to the core competency framework and wider job essential training

The full report is contained in the appendices. The following is a summary of key highlights.

Safety Action 8 of the current Maternity Incentive Scheme (MIS) requires all maternity units to implement all six core training modules of the Core Competency Framework (CCF)

(version 2). This safety action aims to address known variation in training and competency assessment across England and address areas of significant harm. A three-year training plan was developed for maternity and neonatal services (2025-27) and agreed with the quadrumvirate and signed off by the LMNS/ICB which is then reviewed annually. There are six core modules of the CCF:

- Saving Babies Lives Care Bundle
- Fetal monitoring and surveillance
- Maternity Emergencies and multi professional training
- Equality/ equity and personalised care
- Care during labour and immediate post-natal period
- Neonatal basic life support

The MIS year 8 requirement is for 90% attendance for each relevant staff group at fetal monitoring training, multi-professional maternity emergencies training and neonatal life support by 30th July 2026. The other core modules were not measured within the MIS requirements.

During Q1, training compliance has met the ≥90% target for all staff groups for fetal monitoring, in maternity emergencies (PROMPT) including anaesthetists and NLS.

All elements of the Saving Babies Lives Care Bundle were met.

Figure 9. PROMPT Training Day Compliance

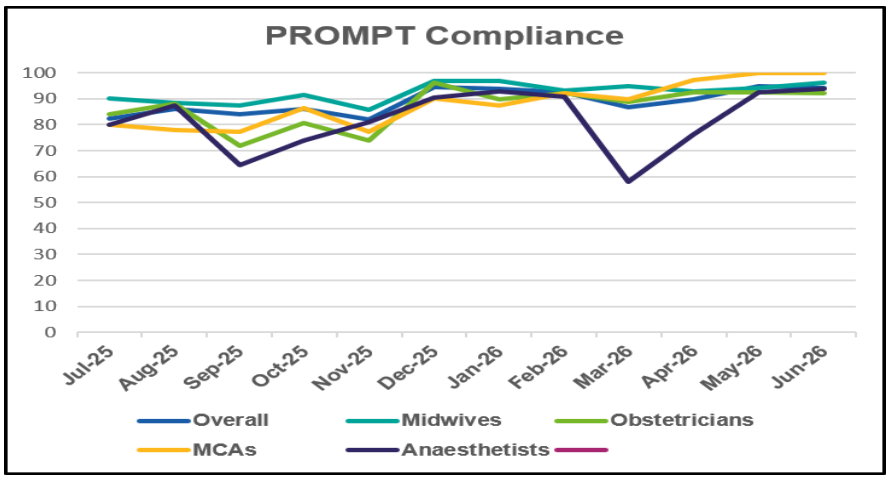


Figure 10. Fetal Monitoring Training Compliance

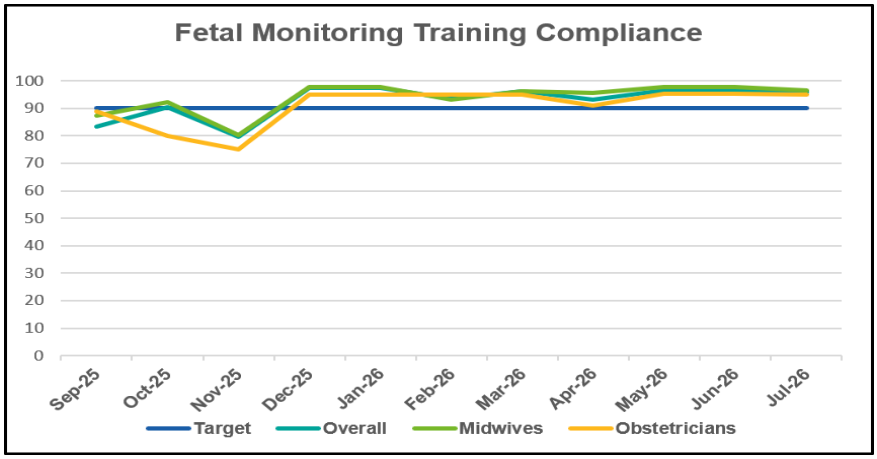
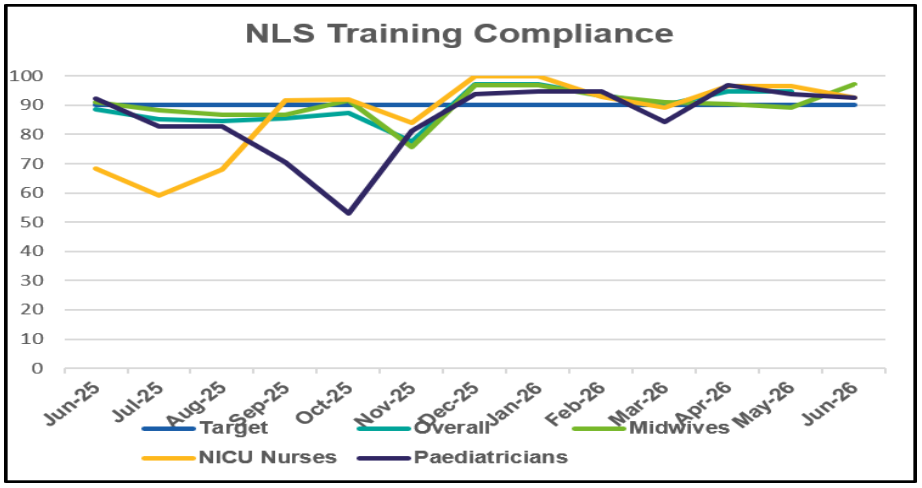


Figure 11. NLS Compliance Training



9. Maternity & Neonatal Safety Champions meetings

This section provides evidence of staff and service user feedback from frontline champions and walk-abouts and outline discussions regarding safety intelligence.

The Maternity and Neonatal Safety Champions meetings occur on the third Thursday of each month. Please see the Terms of Reference which is available on EOLAS for further details of the meeting requirements: Eola's Medical

9.1 Maternity and Neonatal Safety Champions meeting attendance by role for Q1

Figure 12. Maternity and Neonatal Safety Champions attendance by role in Q1

Staff groups	April	May	June
Trust Executives	Chief Nursing Officer	No meeting held	Non-Executive Safety Champion (outgoing) Non-Executive Safety Champion (incoming)
Obstetric	Obstetric Lead		
Midwifery	Director of Midwifery& Neonatal services Assurance Lead Midwife Family Experience & Inclusion Midwife Risk Lead Midwife Community Midwife Digital Lead Midwife Clinical Midwives Student Midwives		Director of Midwifery & Neonatal services Head of Midwifery & Neonatal services Family Experience & Inclusion Midwife Digital Lead Midwife Outpatient Matron Community Midwife
MSW	Maternity Support Workers		
Neonatal	Neonatal Clinical Lead Neonatal Matron Neonatal Nurse		Neonatal Matron Neonatal Clinical Lead
MNVP	MNVP Representative		MNVP Representative
Secretarial support	Maternity & Neonatal Admin Manager		Operational Manager

	Maternity & Neonatal Admin Team Lead		
Quad support	Operational Manager Neonatal Clinical Lead Obstetric Lead		Operational Manager Head of Midwifery & Neonatal services Neonatal Clinical Lead

9.2 Positive points recognised in Q1

The following positive points were highlighted:

- The Perinatal Quad are working on a programme of work related to 'Civility Save lives' and have established a group of staff as 'Civility Champions' who have received training on practical skills and methods to use to address incivility in the workplace. This work will also include an ongoing evaluation of the work and support for the staff members involved.
- Two video laryngoscopes recently purchased via a NHSE Maternity bid – benefits already realised when twins care for concurrently due to the availability of this new equipment.
- A Continuity Maternity Support Worker is now in post in the community. This role is to support families through visits in their own homes, who may be more vulnerable, supporting antenatal education, use of BadgerNet app, signposting to other services.

9.3 Concerns raised in Q1

Figure 13. Concerns raised in Maternity and Neonatal Safety Champions meetings*

Concerns raised	Action and Progress
Inconsistent handovers between the neonatal unit and the Postnatal ward. .	Process reviewed by Neonatal Matron with introduction of SBAR proforma which has demonstrated a more robust handover.
Concern raised about lack of a direct IT contact for urgent clinical systems (e.g. BadgerNet-related issues).	CNO to raise at Digital Steering Group and to explore named IT escalation contact.

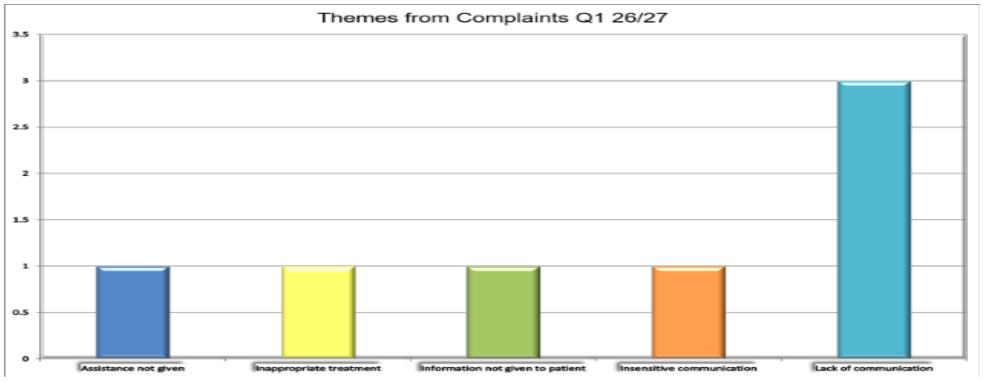
**The detail above informs the 'You said, we did' information displayed on the Maternity Safety Champions boards.*

9.4 Concerns raised by service users

7 complaints and 6 concerns were received in this quarter. The top theme being '**Lack of communication**' and '**Access and Waiting**'. There has been an increase in both

complaints and concerns raised this quarter.

Figure 14. Summary of themes of complaints in Q1 26/27



In Q1, 9 complaints were closed, and **100%** were closed within the target time. This represents an improvement of **33.6%** compared to the previous quarter when the compliance rate was **66.4%**.

For learning and action points taken from closed complaints in Q1 please see appendix 3.

9.5 Additional Safety Champions intelligence

Both executive and non-executive safety champions escalate serious safety concerns raised. The following escalations were reported in Q1:

Figure 15. Concerns escalated in Q1

Concern	Escalation	Outcome
IT issues with Tidworth clinic, high level of DNAs when unable to operate at Tidworth. Safety concerns for these vulnerable women from a health inequalities point of view.	Chief Nursing Officer escalated to Trust Board and Group Chief Digital and Information Officer.	Awaiting approval for installation of dedicated broadband line at Tidworth clinic to support IT needs including Viewpoint for sonography.
Challenges with capacity of only one obstetric theatre – estates options are being considered to accommodate a second obstetric theatre.	Chief Nursing Officer escalated to executives.	Options SBAR has been reviewed by exec team – plan for a business case to be progressed. Architectural processes commenced to support exploring options available prior to a potential bid/options

		discussion re second theatre build/Pod.

9.6 Culture

9.61 Perinatal Culture Improvement Plan

As part of MIS year 8, all trusts must demonstrate that they have an agile perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six monthly.

The focus is on incivility as there is a large body of evidence to show how this impacts on patients and staff wellbeing. Incivility and its impact have been identified through the staff survey, SCORE survey, exit interviews, triangulation, complaints, MNVP feedback. In-keeping with the Trust QI methodology of Improving Together, an A3 has been developed, which details the problem statement, vision, current situation, root cause analysis and countermeasures. This will be reviewed in our regular maternity and neonatal services performance review meetings.



Civility A3 July 2026.docx

10. Saving Babies Lives V3.2

Saving Babies Lives Care Bundle (SBLCB) version 3 was originally published on 31st May 2023. This has since been updated with version 3.2 being published on 24th April 2025.

The SBLCB represents Safety Action 6 of the Maternity Incentive Scheme for Trusts.

The full report is contained in the appendices. The following is a summary of key highlights.

10.1 Update

The current Saving Babies Lives Care Bundle (v3.2) contained new requirements and has since been implemented. The NHS England national SBLCB implementation tool is used by maternity services to use to track and evidence improvement and compliance with the requirements.

Whilst the full report included in the appendices details the specific ongoing action planning

and work, as detailed above, trajectory had been slow. SFT's initial assessment in October 2023 was validated at 7%, followed by submissions that have shown steady progress to 86% compliance (Q4 submission). SFT self-assessments are largely in-line with LMNS validated assessments. Areas that remain challenging include audit compliance and the implementation of PLGF testing. SMART action plans are in place for all non-compliant requirements to support increased compliance.

11. NHS Resolution Maternity Incentive Scheme

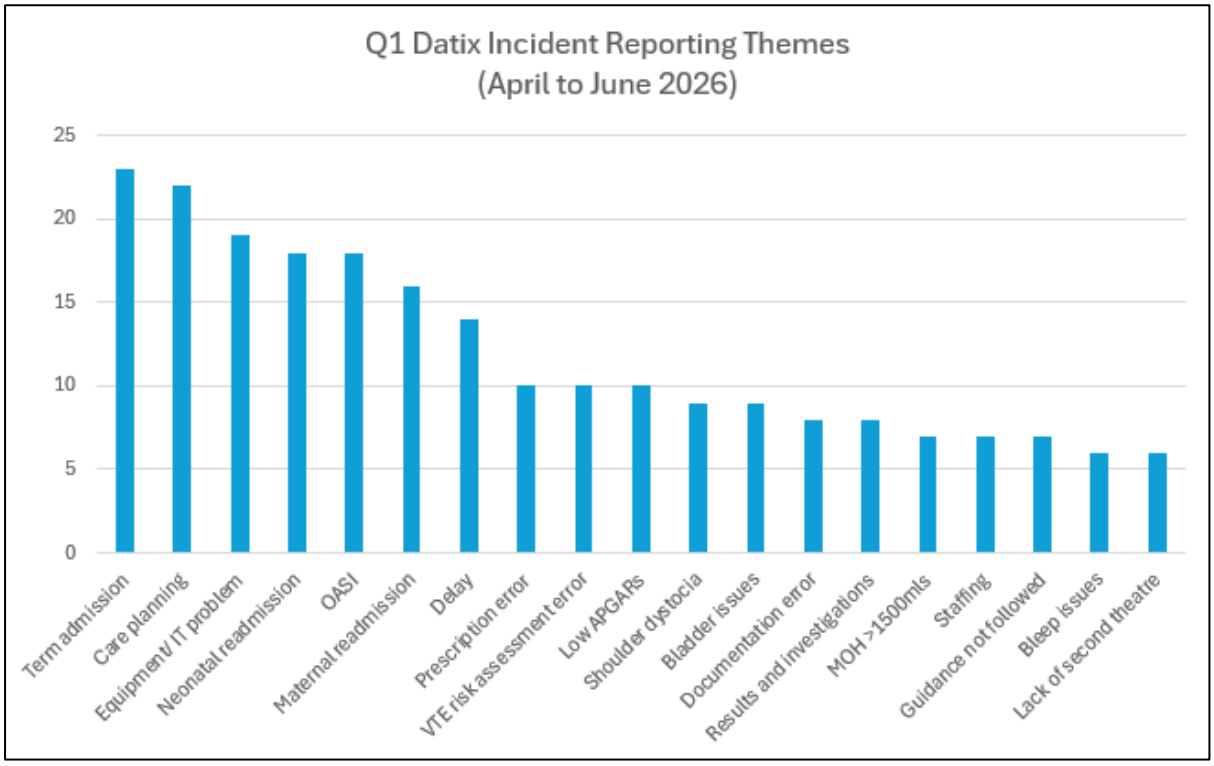
MIS Year 8 requirements were published in April 2026 and SFT is required to be compliant by 30th November 2026.

Following full 10 out of 10 compliances with MIS Year 7, Salisbury has continued the monthly CNST working groups to ensure compliance against year 8 requirements.

12. The number of incidents in Q1 and actions being taken

A summary of incidents themes reported in Q1 are provided below. This data is pulled directly from Datix as a listing report which codes incidents accordingly.

Figure 16. Datix incident report themes during Q1

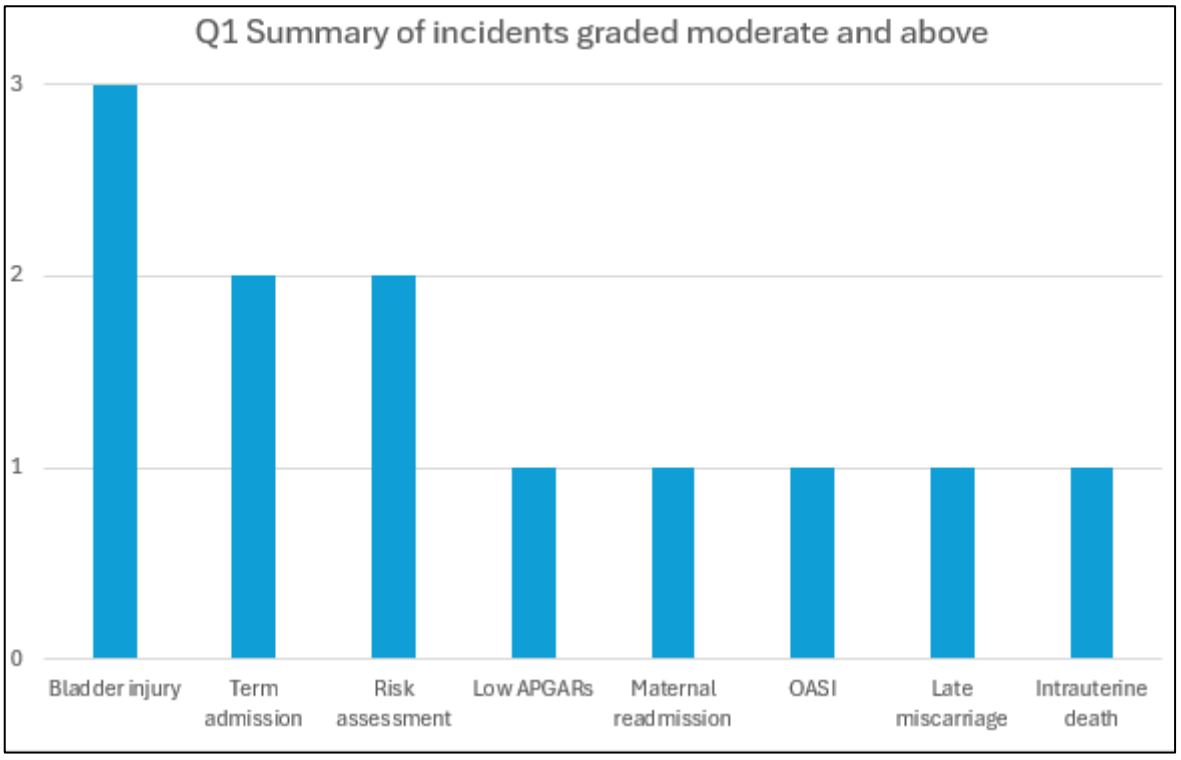


Throughout Q1 there continued to be several acuity related delays and staff unable to facilitate breaks. Some of the acuity related delays involve obstetric reviews on the Maternity Day Assessment Unit, delaying induction of labour and postponing elective caesarean sections to the following day. These decisions have been made within the multidisciplinary team and women have received appropriate safety netting clinical advice.

The incidents graded moderate or above at the end of Q1 are detailed below. As Datix is a live reporting system the below does not include the cases that have been reviewed, reclassified and closed. It includes cases that have been triaged but are awaiting full review (so may be reclassified), cases that remain moderate following review, and open MNSI cases. These numbers were extracted from the Datix reporting system and a search created using the following data:

Date: 01/04/2026 - 30/06/2026
Severity: Moderate and above
Directorate: Women and Newborn Division

Figure 17. Summary of incidents graded Moderate or above incidents at the end of Q1



The Trust Patient Safety Incident Response Plan (PSIRP) outlines nationally and locally mandated responses to incidents. This includes PSII triggers and PSR processes with associated methodology. Within this quarter there were 98 incidents reported as ≥ moderate which have been or are in the process of being reviewed. The themes and learning from

incidents in the last quarter are summarised below.

Key themes relate to:

- Documentation quality and completeness
- Risk assessment and escalation
- Bladder care, trial-without-catheter and urinary retention management
- Fetal monitoring and cardiotocograph interpretation
- Adherence to guidelines and care pathways
- Communication and quality of SBAR handovers
- Antenatal follow-up and continuity of care
- Training and workforce development
- Operational capacity and resources.

Figure 18. Summary of themes and learning from incidents in Q1

Incident Category & (numbers of incidents)	**Key Themes**	**Learning / Actions**
Bladder care (8)	• Incomplete fluid balance documentation. • Delayed recognition of urinary retention. • Bladder distention not escalated appropriately. • Inconsistent adherence to bladder care guidance.	• Ongoing bladder care education. • Reflective conversations with staff. • Review of guidance. • Audits. • Monthly learning updates. • Focus groups. • Increased awareness through study days, MOMA board and tea trolley teaching.
Term admissions to the neonatal unit (5)	• Delays in escalation. • Inconsistent CTG interpretation and documentation. • Incomplete SBAR handovers. • Delayed neurological observations. • Equipment availability issues. • Gaps in follow-up processes.	• Case reviews shared with obstetric and fetal monitoring leads. • Audits of neonatal documentation and SBAR use. • Equipment reviews. • Reflective conversations with staff. • Inclusion of learning in training days.
Low APGARs (3)	• Guidance not followed. • Incomplete fetal monitoring risk assessments. • Delayed response to concerns. • Incomplete neonatal documentation.	• Reflective discussions with staff. • Targeted sharing of case learning. • Process reviews. • Reinforcement of expected management pathways through education sessions.
Hypoxic ischaemic encephalopathy (2)	• Opportunities to improve cerebral function monitoring. • Review of antenatal investigations. • Escalation of abnormal observations. • Communication with parents.	• Training programme for cerebral function monitoring. • SOP development. • Review of result-review process. • Reminders around communication, documentation and debriefing of parents.

	• Documentation of birth injuries.	
Fetal loss, stillbirth and intrauterine death (5)	• Missed opportunities to follow guidance. • Inadequate follow-up. • Inconsistent safety-netting advice. • Delays due to theatre capacity. • Discharge planning concerns. • Observations not completed in line with guidance.	• Staff reminders regarding symphysis fundal height monitoring and escalation. • Review of caseload tracking processes. • Continued work relating to theatre capacity. • Improved accessibility of flowcharts and guidance.
Risk assessment (1)	• Risk assessments not fully completed and care did not follow established guidance.	• Reflective discussion with staff member and sharing of learning to strengthen risk assessment practices.
Postnatal maternal readmission (1)	• Medication not prescribed in line with guidance. • Inconsistent documentation. • Postnatal hypertension management requiring review.	• Thematic review of hypertension readmissions. • Implementation of electronic MEWS. • Review of medication protocols.
Postnatal return to theatre (1)	• Inconsistent documentation and escalation. • Guidance difficult to access.	• Re-implementation of escalation toolkit. • Consideration of development of guidance in collaboration with other specialities and BSW Trusts.
Complicated birth (1)	• Proforma not utilised during an emergency situation.	• Reminder to workforce regarding use of emergency proformas during obstetric emergencies.

The incidents collectively highlight recurring themes of documentation, risk recognition and escalation, adherence to guidance and effective communication through SBAR handovers. Actions largely focus on education, audits, reflective practice, strengthened governance oversight, and improved standardisation of care processes. Continued monitoring through governance structures will support progress towards sustained improvement.

13. Safe Maternity Staffing

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017), states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings. Maternity and Midwifery staffing is reported separately to the Maternity and Neonatal Assurance committee and Trust Board biannually to meet the requirements for the maternity incentive scheme.

A full report is contained in the appendices (appendix 5). The following is a summary of key highlights.

13.1 Midwifery Staffing

Planned Versus Actual Midwifery Staffing Levels

The following table outlines percentage Registered Midwife (RM) fill rates for the inpatient areas by month.

Figure 19. Percentage shift fill rates for the inpatient areas by month in Q1

Month	Day qualified %	Night qualified %
April 2026	98.3	99
May 2026	96.9	99.4
June 2026	97.5	99.3

When staffing is less than optimum, the following measures are taken in line with the Maternity Operational Escalation Policy:

- Elective workload prioritised to maximise available staffing.
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Utilisation of Bank Midwives.
- Community staff working flexibly in the unit as and when required.
- Non-clinical midwives working clinically to support acuity.
- Support of Maternity and Neonatal Duty Manager Day and night, as required to coordinate the escalation process ensuring coordination of staff and work as acuity dictates necessary.
- The daily staffing/safety huddle involving clinical leaders across all areas of maternity services, to ensure a team approach to day to day working also contributes to ensuring staff are assigned to clinical areas according to fluctuating activity levels.
- Recruitment of nurses to the Maternity Services.
- Liaise closely with maternity services at opposite sites to manage and move capacity as required.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

13.2 Obstetric staffing

The Obstetric Consultant Team and Maternity Senior Management Team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: *'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'* into their service. This includes obstetric staffing on the labour ward and any rota gaps.

Trusts should monitor their compliance of consultant attendance for the clinical situations listed

in the RCOG document when a consultant is required to attend in person.

In Quarter 1 (1st April 2026 – 30th June 2026), there were 17 cases meeting the criteria above. The audit demonstrates 100% compliance to the standard and is detailed in the table below.

Figure 20. Cases meeting the above criteria

Date	Clinical Situation(s)	Comments
11/04/2026	If requested to do so ? sepsis 31/40	Consultant Present
20/04/2026	PPH >2L	Consultant Present
21/04/2026	If requested to do so Confirmation of IUFD	Consultant Present
25/04/2026	If requested to do so 2nd opinion required due to level of pain patient was in whilst labouring with IUFD	Consultant Present
27/04/2026	If requested to do so ? sepsis & required CS	Consultant Present
28/04/2026	If requested to do so Low lying placenta & CS	Consultant Present
01/05/2026	Return to theatre	Consultant Present
01/05/2026	Return to theatre	Consultant Present
26/05/2026	BMI > 50 - CS	Consultant Present
11/06/2026	2nd theatre required - taken to Main theatres	Consultant Present
18/06/2026	Premature twins < 30 weeks	Consultant Present
18/06/2026	2nd theatre required – Anaesthetic room used	Consultant Present
21/06/2026	4th degree tear	Consultant Present
22/06/2026	CS & BMI > 50 & taken to Main theatres	Consultant Present
23/06/2026	Asked to do so - patient concerned something was wrong in 2nd stage	Consultant Present
23/06/2026	Asked to do so - make a plan for delivery	Consultant Present
23/06/2026	Asked to do so - deteriorating patient in theatre	Consultant Present

13.3 Short Term Locum usage

NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

a. currently work in their unit on the tier 2 or 3 rota
   or
b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
   or

c. hold a certificate of eligibility (CEL) to undertake short-term locums.

An audit of compliance with our Medical HR colleagues was completed for the time period 1st April 2026 – 30th June 2026.The audit demonstrated that during this period, 34 (short term) middle grade locum shifts were required. 5 Doctors completed these shifts, all of these Doctors were employed by Salisbury NHS Foundation Trust at the time of undertaking the shifts, therefore the trust is 100% compliant with the criteria described above.

13.4 Long term locum usage

During the period 1st April 2026 – 30th June 2026, the trust has utilised 3 long-term middle grade locum doctors.

Figure 21. Long-term locum compliance with standards

Standard	Compliant Locum 1	Compliant Locum 2	Compliant Locum 3
Standard 1 Locum doctor CV reviewed by consultant lead prior to appointment	Yes	Yes	Yes
Standard 2 Discussion with locum doctor re clinical capabilities by consultant lead prior to starting or on appointment	Yes	Yes	Yes
Standard 3 Departmental induction by consultant on commencement date	Yes	Yes	Yes
Standard 4 Access to all IT systems and guidelines and training completed on commencement date	Yes	Yes	Yes
Standard 5 Named consultant supervisor to support locum	Yes	Yes	Yes
Standard 6 Supernumerary clinical duties undertaken with appropriate direct supervision	Yes	Yes	Yes
Standard 7 Review of suitability for post and OOH working based on MDT feedback	Yes	Yes	Yes
Standard 8 Feedback to locum doctor and agency on performance	No	To be arranged	To be arranged

13.5 Anaesthetic staffing

For safety action A of the Maternity Incentive Scheme, evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to

delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients (ACSA standard 1.7.2.1).

The following table demonstrates compliance with this standard by month. The service will continue to audit this standard monthly.

Figure 22. Anaesthetic staffing compliance

Month	April 2026	May 2026	June 2026
% compliance	100	100	100

13.6 Neonatal Services Staffing

Neonatal medical staffing

The Neonatal Unit remains non-compliant with BAPM standards for the medical staffing. A report has been submitted through the Divisional performance review and Maternity and Neonatal Safety Champions meeting to the executive team to ensure the Trust board have a full overview of the situation. This report and its action plan was also agreed by Trust Board and ICB, with reference to the movement of a business case for medical workforce. The action plan around Neonatal medical staffing was submitted to Trust Board in December 2025. A business case has for additional staffing has been reviewed by the divisional DMT and a full paediatric workforce review has been requested to support the business case progressing to the next stage. The progress of the business case has stalled at present, and this has been escalated via DPRM and via PQOM to Board.

Neonatal nursing staffing

To meet safety action A of the Maternity Incentive Scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards, and the Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.

The nursing workforce review was completed in June 2026 using the Workforce calculator seen below. This demonstrates that the unit is now compliant to the BAPM standards. The unit is marginally over funded for Qualified in Speciality (QIS) registered nurses but under-funded for non-registered nurses, however the total number of direct care nurses is in line with BAPM requirements. There are mitigations in place for increasing the number of nurses who are QIS trained. 1 WTE commenced their training in Q4 25/26 with a plan for 2 –3 WTE to undertake the course in 2026 as part of the ongoing development of staff.

During Q1 there has been successful recruitment to Band 5 nurses who will commence

employment in 26/27 Q2 reducing the vacancy.

It is important to note that activity and acuity are variable, and this consequently means a variation in BAPM neonatal nursing requirements from month to month.

14. Insights from service users and Maternity Voices Partnership Co-production –

During Q1 there have been several workstreams that have continued to be progressed around patient experience and health inequalities.

Health inequalities:

- Health inequalities dashboard — Work continues the local dashboard to track birth outcomes by ethnicity and deprivation and now including a limited English tab supporting national and local equity priorities.
- Collaboration with Wiltshire Council's Refugee Resettlement and Migration Service to deliver three educational sessions in June 2026 which focused on accessing maternity and early pregnancy services for Afghan resettlement families.
- Translated patient information leaflets — All maternity PILs are being uploaded to the website so they can be easily translated using the new accessibility function.
- Pocketalk embedded and used within the maternity service to aid real-time communication. This is to ensure non-English speaking service users receive safe, person-centred communication when in our care.
- EDI working group — Established in Q3 to drive equity, diversity and inclusion; priority setting continued through Q2.
- Continuity Maternity Support Worker — The 12-month funded role is now fully established, providing dedicated support for women with language barriers or special educational needs and improving continuity of care.

Patient experience:

Complaints & Concerns -

- 7 complaints and 6 concerns received.
- Main themes: “lack of communication” and ‘Access and Waiting’.
- In Q1, 9 complaints were closed, and 100% were closed within the target time. This represents an improvement of 33.6% compared to the previous quarter when the compliance rate was 66.4%.

Feedback Mechanisms -

- Friends and Family Test (FFT) remains paused due to BadgerNet implementation.
- Real-time feedback not captured in Q1 however plans made to reintroduce this in Q2 to capture immediate patient views.

Neonatal Feedback -

- Participation in NHSE National Neonatal Care Experience Survey underway; results expected Q2 2026/27.

- Ongoing local neonatal parent survey shows consistently high satisfaction; reported monthly at governance meetings. - New revised parent Experience survey expected to be launched in July 2026.

Maternity Survey -

- National Maternity Patient Survey 2025 score: 85.2% (↑3.7% from 2024).
- Action plan in place with MNVP; monitored via Safety Champions Forum and Mat/Neo Assurance Group.

Birth Reflection Service -

- Service was temporarily paused in Q1 due to the transition between post holders, relaunch in Q2.

Key priorities for next quarter:

- 'Scaling up' of the 'Pocketalk' translation device, and the implementation across the wider Trust.
- Progress the work on our local Health Inequalities dashboard.
- Continued monitoring of the 2025 National Patient Experience Maternity Survey action plan and support the introduction of the National Neonatal Care Experience Survey.
- Progress the actions detailed in the Three-Year Delivery Plan.
- Continue the quarterly Triangulation meetings to coordinate service users feedback to identify service improvement opportunities.
- FFT - Support the reintroduction of SMS text messages in Q2 2026 for the Friends and Family Test.
- Maternity website and the translation toolbar - To Maternity website through the ongoing upload of all Patient Information Leaflets from EOLAS and Badgernet to the Trust website, ensuring they are accessible and available in a format that enables translation using the websites translation toolbar.
- Reinstate the Birth Reflection Service offering Virtual and over the phone appointments and continue to source a suitable location within the Trust to offer women and families the option of face-to-face appointments.
- Continue to work with Wiltshire Councils Refugees Resettlement and Migration Service to support women who are underrepresented requiring maternity services.
- Expansion of the criteria to Obstetric debriefs service – currently this service is non-commissioned and unfunded.

15. Quality Improvement projects/ progress

The Maternity and Neonatal department follow the Trust wide 'Improving Together' methodology which focusses on a programme of continuous improvement underpinned by coaching support and training. The Senior Leadership Team have undertaken the training,

and it is currently being rolled out to some of the individual teams. The drivers for the QI projects are locally driven being aligned to both divisional and the main trust drivers.

Projects which have been rolled out and are continuing include:

- Exit interviews
- Fluid balance compliance.
- Re-launch of the local escalation toolkit (based on RCOG Escalation toolkit)
- Review of BSOTS antenatal triage compliance
- Increasing the use of Beatrice Birth Centre
- EDI working group
- Decoration of staff rest areas
- Improving compliance to Datix closure
- Improved signage to maternity and neonatal unit
- Upgrade and redecoration of Benson bereavement suite
- Mapping of antenatal clinic
- Re-launch of in person antenatal education classes – pilot in progress

Projects planned in the next quarter (Q2):

- Re-launch of Birth Reflections service (hybrid model offer)
- Launch of hybrid model of antenatal education classes
- Launch of new communications channel for women and families via TikTok

16. Implementation of the A EQUIP model

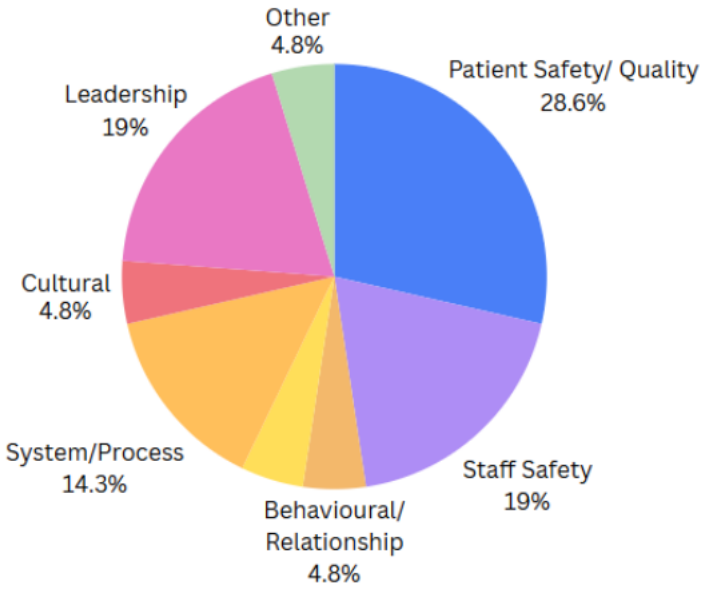
The Professional Midwifery Advocate (PMA) Team is responsible for implementing and deploying the A-EQUIP model (Advocating for Education and Quality Improvement), which supports a continuous improvement process that aims to build personal and professional resilience, enhance quality of care and support preparedness for appraisal and professional revalidation.

16.1 PMA Update

- Restorative Clinical Supervision (RCS) is offered to all new starters including midwives, student midwives, maternity care assistants, those returning from long term sickness and following a potentially traumatic event. There was a total of 15 RCS in Q1 delivering RSC to 25 members of staff. There were also 3 career conversations, and 2 Student Midwives attended a PMA drop in. Most of the support was for early career members of staff and included check ins for those new to Trust.
- The PMA drop in was created following feedback from Student Midwives, in addition to the continued support from the Education team. Student Midwives were also supported in 1:1s following the recruitment drive for Band 5 Midwives,

to ensure development and support for this group of staff considering current recruitment pressures nationally.

- There was one group RCS session with the Preceptee Midwives in Q1, as well as 3 monthly 1:1s with the Preceptorship Co Lead Midwife who is also a PMA and can offer wellbeing support at these 1:1s.
- Anonymous data is kept on themes and numbers of RCS sessions. These are being shared with the Director and Head of Midwifery and Neonatal Services for awareness and via appropriate channels to support action and improvement. The themes for Q1 are below:



- The newsletter has gone out to staff and members of the PMA team continue to support on the monthly Maternity study day, ensuring visibility within the workforce.

16.2 Plans and Actions

The PMA team consists of a team of 6 trained PMA's that are being given protected time from their substantive hours each month. This is to carry out restorative supervision, teaching activities and other PMA activities.

The PMA team has met with the Perinatal Quad, and the team will support with improving culture work stream, this will include anonymous feedback of themes from RCS and ongoing initiatives. Monthly meetings with Director of Midwifery and Neonatal Services and Head of Midwifery and Neonatal Services are being completed.

As a team they are refocusing and starting to come together as a team to work on a collective focus. The PMA team have decided to focus on a remodel of the staffrooms in both in the labour ward and the postnatal ward and are also looking to develop some team building sessions with groups of staff such as the community midwifery teams.

17. Avoidable Admission into the Neonatal Unit (ATAIN)

The full report is contained in the appendices. The following is a summary of key highlights.

17.1 The National Ambition

In August 2017, NHSI mandated a patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. The national ambition for term admissions is below 6%, however, Trusts should strive to be as low as possible.

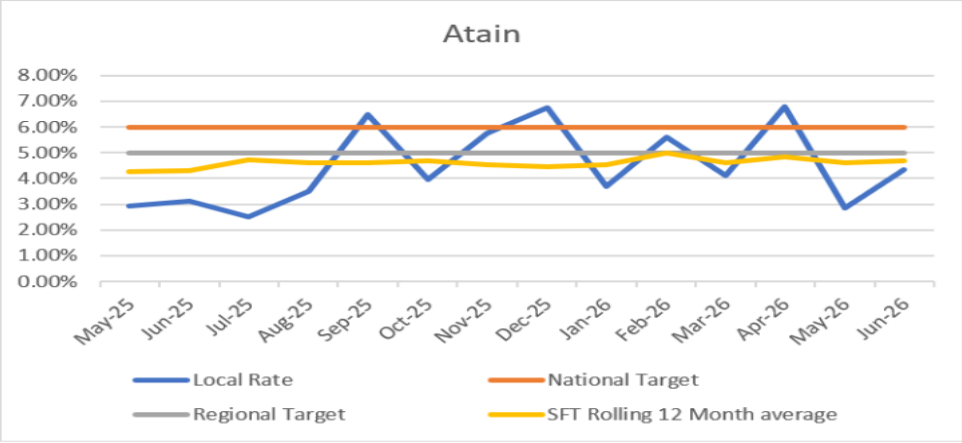
This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme with a key focus on:

- Reducing harm through learning from serious incidents and litigation claims.
- Improving culture, teamwork and improvement capability within maternity units.

17.2 Why is it important?

There is strong evidence that separation of mother and baby soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

Figure 23. Monthly ATAIN rates for Salisbury NHSFT Trust



The ATAIN meeting action tracker contains evidence of actions agreed by both maternity and neonatal leads, which address the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks.

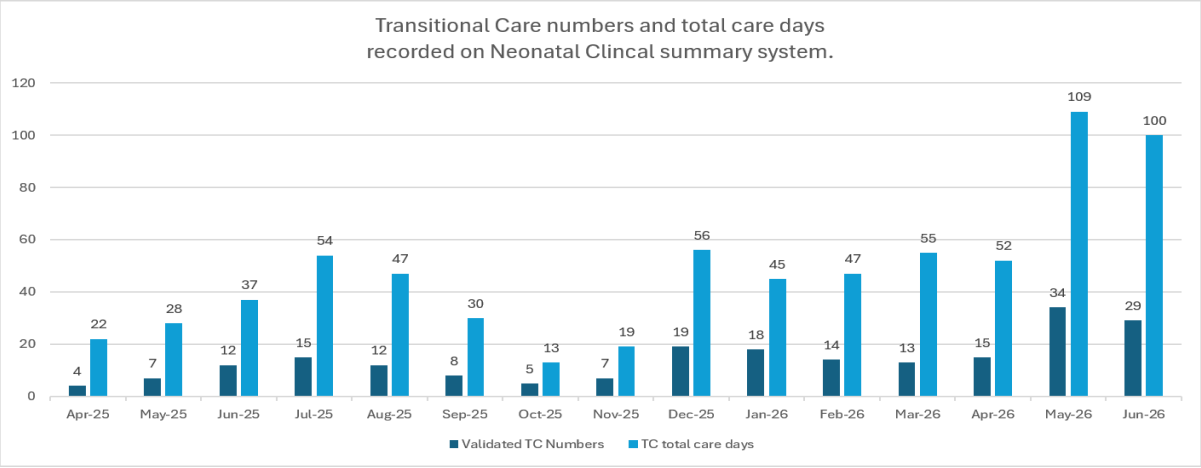
Figure 24. ATAIN reviews during Q1 (babies equal or >37 weeks' gestation)

	April 2026	May 2026	June 2026
Total number of admissions in month	12	5	8
Number of babies admitted to the LNU that would have met current TC admission criteria but were admitted to the LNU due to capacity or staffing issues.	0	0	0
Number of babies that were admitted to or remained on LNU because of their need for nasogastric tube feeding but could have been cared for on TC if nasogastric feeding was supported there.	0	0	0
Total number of case reviews undertaken in month	7	9	8
Total number of case reviews with both maternity and neonatal staff present	7	9	8

17.3 SFT Trust transitional care rates

The number of babies born that met transitional care criteria in the last quarter are shown below. Further detail is contained within the appendices. All babies eligible for TC were cared for on either on the neonatal unit with primary parent in the KC rooms or on Beatrice Maternity Ward, as outlined in the full report in the appendices. The total patient figures for all TC eligible babies are available in Appendix 6.

Figure 25. Transitional care numbers and total care days.



18. Staff Survey

Results of the 2025 staff survey were shared with the leadership team in Q1 26/27, with a series of listening events which were held across both the inpatient and outpatient services. There is an associated action plan in place which is being led by the Matron team and supported by O, D & L.

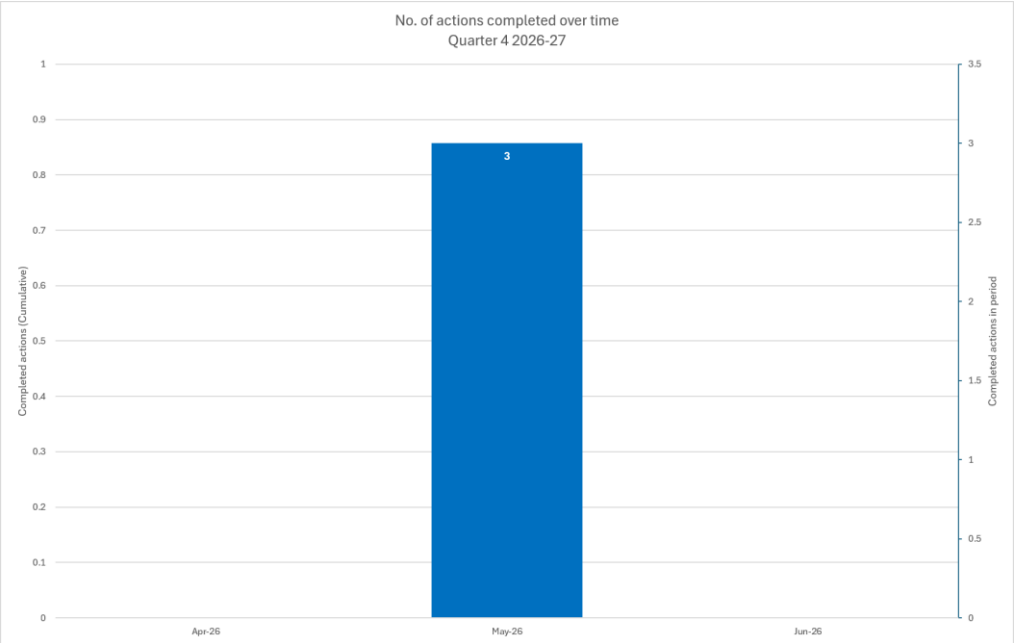
19. Maternity and Neonatal Safety Improvement Plan

Every Trust is required to develop a bespoke Maternity & Neonatal Safety Improvement Plan, which brings together existing and new plans to progress these projects into one place. Salisbury NHS Foundation Trust exited the NHSE Maternity Safety Support programme in November 2024 but continue to focus on and utilise the Maternity & Neonatal Improvement Plan to support SFT's progress and improvement journey and remains on the NHSE sustainability phase.

19.1 Progress made over the last quarter

In Q1, there has been a continual focus on the remaining four open workstreams. More of an 'inch-wide mile-deep' approach has produced results in Governance, Digital, and Three-Year Delivery Plan workstreams. Maternal Care Bundle and CNST-MIS Year 8 have been launched and benchmarking against these is in progress.

Figure 26. Progress with Maternity Improvement Plan actions Q1



20. Risk Register highlights

The Maternity and Neonatal Departmental Risk Register is reviewed bi-monthly with leads being encouraged to review and update any risks ahead of this. The current open risks on the risk register are noted below.

The highest risk is 'Harm to Women and Babies through lack of dedicated second Obstetric theatre' Risk ID:6412.

At present current obstetric theatre capacity is insufficient to safely meet the increasing demand for its use. With reliance on a single dedicated maternity theatre, alongside an anaesthetic room frequently used as a second operating space despite not being designed for surgical procedures, significant risk is being held by Maternity and Neonatal Services, and the Trust.

These competing demands are creating delays to both elective and emergency care, in addition to preventing timely access to theatre in time critical emergency situations. This carries a risk of adverse clinical outcomes, as well as increasing the risk of avoidable maternal and neonatal harm alongside breaches of national delivery standards.

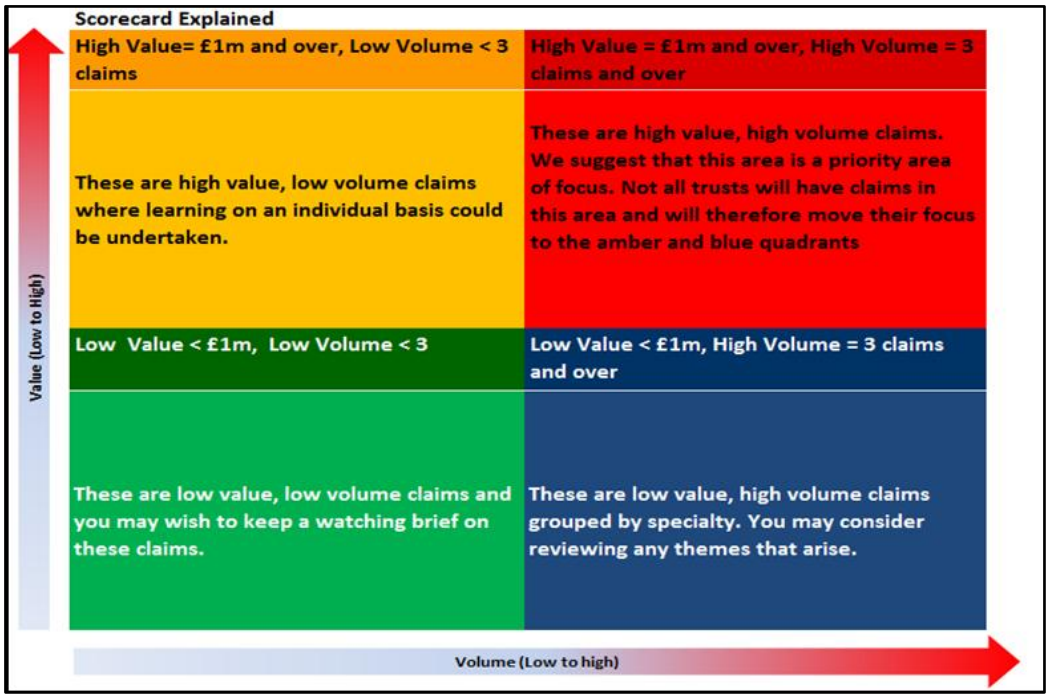
Figure 27. Current Open Risk Register items for Maternity and Neonatal services

ID	Title	Rating (current)
7109	There is a theorectical risk of infection to women and babies as the Labour Ward birthing pools are over recommended manufactu	5
8669	Health disparities identified at a local and national level for service users from marginalised groups.	6
8636	Inadequate infrastructure, commissioning and funding for the Maternity & Neonatal Voices partnership	6
8447	No specialist epilepsy nurse or midwife in the Trust or in BSW to support pregnant women with Epilepsy	6
8878	Poor internet and IT accessibility at Tidworth community clinic impacting safe delivery of obstetric/sonography services	6
8309	AUDIT NON-COMPLIANT re Documentation of BP, Urine, CO testing, FM's, FH and risk assessment in ANC	8
8333	AUDIT NON-COMPLIANT re BSOTS triage and review	8
8684	Non-complaince with Saving babies lives version 3.2 element 3 (Next working day USS with Reduced Fetal movements)	9
8670	Risk of unidentified growth restricted babies due to lack of admin resource in antenatal clinical	9
8733	BadgerNet data Quality	10
8857	Large number of open and overdue Datix incidents not being managed in a timely way to meet Trust targets	10
8386	Saving babies lives Version 3 - Element 2. Fetal growth, non compliance	10
8382	SBL v3 - Element 1 (Smoking) - non-compliance of staff training for VBA and Co monitoring	10
8787	Increase in incidents involving bladder distention	12
8685	Increase in incidents with poor outcomes - referred to MNSI for investigation between Aug 2025 and Feb 2026	12
8877	No process in place to ensure that only those staff required for emergency situations have access to maternity and neonatal uni	12
8568	Risks Identified from Digital CTG Storage Rollout within BadgerNet and Centralized Monitoring	12
6412	Harm to women and babies through lack of dedicated 2nd obstetric theatre	20

21. Litigation Scorecard and Triangulation of Incidents and Complaints

The NHSR Litigation Scorecard is updated and published annually for the Trust. It contains 10 years of claims data and is based on incident date. The scorecard is a Quality Improvement Tool for CNST, and it is a requirement that a quarterly review of incident and complaints data against the annual scorecard themes is reported to Trust Board level Safety champions as part of the Year 8 Maternity Incentive Scheme. The scorecard can be understood within the following table.

Figure 28. NHSR litigation scorecard explained in terms of value and volume of claims

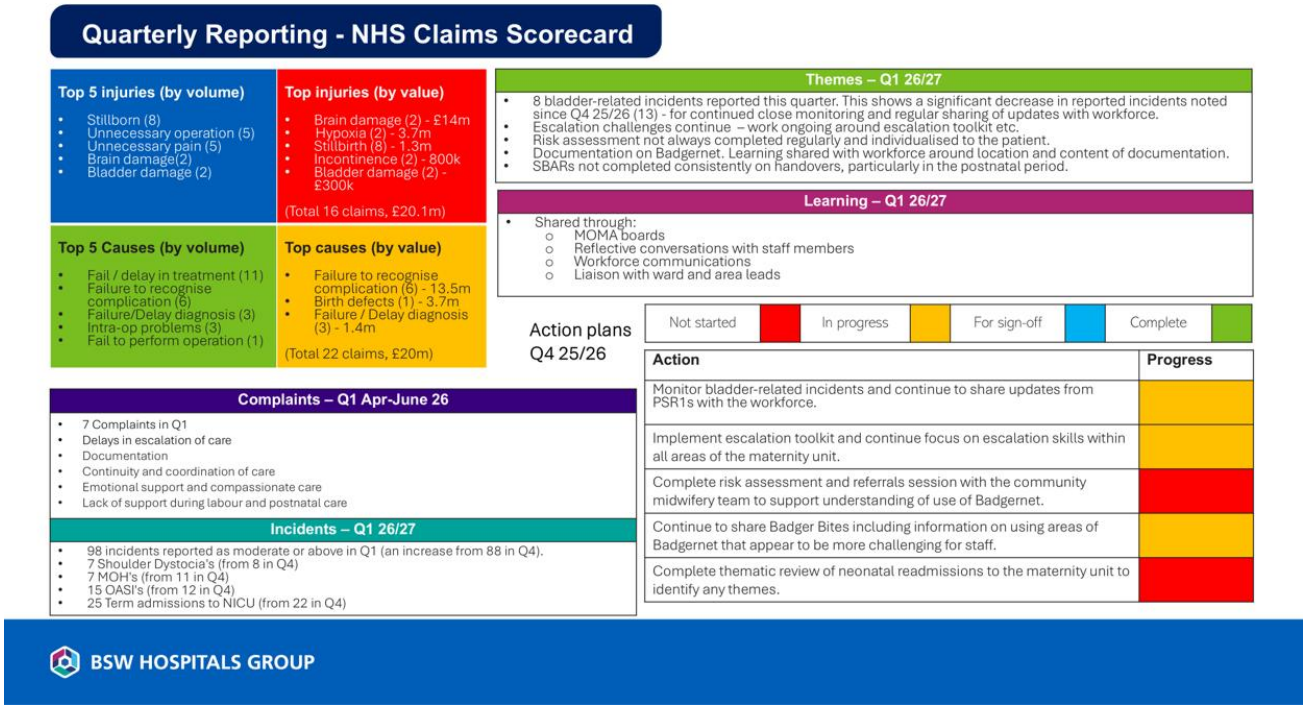


Themes from incidents, claims and complaints are reviewed at the quarterly triangulation meeting and Maternity Governance meeting.

These can be summarised as follows and, in the figure, below:

- Legal claims over the last 10 years - the top injury claim by **value** is brain damage (2) and by **volume** is stillbirth (8).
- Incidents – the 'top 3' DATIX are term admissions to the neonatal unit, care planning and risk assessments, and equipment or information technology problems. Term admissions are listed on the trigger list, and all receive a robust review using the 'Datix Incident Review Proforma' and are included in a continuous rolling audit. This is in line with the Trust PSIRF plan and SFT are not outliers for this against national targets.
- Themes from complaints include labour care, delayed management, lack of communication and issues with pathways for early fetal loss.

Figure 29. Litigation scorecard - triangulation of complaints, incidents and legal claims in Maternity and Neonatal services



The themes from DATIX risks, legal claims, local and national patient feedback surveys, the Birth Reflections Service and through the intelligence obtained by the Maternity and Neonatal Voice Partnership (MNVP), inform and drive the priorities of service development and quality improvement. These are presented and discussed at the Triangulation meetings.

22. Recommendation

The Trust Board is asked to receive and discuss the content of the report. They are also asked to record in the Trust Board minutes as requested to provide evidence for the maternity incentive scheme.

Great Western Hospitals NHS Foundation Trust

Report Title	**Quarter 1 2026/27 Maternity and Neonatal Quality and Safety Report**				
Meeting	**Quality & Safety Committee**				
Date	**29/07/2026**	Part 1 - Public	♦	Part 2 - Private	♦
Accountable Lead	Luisa Goddard – Chief Nurse				
Report Author	Jennie Davies- Patient Safety Lead for Maternity and Neonatal ServiceS				
Appendices	3				

Purpose

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

Assurance Level

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

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

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

Good evidence of the governance and oversight across all elements of safety.

Report

This report provides an oversight of Maternity and Neonatal safety including an update on:

- Staffing metrics recognising the gap in funded establishment in the neonatal nursing workforce
- Update on compliance across National guidelines, including Saving Babies Lives v3, CNST standards and the Ockenden action plan
- Oversight of Perinatal Patient Safety Incident Investigations
- Patient experience
- Overview of new and closed risks
- Review of the 2025 Trust Score card against patient feedback, incidents and learning in Q4.

- Overview of the inquest relating to maternity services and the subsequent regulation 28 report on actions to Prevent Future Deaths (PFD) issued to the Trust on 10th September 2025.
- Update on overdue actions from Patient Safety Incidents Investigations
- Review of Postpartum Haemorrhage rates and data during Q4 including action plan.
- Review of 3rd or 4th Degree Tear rates and data during Q4 including development of an action plan.
- Update on Baby Friendly Initiative Infant Feeding data with action plan.

Strategic Alignment – select one or more		Outstanding care		Valued teams		Better together		Sustainable future
Link to CQC Domain – select one or more	**Safe**		**Caring**		**Effective**		**Responsive**		**Well-led**	

Risk + Oversight		**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	**New Risk 1560 – risk score 12 – under review for increasing to 16** There is a risk that the current layout and location of the Maternity Care Centre and Day Assessment Unit (DAU), which are not optimally designed to support maternity front-door services, may lead to delays in accessing emergency care, resulting in compromised patient safety, reduced staff wellbeing, and decreased efficiency of care delivery. Root Cause: Because maternity triage was relocated at pace to meet a CQC Must Do requirement, into an area not designed for maternity front-door activity, and because demand, complexity and DAU attendances have increased beyond available capacity — with clinicians unable to maintain visual oversight of service users awaiting assessment — there is a risk that delays in primary survey, ongoing care or medical review may occur, potentially compromising patient safety and operational efficiency. **Risk 1525 – risk score 6** There is a risk LDR theatre 2 is non-compliant with HTM - LDR have this also on their Risk register following CQC visit. **Risk 1370 – risk score 12** There is a risk that patient safety might be compromised because of inappropriate documentation of care resulting in patient harm. Where use of the new system does not follow agreed processes, this could result in incorrect management of patient conditions	

Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	The Quality information will be reviewed by the Executive Committee and Divisional Governance meetings. Investigations into Serious Incidents are reviewed at the weekly Serious Incident and Learning Groups. Divisional quality performance is reviewed at the monthly Divisional performance reviews.	
Next Steps	Key findings and actions will be taken forward through individual services and improvement groups.	

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

Explanation of above analysis:

The report outlines the work streams within Maternity and Neonatal Services that aim to meet the objectives within the NHS England Three Year Plan to reduce health inequalities.

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board/Committee/Group is requested to note the quality matters within the report and the actions taken to support improvement

Accountable Lead Signature	Luisa Goddard.
Date	**22/07/2026**

Quarter 1 2026/27 MATERNITY AND NEONATAL QUALITY & SAFETY REPORT	
Date:	20.07.2027
Author:	Jennifer Davies, Patient Safety Lead for Maternity and Neonatal Services Chantal Woog, Head of Midwifery and Neonatal Services
Summary of Report	ALERT: • Neonatal workforce and cot capacity remain a significant risk, with current medical staffing not meeting revised BAPM Tier 2 requirements for night and weekend cover and nursing establishment insufficient to meet rising demand. Actions to improve compliance and resilience are underway, including implementation of the South West ODN workforce plan, enhanced oversight and escalation processes, recruitment and skill-mix initiatives, and the introduction of 12-hour, 7-day ANNP day cover from September 2026. • Increasing maternity activity continues to challenge theatre capacity, with workforce levels not fully meeting AfPP staffing recommendations. Service reviews and mitigations are underway, and no patient safety incidents have been reported. ADVISE: • A thematic review of neonatal hypoglycaemia incidents identified hypothermia as the main contributory factor, alongside pathway compliance, training and system challenges, resulting in targeted improvement actions and development of the FORTRESS project to improve neonatal outcomes. • PPH rates remain within expected variation and show a stable to improving trend, with multidisciplinary review identifying no care concerns, while implementation of the Postpartum Haemorrhage Care Bundle and ongoing governance oversight support continued quality improvement and reduction of inequalities in care. • Incident reporting remained stable throughout Q1, reflecting a positive reporting culture, with only two emerging themes identified (TTA processes and failed trials without urinary catheter), while no other significant safety concerns were noted; however, timeliness of incident closure remains a challenge due to capacity pressures, with enhanced senior leadership and multidisciplinary oversight, including a new review meeting, implemented to reduce overdue investigations and support timely learning and closure. ASSURE: • Training compliance remains strong across maternity and neonatal services, with most staff groups exceeding the 90% target and robust mitigation plans in place to achieve full compliance across all disciplines, providing continued assurance against CCFv2 and MIS requirements. • In line with the Maternity Outcomes Signal System (MOSS) Standard Operating Procedure and Year 8 Maternity Incentive Scheme (MIS) requirements, a Tier 2 MOSS signal drill was undertaken during the week commencing 22 June 2026. The exercise included external review and tested the service's ability to respond effectively to a MOSS trigger through completion of the critical safety check process. The drill was delivered collaboratively by the perinatal leadership team and frontline clinical staff, ensuring that the process was not reliant on a single individual and reflected routine operational practice.

SAFETY

Serious incidents

	Serious Incidents
Closed in Q4 25/26	0
Closed in Q1 26/27	0
Closed in Q2 26/27	-
Closed in Q3 26/27	-
Open cases	7

Case summaries and key learning for closed cases:

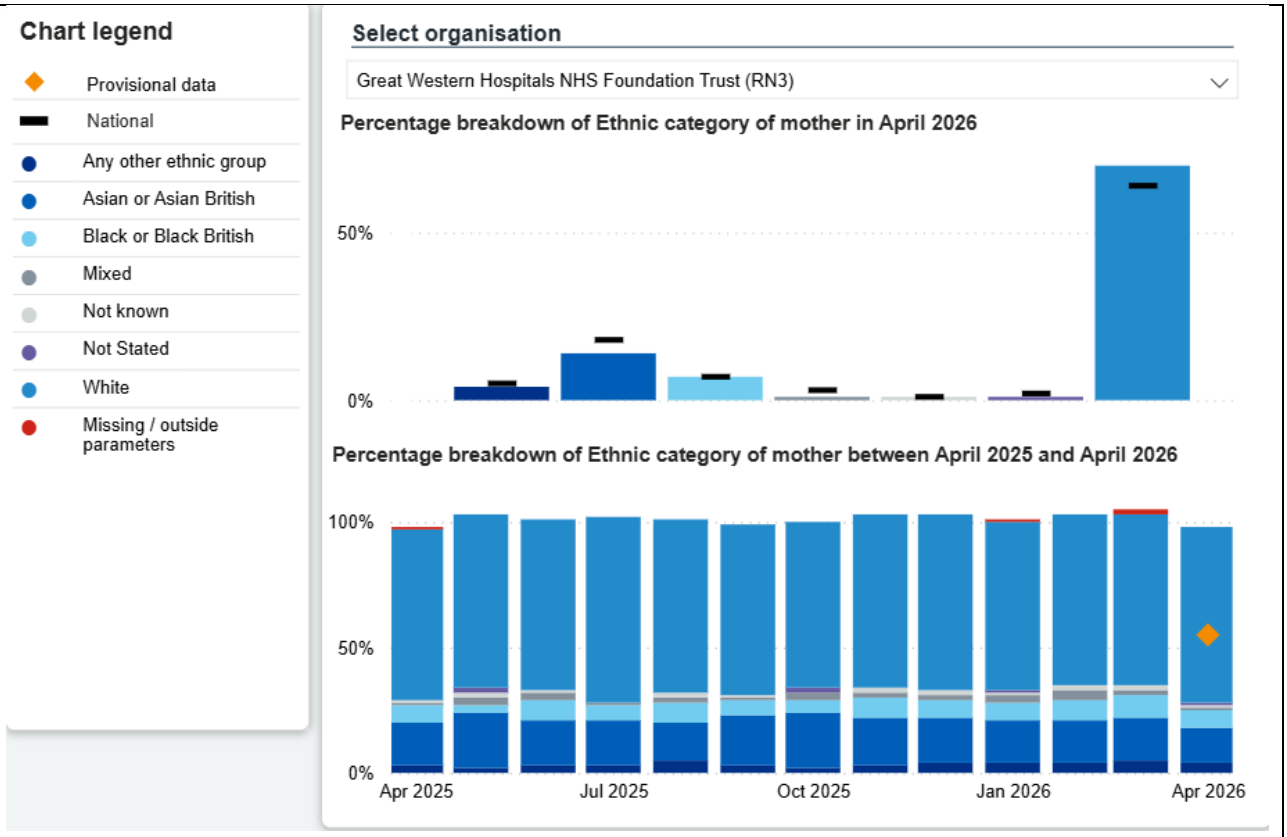
- No patient safety incident investigations were closed in Q1.

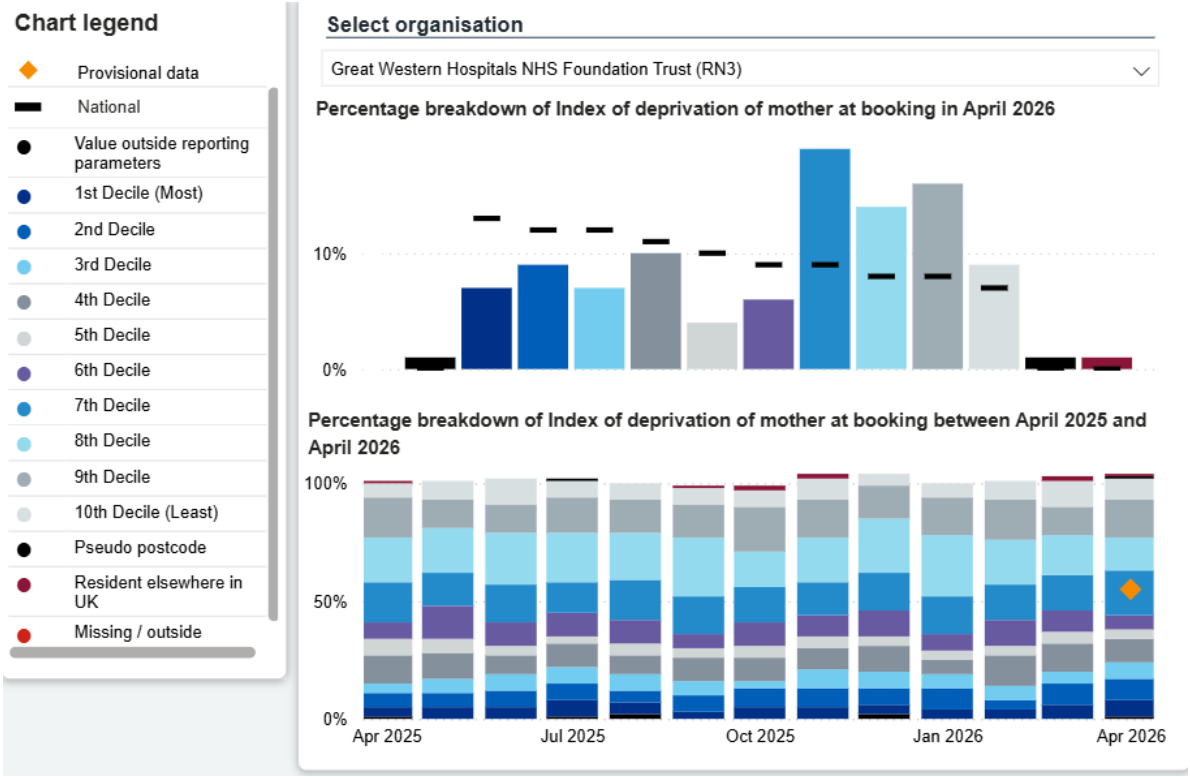
Training

- The current headroom and education program strategy meets the delivery of the Core Competency Framework v2 (CCFv2) which was released in May 2023. It has been recognised that training needs have further increased since this publication which indicate that 27% headroom would be needed to achieve this.
- A local training strategy has been developed to achieve all elements of the CCFv2 by the end of the training year 2025/26.
- There is continued oversight of the education plan by the perinatal quadrumvirate, Trust board, and Integrated Care Board (ICB).
- The approved local education program for year one delivery of CCFv2 was completed in July 2024. Year two completed in July 2025, and year three will be completed in July 2026. The programme has been adapted to incorporate both local and national learning highlighted through collaborative working between the Perinatal Quality Safety and Assurance team (PQSA) and Education teams.
- The Mandatory Study Day attendance and trajectory is included in the monthly Perinatal Quality Oversight Model (PQOM) reporting to provide oversight and assurance of compliance with the CCFv2 and Maternity Incentive Scheme (MIS) training safety action B.
- Training compliance remains strong across all disciplines. Practical Obstetric Multi-Professional Training (PROMPT) training shows high compliance among Midwives (95.15%) Consultants (92.86%), Anaesthetists (90.38) and MSWs (95.38), and Obstetric Doctors (100%). There is a robust action plan in place to ensure compliance trajectories continue to meet 90% for all staff groups. Fetal Surveillance training is high overall, with Consultants at 92.86%, Midwives at 94.47%, and Resident Doctors at 100%
- Neonatal Newborn Life Support (NLS) compliance within the Local Neonatal Unit (LNU) nurses remains high for Nursery Nurses' (100%) & Neonatal Nurses (91.30%). June data is currently showing Neonatal Consultants at 85.71% & the Neonatal Doctors & Advanced Neonatal Nurse Practitioner (ANNP's) at 86.84% - this is below the 90% MIS compliance recommendation – mitigation actions are in place to reach the 90% compliance by July submission criteria.
- A temporary fall in PROMPT and Fetal Surveillance compliance among doctors is routinely seen each February & August due to rotation of new staff. This reflects timing of rotation rather than training concerns.
- Following GWH successfully leading the Maternity Support Worker (MSW) development programme across BSW, the MSW education lead has completed a train the trainer program (TTT) and is now carrying out inhouse clinical skills training for the band 2 & 3 team at GWH. This is in response to feedback requesting MSW focused training. It is anticipated that this dedicated and bespoke training investment into the MCA & MSW workforce will increase confidence with clinical skills, improve patient safety and positively impact retention within this staff group. Following feedback from our MCA/MSW workforce, the education team have tailored a monthly bespoke MCA/MSW training day to provide sustainability for their

	knowledge and clinical skills. In March 2026 the first Transitional Care (TC) study day was held, this day provided training, both clinical skills and knowledge base essential for our transitional care babies. • This programme has been recognised as flagship work, demonstrating organisational leadership in training design and providing a transferable model for use across other hospitals and regions. • Two hospital-based Simulation-Based Training (SIMs) have been completed in Q1. NLS SIMs are completed in the community hubs. This has a focus on out of hospital setting emergency responses. A full SIM with maternal PPH in the community setting is planned for Q2 and will involve input from the ambulance service. This is anticipated to be completed to align with the November MIS submission. • Learning notes from all SIMS held between January and June 2026 will be presented in the July Perinatal Governance for discussion and oversight. Future learning will be reported through the Perinatal Governance meeting on a quarterly basis, with assurance provided to the Senior Leadership Team and Trust Board through the quarterly Safety Report.
Equality Diversity and Inclusion Do you know where you are in achieving the maternity safety ambition?	• Following the staff listening event reported in Q4, the service has continued to progress actions aimed at strengthening an anti-racist and inclusive workplace culture, in line with the priorities of the Maternity and Neonatal Single Delivery Plan. The publication of both the Amos National Maternity and Neonatal Investigation and the Ockenden Report has reinforced the importance of this work, highlighting the persistent impact of racism, discrimination and cultural barriers on staff wellbeing, patient experience and safety outcomes across maternity and neonatal services. Local actions remain focused on improving staff experience, psychological safety and equitable opportunities for development. Encouragingly, there has been sustained increased engagement with the Professional Midwifery Advocate (PMA) service, greater utilisation of line management support, and continued improvements in staff confidence to raise concerns and seek guidance. Staff are also increasingly engaging in professional development opportunities, including additional training, master's-level study and career progression initiatives. These developments suggest growing trust in leadership and demonstrate early progress towards embedding a more inclusive, supportive and equitable culture, consistent with the expectations set out in recent national maternity reviews. • The Professional Midwifery Advocate (PMA) service has been further strengthened through the allocation of additional PMA hours, increasing visibility, accessibility and support available to staff across maternity services. This has contributed to sustained engagement with restorative clinical supervision and wellbeing support, supporting the development of a psychologically safe working environment. Progress has also been made in refining the Professional Nurse Advocate (PNA) role within neonatal services through the BSW-wide review of PMA/PNA roles and responsibilities. Following completion of this work, plans to recruit into the neonatal PNA post are being progressed. Psychological safety remains a key priority, supported through increased advocacy provision, strengthened managerial engagement and continued promotion of speaking-up and support mechanisms, enabling staff to access timely support and professional development opportunities. These developments align with the recommendations of the recent Amos and Ockenden reports, which emphasise the importance of supportive workplace cultures, staff wellbeing and psychologically safe environments as fundamental enablers of safe and equitable maternity and neonatal care. • Perinatal service leaders continue to embed inclusive leadership practices through active participation in the NHS England Changing and Growing Together reverse mentoring and talent programme. Cohort 2 successfully concluded during the reporting period, with participants reporting increased confidence in addressing inclusion, equity and cultural awareness within their leadership practice. • A notable outcome of the programme was the successful support provided by one participant to their mentee, who secured a promotion following a competitive interview process, demonstrating the tangible impact that mentoring and sponsorship can have on career development and progression. • Building on this success, Cohort 3 has now commenced with representation from both maternity and neonatal services, reflecting sustained organisational commitment and growing multidisciplinary engagement. The programme continues to provide an important mechanism for developing culturally competent leaders, increasing awareness of lived experience, and strengthening inclusive leadership behaviours across perinatal services. While formal

	workforce metrics continue to be monitored through established governance arrangements, early feedback indicates positive impacts on staff confidence, career development opportunities and the creation of a more inclusive and supportive workplace culture, aligned with the ambitions of the Three-Year Delivery Plan, Maternity Safety Support Programme, and the recommendations emerging from recent national maternity reviews. • After observing a recent theme of suboptimal interpretation provision across perinatal services, specifically the accuracy of the interpretation as fed back by partners in the room, the team are working with clinical staff to capture incidents via Datix (electronic incident reporting system) and are building a case to take to PALS to support improvements. The central governance team are aware of this work and have been asked to provide cross divisional supporting data spanning the last 5 years. This piece of work is not yet concluded. • The Equity and Patient Safety National Dashboard remains operational and continues to provide Trust-level insight into the local demographics of the service users in our care. The long-term ambition remains to expand reporting to include additional protected characteristics, enabling a more comprehensive understanding of inequalities in outcomes, experience and access to care. • Progress towards this objective has been slower than anticipated due to competing organisational priorities and reduced Informatics capacity, which has impacted the pace of system developments and requested system changes. Regular meetings between the Patient Quality and Safety Assurance (PQSA) team and Informatics colleagues continue to provide oversight of dashboard functionality, data quality and coding accuracy, ensuring ongoing progression of key deliverables. To support accurate interpretation of data and inform system improvements, the PQSA team coordinates attendance from relevant clinical specialties and professional groups as required, ensuring that proposed changes reflect broader maternity, neonatal, safeguarding and perinatal service requirements. • In addition, Informatics teams across the Bath and North East Somerset, Swindon and Wiltshire (BSW) system are strengthening collaborative working arrangements to support greater alignment of data definitions, reporting methodologies and dashboard development, promoting consistency of approach and enabling more meaningful benchmarking across maternity and neonatal services. Despite ongoing capacity challenges, continued focus on data quality, governance and collaborative review processes is supporting the development of a more robust platform for identifying and addressing inequalities in line with national priorities for equity, transparency and patient safety. Below is the national dashboard data for ethnicity and Index of Deprivation of mothers at booking for Great Western Hospital. • The table presents the monthly percentage breakdown of the ethnic categories and Index of Deprivation of mothers receiving care within our maternity service. It shows both the most recent month's distribution and the trend across the year. The data highlights the demographic profile of the women using the services, with the majority identifying as White, followed by Asian or Asian British, Black or Black British, Mixed, and other ethnic groups which is in line with the national picture. It also shows the largest proportion of cases of women we care for are within the 9th, 8th, 7th, 6th and 4th Index of Deprivation which is different to the national picture. This data helps us understand who is using our maternity service and highlights where inequities may exist, next steps are to start to triangulate this with our incidents and outcome data enabling us to target improvements that make care safer and more equitable for all women and babies. This table below is national data and is 3 months in arrears.

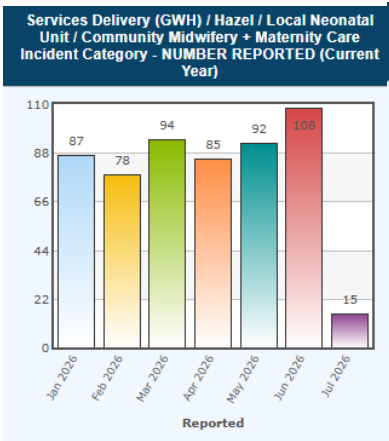


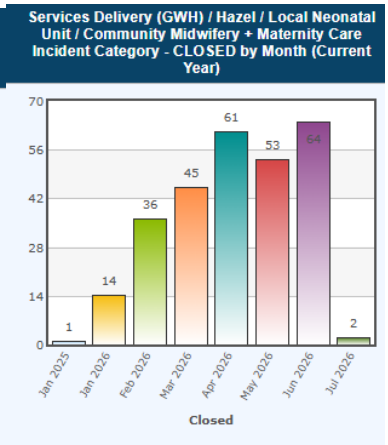


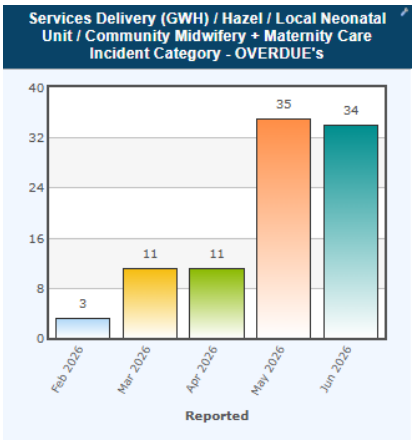
Incident reporting	• All perinatal incidents continue to be reviewed through a multidisciplinary weekday safety huddle, with Family and Specialist Services (FaSS) divisional oversight, enabling timely risk assessment, immediate safety actions and early identification of learning. This is supported by weekly multidisciplinary incident review meetings and formal investigations in line with PSIRF principles. • Incident reporting levels remained largely consistent throughout Q1, providing assurance of a positive reporting culture and continued staff confidence in raising concerns. Review of incidents has identified two emerging themes relating to take-home medication (TTA) processes and failed trials without urinary catheter. Both are subject to further review to identify

contributory factors and inform improvements to practice. No other significant recurrent themes or emerging safety concerns were identified.

- Timeliness of incident closure remains an area for improvement. Ongoing acuity pressures and planned annual leave have continued to impact review capacity, resulting in limited progress in reducing overdue investigations. Weekly oversight of overdue Datix incidents remains in place through senior leadership review, with focused multidisciplinary discussions supporting proportionate investigation, learning and timely closure. To accelerate progress, an additional multidisciplinary review meeting has been established to target the most overdue incidents and strengthen oversight of investigation completion. Closure performance continues to be monitored weekly, recognising the importance of embedding learning in a timely manner while maintaining the quality and robustness of investigations.
- The below charts demonstrate the monthly reporting and closure of incidents up to 30th June 2026.







- Q1 has also focused on embedding the NHS England Perinatal Quality Oversight Model (PQOM) within routine governance arrangements following its implementation across the BSW system in March 2026. Early work has centred on reviewing outputs, ensuring consistency of reporting and strengthening the escalation of quality and safety risks across Trust, ICB and system-level forums. This approach supports greater alignment of oversight processes across BSW and enhances collective learning in response to emerging patient safety risks.
- In response to Year 8 Maternity Incentive Scheme (MIS) requirements, SPEN (Single Point of Entry Notification) reporting has been embedded within perinatal governance processes to support the timely identification and notification of maternity and neonatal incidents meeting national reporting criteria. A triangulated assurance process has been established whereby SPEN notifications are routinely cross-referenced against the PQSA incident tracker, perinatal Datix incidents and bereavement notifications to ensure completeness of reporting and identify any missed or delayed notifications. Compliance with notification requirements, including timeliness and completeness, is reviewed through routine governance processes, with any exceptions subject to review, agreed actions and ongoing monitoring. This provides assurance that SPEN reporting is subject to consistent oversight through maternity and neonatal governance structures and Board reporting arrangements, in line with Year 8 MIS requirements.
- In line with the Maternity Outcomes Signal System (MOSS) Standard Operating Procedure and Year 8 Maternity Incentive Scheme (MIS) requirements, a Tier 2 MOSS signal drill was undertaken during the week commencing 22 June 2026. The exercise included external review and tested the service's ability to respond effectively to a MOSS trigger through completion of the critical safety check process. The drill was delivered collaboratively by the perinatal leadership team and frontline clinical staff, ensuring that the process was not reliant on a single individual and reflected routine operational practice.
- The exercise resulted in an Amber assurance rating, demonstrating that the service has the required processes and governance arrangements in place but identifying opportunities for further strengthening and standardisation to assure oversight and timely access to the necessary data. An executive-approved action plan has been developed in response to the findings and will be submitted through the appropriate assurance routes. Actions primarily focus on improving the capture, documentation and oversight of key critical safety elements to

	support more efficient evidence gathering and assurance should a live MOSS signal occur. Recognising the complexity of these requirements, implementation timescales have been agreed and proportionate actions incorporated into existing governance and quality improvement workstreams. • Progress against the action plan will be monitored through established maternity and neonatal governance structures, with oversight provided by the perinatal leadership team and escalation through Trust governance processes where appropriate. Learning from the drill will be embedded into routine practice and future exercises, providing continued assurance to the Trust Board that the service can respond promptly, effectively and collaboratively to any future MOSS signal, whilst ensuring that identified improvements are implemented at pace • No MOSS signals or notifications have been received to date. • Martha's Law (Perinatal Services) continues to be embedded within maternity and neonatal services, providing women, families, carers and staff with a clear route to request a rapid clinical review where concerns about deterioration are not being adequately addressed. Martha's Law was introduced in maternity services in 2025, and a plan is in place to launch this service fully in the neonatal unit in Q2, which is currently limited by the accessibility of a second consultant with a suitable specialist skill set. The initiative supports a culture in which patients, families and staff are empowered to speak up and escalate concerns, ensuring concerns are heard and acted upon in a timely manner. National reporting continues to highlight the positive impact of Martha's Law in strengthening patient safety through earlier recognition of deterioration, improved communication, timely access to senior clinical review and greater involvement of patients and families in care decisions. • During Q1, no requests for review were received through the Martha's Law pathway. The number and nature of contacts, together with any themes, learning and actions arising, continue to be monitored through the monthly Patient Quality Oversight Meeting (PQOM) to provide assurance regarding utilisation of the process, effectiveness of escalation pathways and opportunities for service improvement. • The Patient Quality and Safety Assurance (PQSA) Team and Maternity and Neonatal Voices Partnership (MNVP) have continued to work collaboratively to raise awareness and understanding of Martha's Law within local communities. Engagement with the local Afghan community has been particularly successful, providing valuable insight into community awareness, communication preferences and potential barriers to accessing escalation pathways. Building on the positive outcomes of this initiative, the PQSA Team and MNVP are exploring opportunities to extend engagement activities to other ethnic minority and seldom-heard communities, supporting equitable awareness and access to Martha's Law across the maternity pathway. • Recent national maternity safety reviews have reinforced the importance of listening to women and families, responding proactively to concerns and fostering a culture where speaking up is encouraged and valued. Martha's Law continues to support these principles locally, strengthening patient advocacy, multidisciplinary collaboration and equitable access to escalation processes, while contributing to a positive and open safety culture across maternity and neonatal services • Safeguarding concerns within maternity services continue to be monitored through established governance processes. During Q1, no new themes or trends have emerged through incident reporting in relation to safeguarding practice, providing assurance that the targeted training, education and shared learning delivered following the Q4 review are supporting improvements in staff awareness and decision-making. • The review undertaken in Q4 identified variation in the management of substance misuse during pregnancy, including inconsistencies in multidisciplinary working, information sharing and care planning across the maternity pathway. This remains an area of focus for the service and work continues to strengthen leadership, governance and consistency of practice. • Progress has been made towards the development of a more coordinated approach, including plans to recruit a Named Maternity Lead for Substance Misuse in Pregnancy. Work is underway to review the existing service framework and develop a trust-wide multidisciplinary pathway to support consistent assessment, escalation, information sharing and care planning for women with substance misuse vulnerabilities and their infants. • This work will be supported through strengthened collaboration with community, safeguarding and partner agencies, alongside continued staff education, multidisciplinary learning and governance oversight. The aim is to promote a consistent, evidence-informed approach across

the maternity pathway, improve safeguarding outcomes and ensure women and babies receive coordinated and equitable care.

- Ongoing monitoring through incident reporting, safeguarding reviews and governance forums will continue to provide assurance regarding the effectiveness of the actions implemented and identify any emerging risks or learning opportunities.
- The PQSA Team completed a deep dive review of ten uterine rupture cases occurring between 2021 and 2025 to identify common themes, explore contributory factors, challenge assumptions and inform quality improvement opportunities within maternity services.
- The findings are currently being reviewed in collaboration with the obstetric team to develop a greater understanding of the clinical management, decision-making and care pathways associated with these complex cases, and to identify any additional learning or service improvements required.
- As part of the Maternity Incentive Scheme (MIS) Year 8 work programme, the PQSA Team is leading the development of a programme of thematic reviews to strengthen organisational learning, provide assurance regarding standards of care and support safety improvement across maternity services. This approach will include supporting clinical and operational leads to undertake structured reviews within their own areas of responsibility, promoting local ownership of learning and improvement actions.
- Findings and recommendations from thematic reviews will be presented through the Perinatal Governance structure to facilitate multidisciplinary discussion, oversight of action plans and the dissemination of learning across the service.
- Consideration will be required regarding the sustainability of this approach to ensure thematic review activity can be maintained over time, balancing governance requirements, available resource and the development of capability within clinical teams to undertake and lead future reviews.
- Newborn hypoglycaemia incidents continue to be monitored through established governance arrangements. A thematic review of incidents reported between 2022 and 2025 has been undertaken by the Transitional Care Clinical Lead Nurse and Education Lead to identify contributory factors, variation in practice and opportunities for improvement. Learning from incident investigations has already informed immediate safety actions, and a Quality Improvement project has been established to further strengthen screening and management processes. Further detail on incident themes, improvement work and governance oversight is provided within the Thematic Review section of this report.

MNSI

What is the culture in your maternity services?

Current cases under review	Cases declared Q1	Draft reports to staff Q1	Final reports received Q1
5	3 (1 rejected)	2	0

Criteria for referral:

- Therapeutic Hypothermia
- Maternal Death

	Therapeutic Cooling	Neonatal death	Intrauterine Death (with element of labour)	Maternal Death
Total of new referrals Q1	3	0	0	0

Modes of birth for Maternity and Newborn Safety Investigations (MNSI) cases under investigation

Spontaneous vaginal birth	Caesarean birth (Elective/Emergency)	Instrumental birth
3	0	0

- Quarterly / biannual meetings with MNSI are arranged to provide information and feedback; the next virtual meeting will be arranged for the combined BSW hospitals' group in September 2026. All qualifying cases have been referred to MNSI and to NHS Resolution's Early Notification scheme and demonstrate compliance with CNST Safety Action C.

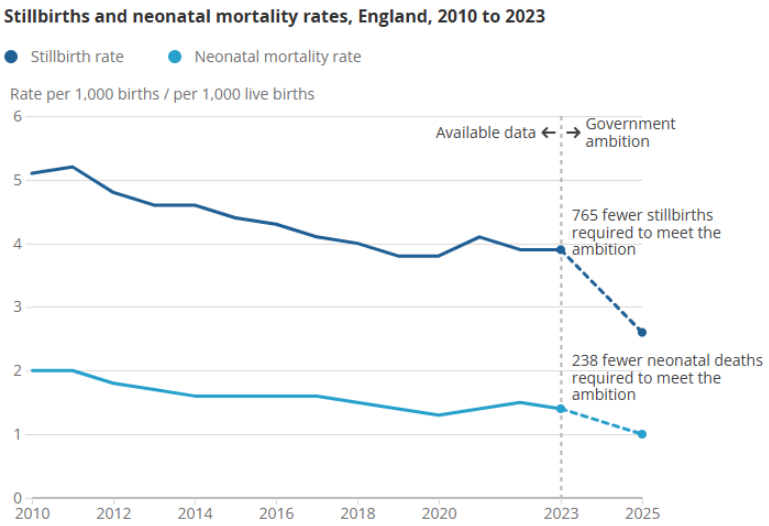
Perinatal Mortality Review Tool

What tools /methods do you use to understand this?

Do you know what your perinatal mortality rate is?

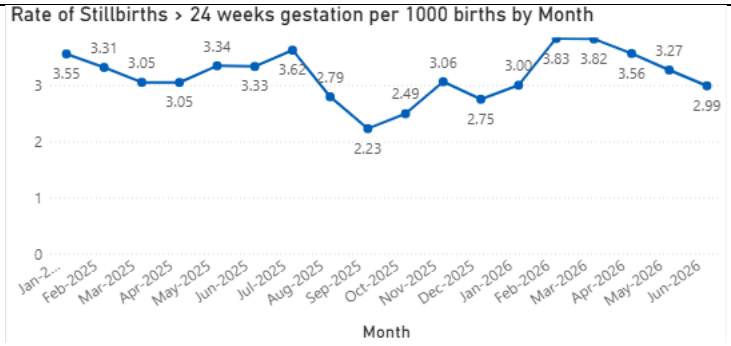
- There have been five pregnancy losses in Q1 reported to MBRRACE via SPEN by GWH.
- Two cases were terminations of pregnancy for medical reasons, two cases were babies born before 22 weeks' gestation who died following birth, and one case was a late pregnancy loss at 22+4 weeks. None of these cases met the criteria for a full PMRT review.
- All reported cases have been declared and reviewed within the required timeframe during Q1. Learning from these deaths is captured within the Trust Mortality Report.
- No recurring themes have been identified in Q1 following detailed review of all reported cases.
- A quarterly PMRT report providing case-level detail is submitted through established governance processes for Trust oversight.
- Parents are actively encouraged to contribute their comments, questions and concerns through the PMRT process. This engagement is supported by the Maternity Bereavement Team, who work sensitively with families to ensure involvement is personalised to their individual needs, preferences and circumstances.
- The Bereavement Team facilitates opportunities for families to provide feedback, raise questions for review panels and receive updates on the review process, ensuring that the family voice is meaningfully incorporated into reviews, investigations and organisational learning.
- Records of family engagement and evidence of how parental feedback has informed PMRT discussions, findings and subsequent improvement actions are maintained. Recognising the enhanced assurance requirements of MIS Year 8 Safety Action C, the Patient Quality and Safety Assurance (PQSA) Team and Maternity Bereavement Team are jointly reviewing current data collection and reporting arrangements to strengthen the consistency and robustness of family engagement documentation. This will support improved governance oversight and provide clearer evidence of how family feedback contributes to PMRT reviews, organisational learning and quality improvement.
- Family feedback and any emerging themes identified through the PMRT process are reviewed through routine maternity and neonatal governance arrangements. Learning and improvement opportunities arising from parent feedback are incorporated into governance reporting and contribute to Board assurance regarding family involvement and learning from reviews.
- Inclusion of the Maternity and Neonatal Voices Partnership (MNVP) at PMRT meetings commenced in Q2 2024/25 in line with CNST Maternity Incentive Scheme standards. MNVP feedback has informed the development and review of family engagement approaches and parent-facing information, helping to ensure processes remain responsive to the needs and experiences of bereaved families.
- External multidisciplinary participation remains an established component of the Trust's PMRT process and provides independent scrutiny, professional challenge and shared learning opportunities across maternity and neonatal services.
- In response to the revised MIS Year 8 requirements, reporting arrangements are being further developed to provide explicit assurance regarding compliance with the requirement for external representation at a minimum of 60% of eligible reviews, including documentation of attendance within PMRT records and oversight of any identified gaps or associated actions.
- Learning and recommendations arising from reviews involving external specialists continue to be incorporated into routine maternity and neonatal governance processes, supporting quality improvement and the dissemination of learning across services.

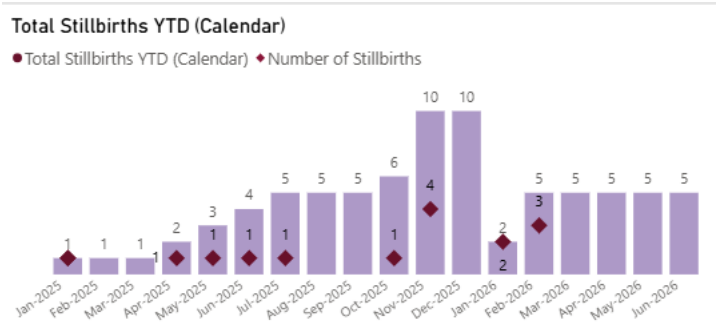
- Providing families with information regarding the MNSI investigation process, NHS Resolution Early Notification Scheme (ENS), PMRT reviews and Duty of Candour is an established component of the Trust's response following an eligible perinatal death and is delivered jointly by the Maternity Bereavement Team and the Patient Quality and Safety Assurance (PQSA) Team.
- Families are routinely provided with timely, sensitive and accessible information about the review and investigation processes relevant to their circumstances. The Bereavement Team and PQSA Team work collaboratively to ensure information is tailored to individual family needs and preferences.
- The joint working arrangements between the Bereavement Team and PQSA Team support consistent oversight of family engagement and information provision, with any identified gaps reviewed through established perinatal governance processes and actions implemented where improvement opportunities are identified.
- In response to MIS Year 8 requirements, reporting arrangements are being developed to provide routine assurance that information relating to MNSI, NHSR Early Notification, PMRT reviews and Duty of Candour has been provided to families where applicable.
- The Quarter 1 PMRT Report, attached as Appendix C, identifies the requirements of MIS Year 8 Safety Action C and the development of reporting arrangements to support assurance. This will enable routine reporting through PMRT and established monthly governance processes, providing oversight of family information sharing, compliance with requirements relating to MNSI, NHSR Early Notification, PMRT reviews and Duty of Candour, and any actions required to strengthen delivery.
- Families are routinely offered the opportunity to meet with relevant clinicians and specialists following the completion of reviews and investigations to discuss findings, answer questions and receive an explanation of any learning or actions identified.
- The offer and coordination of family meetings are supported through the Maternity Bereavement Team, working in collaboration with the PQSA Team and relevant clinical teams.
- In response to MIS Year 8 requirements, reporting arrangements are being developed to provide routine assurance regarding the offer, uptake and outcomes of family meetings, enabling oversight of compliance, identification of any gaps and monitoring of actions to strengthen family engagement.



Source: Child and Infant Mortality in England and Wales, 2023 from the Office for National Statistics

Great Western Hospital data is captured in the charts below.





Legal Claims	• One new legal claim was received in Q1 within the perinatal service which related to care within gynaecological services due to the gestational age. The claim relates to failure of Recognition and Management of Maternal Deterioration / Maternal Sepsis. • The Trust Score Card is released and reviewed annually alongside incident and complaint data. • The 2015-2025 score card was shared with the PQSA Team towards the end of Q2, and a full review was initially provided in the Integrated Performance Report in November 2025. • The new CNST Year 8 requirements require the Score Card to be reviewed quarterly and the action plan to be updated. The PQSA Lead meets monthly with the Legal Team to review all active legal claims, providing assurance that required actions and information requests are completed within agreed timescales and that case management remains robust and timely. • See Appendix A, where the 2025 Trust Score Card is reviewed alongside incidents and complaints submitted in Q1 26/27. **Completed actions:** • Nil to report this Quarter **Ongoing actions:** • The obstetric outpatient service review remains in progress and is currently awaiting the appointment of the General Manager for Obstetrics. Once in post, they will work alongside the Head of Midwifery and Neonatal Services and the Clinical Lead for Obstetrics and Gynaecology to progress the required system changes, including improvements to the Maternity Triage service and consideration of a call-recording solution. The findings and recommendations from both the Ockenden and Amos reviews relating to Triage will inform operational and strategic decision-making moving forward. In parallel, proposed estates changes continue to be escalated to the Discretionary Spend Committee approval process, which will support the wider programme of service improvement. • Ongoing service review work is being informed by national maternity triage standards and the recommendations arising from the Ockenden and Amos reviews, which continue to shape local decisions regarding governance, triage processes, and supporting infrastructure. • The planned review of events resulting in claims related to psychological impact has been delayed due to a period of absence affecting the Perinatal Mental Health Lead Midwife role, followed by a subsequent reduction in available hours. Whilst this work remains a priority and is planned to proceed, consideration is now being given to how the review can be appropriately

	resourced and whether additional support is required to undertake the analysis. Once this has been determined, the review will focus on identifying common themes, service-level learning and opportunities for prevention, with findings to be reported through future governance arrangements.
Coroner Inquests	• Following the Regulation 28 Prevention of Future Deaths (PFD) report, actions arising from the VBAC improvement plan have been embedded into routine practice. The revised VBAC information leaflet is routinely provided and recorded electronically, with ongoing audit providing assurance regarding the consistency and quality of informed consent discussions. All maternity actions are complete, 1 action, being led by the Trust, remains open and is due to be completed by October 2026. • Monthly review of the maternity safety improvement tracker through Maternity Governance provides oversight of all actions arising from serious incidents, investigations and external reviews, supporting timely completion, escalation of delays and implementation of learning. • In line with Ockenden recommendations, a six-month timeframe for completion of safety actions remains embedded within governance processes. Progress is monitored through Datix, supported by named action leads and regular performance review. • All previously overdue actions arising from Patient Safety Incident Investigations and Serious Incidents within perinatal services have been completed and closed, providing assurance regarding the effectiveness of strengthened action-tracking and governance arrangements. See Appendix B.
Staffing Do you know where you are in achieving the maternity safety ambition?	• The service continues to monitor compliance with the recommendations arising from the Birthrate Plus® (BR+) review through established governance and workforce assurance processes. Birthrate Plus® is a nationally recognised workforce planning methodology that assesses maternity staffing requirements against birth activity, case mix and acuity, providing an evidence-based benchmark for safe staffing. Ongoing assurance is provided through routine monitoring of key safety indicators, including one-to-one care in labour, maternity red flags, missed breaks and periods of increased acuity, with mitigating actions implemented where required. Workforce trends, recruitment and retention activity, staffing establishment and progress against BR+ recommendations are reviewed regularly through governance forums and reported within the monthly PQOM dashboard. This provides assurance that workforce risks are being actively managed and that progress towards implementation of BR+ recommendations continues to support the safe and effective delivery of maternity services. • Supernumerary status of the delivery suite coordinator and 1:1 care in labour continues to be monitored and reported to the Quality and Safety Committee monthly. A review of all cases where 1:1 care has not been met has demonstrated that all possible mitigation steps were taken in line with the Trust escalation policy. • Whilst we will continue to report the Supernumerary status of the delivery suite coordinator and 1:1 care in labour as “Red Flags” They have both been removed from Year 8 Maternity Incentive Scheme (MIS) • The pipeline of newly qualified midwives remains consistently high, and these midwives are allocated to the inpatient setting in their first year of practice and are supported by the Lead Preceptorship Midwife. The pipeline of experienced midwives has also improved in the last 6 months which has positively impacted on recruitment into the Community and Triage teams • BAPM Neonatal Workforce Standards provide a national benchmark for safe neonatal staffing and workforce capability. The standards set expectations for appropriate nurse, medical and allied health professional staffing levels, specialist neonatal competencies, education and training, and workforce planning to ensure the safe delivery of neonatal care. Assurance work is focused on assessing compliance with these standards, identifying gaps and implementing actions to mitigate workforce-related risks. • Recruitment into the Band 5 nurses on the neonatal unit has continued to demonstrate a significant reduction in agency spend. • Band 7 Senior Nurse for Transitional care contract has been funded for a further 12 months to support the development of the Outreach service, in line with British Association of Perinatal Medicine (BAPM) Standards • Additional places on the Qualified in Speciality (QIS) course for neonatal nurses have now been funded to support the work force reaching 70% of staff holding this qualification. Work is

ongoing across the Southwest Neonatal Operational Delivery Network to revise the QIS pathway.

- Band 7 Family Support Service Nurse recruited into and started in April 2026 for a Fixed Term 12 months 0.32 WTE, utilising Neonatal Workforce underspend from Southwest Neonatal Operational Delivery Network. The post holder has already made a significant difference to the families and will continue to evidence feedback to support making this position substantive. GWH is an outlier within the region for Psychological Support for families, so this is a positive step towards building a service.
- A business case has been developed to support an increase in neonatal staffing in line with British Association of Perinatal Medicine (BAPM) standards. The proposal includes the use of a proportion of the Year 7 MIS rebate to support this investment. Next steps are to present the business case to ORBIT in August 2026.
- A daily Operational Pressures SitRep data collection tool was launched in December 2025, replacing the previous fortnightly return, and has been agreed with regions and ratified by NHS England's Data Assurance Board. From July 2026 the data collection will be extended.
- The data populates a shared dashboard providing maternity and neonatal OPEL status to support regional escalation and mutual aid, with separate national reporting to enable oversight of safety pressures, performance and perinatal quality. Data submitted through the portal can be aggregated at the individual hospital level.

Saving babies lives v3.2

Do you know where you are in achieving the maternity safety ambition?

- An updated version of the guidance (version 3.2) was released nationally in May 2025.
- A previous evidence review was undertaken by the Local Maternity & Neonatal System (LMNS) in October 2025.
- Guidance was received from the LMNS on 6th May 2026 to advise that LMNS led formal assurance reviews were being stood down following the move to ICB cluster-based working across BSW, Somerset and Dorset.
- Moving forward each Trust will remain responsible for ongoing implementation of SBL v3.2, quarterly reporting to board committees and ensuring evidence is available to support potential MIS spot checks by NHS Resolution.
- An in-depth review of Trust evidence from Q3 (2025/26), Q4 (2025/26) and Q1 (2026/27) undertaken and presented to Perinatal Senior Leadership for review and oversight.
- The metrics for Saving Babies Lives have previously been reported to Trust Board. Due to changes in the CNST Maternity (Perinatal) Incentive Scheme guidance these will continue to be reported to the Quality and Safety Committee with delegated responsibility to ensure Board oversight of any risks to the strategy for full compliance, pending finalisation of the revised group governance structure.
- A summary of the latest compliance position is below,

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)
Element 1	Smoking in pregnancy	Fully implemented	100%
Element 2	Fetal growth restriction	Partially implemented	75%
Element 3	Reduced fetal movements	Partially implemented	50%
Element 4	Fetal monitoring in labour	Fully implemented	100%
Element 5	Preterm birth	Partially implemented	92%
Element 6	Diabetes	Fully implemented	100%
All Elements	TOTAL	Partially implemented	88%

- Further to the Q2 assessment there has been a period of transition from focussed implementation of the standards to sustainable reporting as part of the service governance reporting routine.

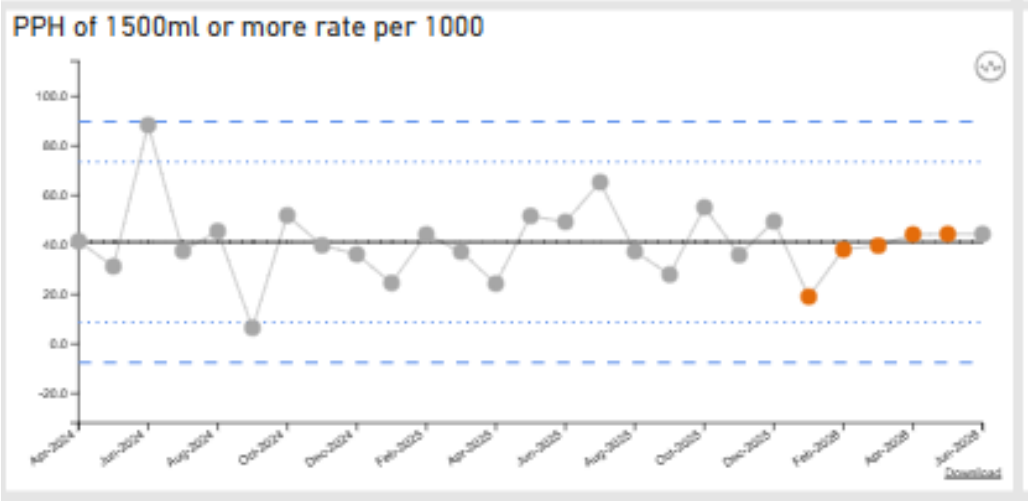
- Ongoing improvement actions required are targeted on the implementation of a new electronic scan system (Go Live date planned for September 2026), the planned continuation of data collection for Element Three. and the completion of two audits for full assurance of compliance.
- In-light of the recent NHSE and RCOG fetal growth chart safety communication, the Trust has undertaken a review of our local SBL priorities to confirm safe and appropriate fetal growth surveillance continue to be implemented.
- The Clinical Lead for Obstetrics & Gynaecology confirms:
    - All GWH fetal surveillance pathways follow the national SBL guidance
    - The current electronic software used by GWH does not provide Estimated Fetal Weight (EFW) charts. Risk mitigating actions are in place for assurance with the Trust committed to introducing a new electronic scanning software (Viewpoint) with a planned go live date of September 2026. The EFW is printed manually on reports from scan machines.

- Regular reviews are undertaken to identify local themes and trends with regards to potential harm within the six elements.
    - **Reducing smoking in pregnancy:**
      This theme did not contribute to identified poor outcomes in Q1
    - **Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction (FGR):**
      This theme did not contribute to identified poor outcomes in Q1
    - **Raising awareness of reduced fetal movement (RFM):**
      This theme did not contribute to identified poor outcomes in Q1
    - **Effective fetal monitoring during labour:**
      One case whereby the mother declined transfer from homebirth for fetal monitoring after suspected fetal compromise in Q1. Baby required uplift to tertiary care and ongoing palliative care, planned Patient Safety Incident Investigation
    - **Reducing preterm birth:**
      There were two cases of preterm delivery in Q1. One case involved a delay in the inpatient transfer of 30 weeks monochorionic diamniotic (MCDA) twins. A review of the care is ongoing to identify learning and actions; however, initial findings indicate that the birth was unavoidable. The second case involved MCDA twins at 21 weeks who were born shortly after discharge following a triage assessment, initial findings indicate that the birth was unavoidable. This case is subject to a PSII, and a lead investigator has been assigned.
    - **Diabetes care**
      This theme did not contribute to identified poor outcomes in Q1
    - **MSU at booking:**
      This theme did not contribute to identified poor outcomes in Q1
- Themes and trends identified across maternity and neonatal services continue to be shared across the BSW system to support collaborative learning and quality improvement. The LMNS Safety Forum is currently suspended pending the ongoing reconfiguration of the ICB and LMNS. To maintain opportunities for system-wide learning and the sharing of safety intelligence, BSW maternity and neonatal leaders are developing interim arrangements, including regular cross-organisational meetings, which are planned to commence during 2025/26.
- An exception reporting process for SBLv3.2 continues to be established to ensure that all identified cases defined within Elements 2, 4 and 5 are reviewed at an individual service user level. All exception reports will be reviewed using an Alert, Advise, Assure SBAR and discussed in the Maternity Governance meetings to share wider learning.
- Evidence of continued learning will be shared across the system, regionally and nationally (as appropriate).
- BSW system data will be reported to regional teams providing the opportunity for benchmarking at local and national level and is reviewed locally via the Maternity and Neonatal Safety Champions.

Quality Assurance

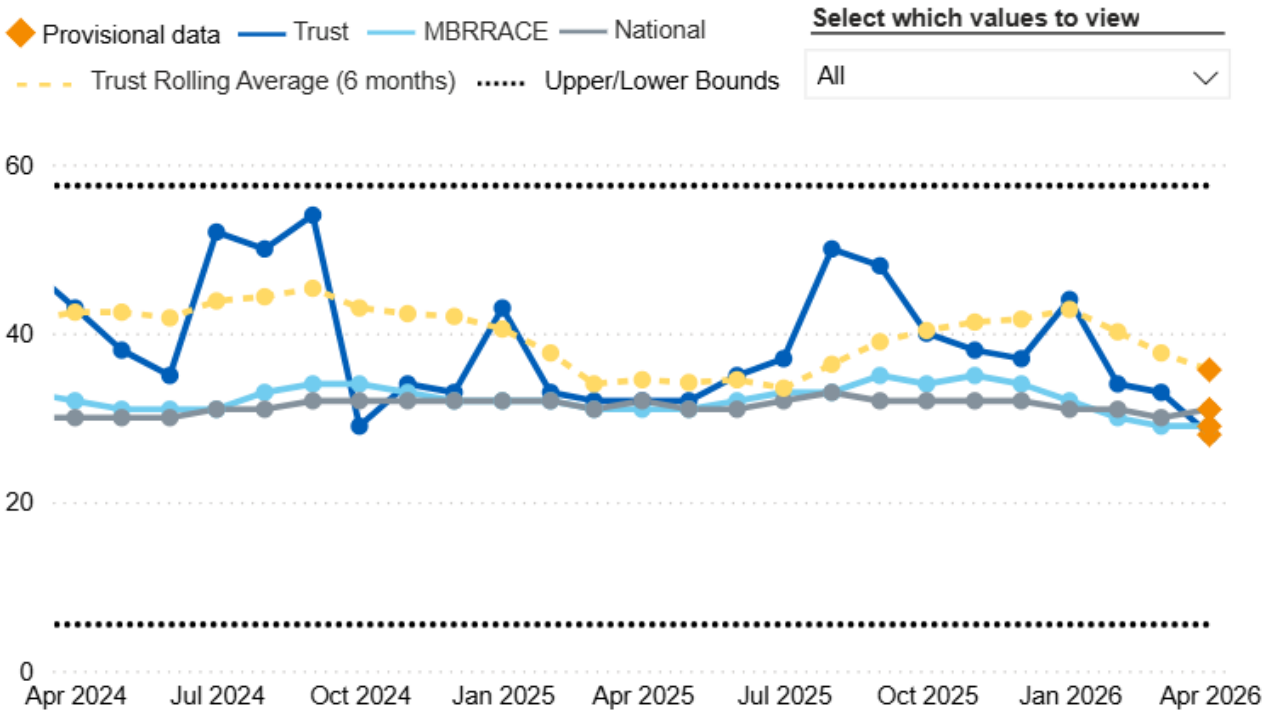
What is the culture in your maternity services?

Post Partum Haemorrhage:



- The rate of PPH ≥1500ml per 1,000 births at GWH has remained within expected control limits throughout the reporting period. Following some month-to-month variation, the most recent data suggest the process is stable, with rates remaining close to the mean and no indication of sustained deterioration or improvement.
- The time-series chart demonstrates that Great Western Hospitals' significant postpartum haemorrhage (≥1500mls) rate has remained within upper and lower control limits throughout the reporting period.
- The rolling average indicates overall stability, with a downwards trend to aligned to national and MBRRACE benchmarks.
- This provides assurance that observed variation represents normal fluctuation rather than emerging risk, this is supported by ongoing routine monitoring through maternity safety governance arrangements.

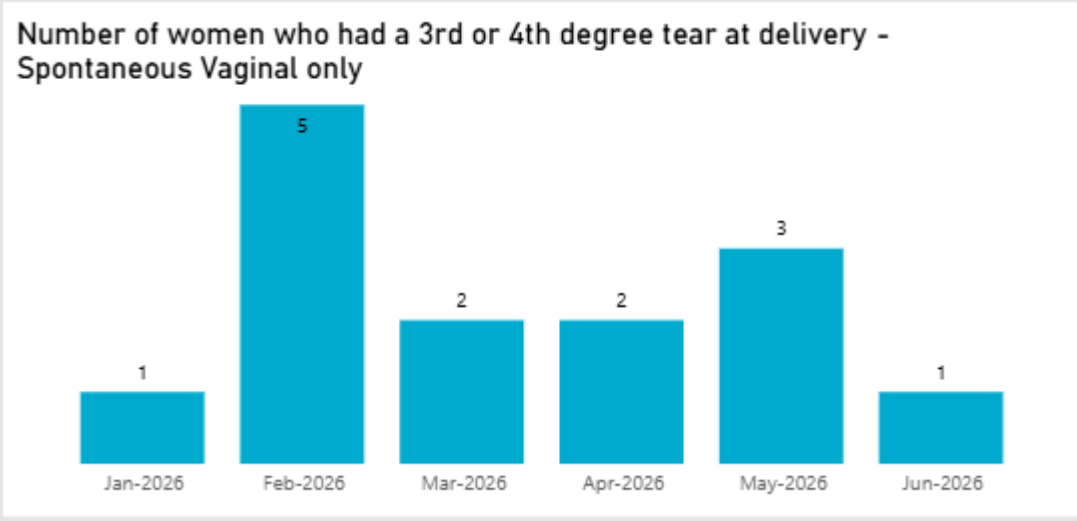
Women who had a PPH of 1,500ml or more values comparison over time for Great Western Hospitals NHS Foundation Trust (Rate per 1,000)

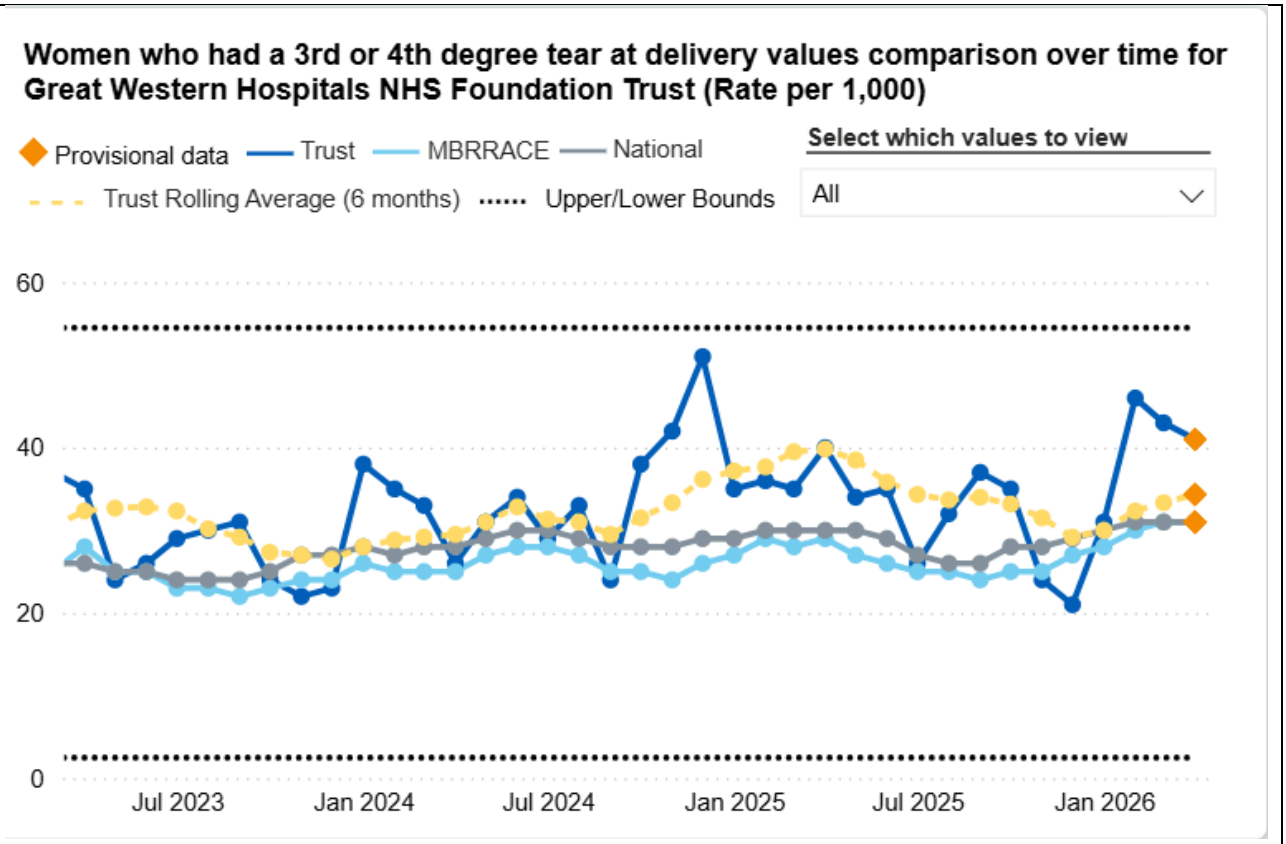


- Preventative actions continued to be explored. Current actions include-
    - Implementation of the Maternity Care Bundle PPH element following release of the national implementation tool
    - Introduction of the use of Carbetocin at all caesarean births is expected to reduce the rate of significant PPH and this will be formally audited by the obstetric team, A downward trajectory from January 2026 is visible from the graph above.
    - There is now scope to consider the use of Carbetocin for instrumental births in theatre.
    - Tranexamic Acid (TXA) being available to midwives on a Patient Group Direction (PGD) to facilitate early use from 500ml loss to prevent significant PPH

Obstetric Anal Sphincter Injury:

- The maternity dashboard identified a rise in Obstetric Anal Sphincter Injuries (OASI) in February. Rates of 3rd- and 4th-degree perineal tears subsequently returned to the expected local average from March and have continued to demonstrate a downward trend.
- All OASI incidents are reviewed through the Datix incident management process to support investigation, learning, and quality improvement.
- The Pelvic Health Lead Midwife has completed a six-month review of local OASI data. An action plan is being finalised to address identified themes, strengthen preventative measures, and support sustained improvement.
- A Quality Improvement (QI) project to introduce heated perineal pads during birth is progressing, informed by a review of the evidence base and ongoing engagement with the supplier.
- Dedicated teaching time has been secured to enable the Pelvic Health Lead Midwife to deliver OASI Care Bundle training to all relevant staff, with full compliance anticipated by June/July 2027.





BFI: Infant Feeding Data

- Breastfeeding initiation rates remained consistently high at approximately 86–89% throughout the reporting period, with March 2026 data demonstrating encouraging improvements in breastfeeding continuation across all postnatal stages, including increases in breastfeeding at hospital discharge (80%), Day 5 (85%) and Community Midwife discharge (81%), alongside significant reductions in artificial feeding and supplement use, indicating improved infant feeding outcomes and sustained breastfeeding support.
- Infant feeding data at birth relates to all inpatient births at Great Western Hospitals. Data from hospital discharge and beyond is collated for babies where GWH is the main provider. Data prior to February 2026 is incomplete due to implementation of a new data system, and this is reflected in reporting.
- The data is routinely reviewed to identify trends and points of drop-off in breastfeeding continuation or increased formula supplementation during the inpatient stay.
- Where variation is identified, targeted deep-dive analysis is undertaken to understand potential contributory factors, including staffing levels, acuity, mode of birth, activity pressures, and patient demographics.
- In a recent audit it was identified that there is a culture of giving formula to breastfeeding mothers without giving essential breastfeeding support. A working group are developing a new pathway of care to reduce unnecessary supplementation.
- The implementation of BadgerNet now supports the effective distribution of national Patient Information Leaflets (PILs) through targeted push notifications, enabling women to receive relevant information at appropriate stages of their pregnancy.
- Trust maternity patient information leaflets have been added to the EOLAS system. The Digital and Communications teams are working jointly to establish the process for uploading these documents to BadgerNotes, further strengthening digital access to patient information.

- Staff have received refresher guidance on uploading patient information leaflets to BadgerNotes and supporting women to access these resources, promoting consistent dissemination of information and patient engagement.
- These developments support improved patient access to information, enhance digital communication pathways, and contribute to informed decision-making throughout the maternity pathway.
- Staffing within the Antenatal and Newborn Screening team is now stable following successful recruitment, improving service resilience and supporting the delivery of the screening programme.
- During Q1, the service experienced challenges in accessing BadgerNet reporting functionality, resulting in a risk of delayed KPI reporting. This has been formally escalated as a patient safety risk and is being actively managed through established governance processes.

ANNB Screening:

- NHS England has identified Antenatal and Newborn Screening as a priority area for quality assurance monitoring during 2026/27. The Screening Quality Assurance Service (SQAS) will provide additional support and oversight throughout the year to strengthen assurance arrangements and support continuous improvement.
- Key areas of focus include strengthening the governance framework for the screening service, enhancing oversight and escalation of risks, improving screening incident management processes, and ensuring ongoing workforce capacity and resilience.
- The antenatal screening action plan continues to be reviewed through Maternity Governance structures, providing oversight of progress against identified actions and supporting compliance with national screening standards.

Homebirths:

- Following the Manchester North Prevention of Future Deaths report into the deaths of Jennifer and Agnes Cahill after a homebirth, the service continues to implement improvements identified through the completed gap analysis. Monthly monitoring of the Home Birth Service remains established through the Perinatal Quality Oversight Meeting (PQOM) framework, providing ongoing oversight of activity, outcomes and emerging risks.
- The audit of homebirths undertaken during 2025/26 remains in progress, with findings being used to inform service development, support compliance with updated guidance, and strengthen quality assurance arrangements.
- In response to CNST Maternity (Perinatal) Incentive Scheme Year 8 requirements, preparations for community-based emergency obstetric simulation training have progressed. A suitable external venue has been identified, and the necessary approval process is underway. Subject to final agreement, training is expected to commence from August 2026 and will include emergency response, escalation and transfer processes to provide additional assurance regarding staff preparedness and the safe delivery of homebirth services.

Neonatal pulse oximetry testing:

- Neonatal pulse oximetry screening was implemented across the Trust in 2023 and is fully embedded within the Newborn and Infant Physical Examination programme. In accordance with the Maternity (Perinatal) Incentive Scheme Year 8 requirements, the Trust has a governance-approved neonatal pulse oximetry guideline aligned to the British Association of Perinatal Medicine framework, which standardises screening, documentation and escalation processes across all birth settings, including home births. The guideline specifies that all eligible babies are offered pulse oximetry screening between 2 and 24 hours of age, with clearly defined amber and red pathway escalation arrangements to ensure timely clinical review and intervention where indicated.
- Pulse oximetry screening supports the early detection of critical congenital heart disease in asymptomatic newborn babies born at or above 34 weeks' gestation and may also

identify respiratory disorders or sepsis before clinical signs become apparent. Congenital heart disease affects approximately 6–12 per 1,000 live births, with critical congenital heart disease accounting for 15–25% of cases, and up to 50% of cases may remain undiagnosed despite antenatal screening. Early postnatal diagnosis can therefore improve morbidity and mortality outcomes.

- Parents are provided with written information prior to screening to support informed decision-making, and screening completion and outcomes are recorded on the national SMART4NIPE system, providing assurance of compliance, coverage monitoring, quality oversight and national reporting.
- The implementation and ongoing delivery of neonatal pulse oximetry screening is overseen through established maternity and neonatal governance arrangements. Staff awareness, competence and compliance are supported through Trust induction programmes for all new and rotating clinical staff, education and competency assessment processes, inclusion within university midwifery training programmes, and the preceptorship programme for newly qualified midwives. This provides assurance that screening is delivered consistently and in accordance with local policy, national guidance and Maternity Incentive Scheme Year 8 requirements.

CQC

- The CQC undertook an unannounced inspection on 20th and 21st January 2026.
- The initial feedback findings aligned with existing improvement priorities already identified by the service
- Provider Information Request (PIR) completed by the service and returned to CQC prior to the deadline on 9th February 2026.
- Formal confirmation of high-level feedback from the CQC received in written form on 4th March 2026.
- The Trust undertook a factual accuracy process on the draft report received from CQC on 14th May 2026 with the Trust response being returned on 29th May 2026.
- Final report received by Trust on 6th July 2026 with confirmed Maternity rating of "Requires Improvement". Summary of scoring provided below.

Key Question		Score Awarded to GWH	Potential Scoring Total	
Safe	Learning Culture	2	4	Requires Improvement
	Safe Sytems, pathways & transitions	2	4	
	Safeguarding	3	4	
	Involving people to manage risks	2	4	
	Safe environments	2	4	
	Safe and effective staffing	3	4	
	Infection prevention and control	2	4	
	Medicines optimisation	3	4	
Effective	Assessing needs	3	4	Good
	Delivering evidence-based care and treatment	3	4	
	How staff, teams and services work together	3	4	
	Supporting people to live healthier lives	3	4	
	Monitoring and improving outcomes	3	4	
	Consent to care and treatment	3	4	
Caring	Kindness, compassion and dignity	3	4	Good
	Treating people as individuals	3	4	
	Independence, choice and control	3	4	
	Responding to people's immediate needs	3	4	
	Workforce wellbeing and enablement	3	4	
Responsive	Person-centred care	3	4	Good
	Care provision, integration and continuity	3	4	
	Providing information	3	4	
	Listening to and involving people	3	4	
	Equity in access	3	4	
	Equity in experiences and outcomes	3	4	
	Planning for the future	3	4	
Well-led	Shared direction and culture	3	4	Requires Improvement
	Capable, compassionate and inclusive leaders	3	4	
	Freedom to speak up	3	4	
	Workforce equality, diversity and inclusion	3	4	
	Governance, management and sustainability	1	4	
	Partnerships and communities	3	4	
	Learning, improvement and innovation	3	4	

- Report to be published on Friday 10th July with comms to both staff and community planned.
- Action plan to be returned to CQC prior to deadline of 2nd August 2026.
- Service to provide regular updates on action plan progress to Quality & Safety Committee for senior oversight and governance.

Ockenden 2022 (SaTH)

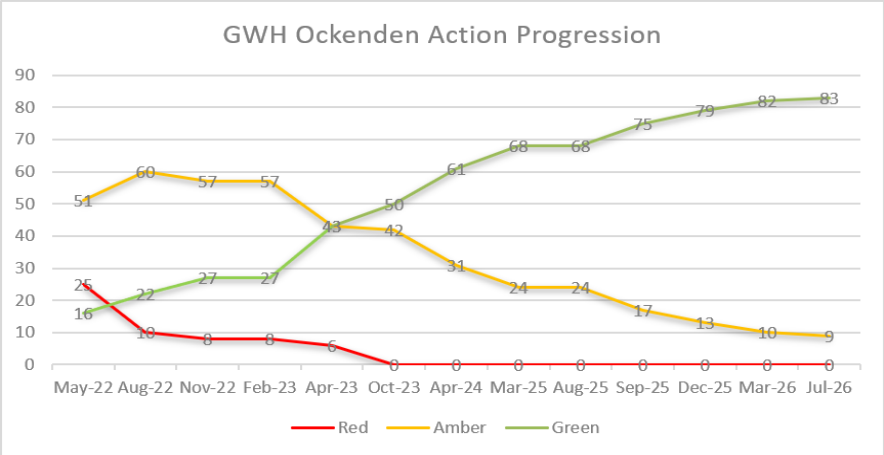
Do you know where you are in achieving the maternity safety ambition?

- Continued focus on the identified improvement actions from Ockenden 2022 (Shrewsbury & Telford Hospital) has remained a priority for Maternity & Neonatal services throughout Q1.
- This has resulted in suitable progress being identified to move 1 of the 10 remaining AMBER actions to GREEN status. AMBER action approved for upgrade to GREEN detailed below.
- **IEA 10.63 (Transfer Times for Birthing Outside A Hospital Setting)**
    - Recommendation for upgrade to GREEN supported by Senior Leadership in July 2026. All birthing women are provided latest available ambulance times (provided by SWAST – please note these figures are typically issued by SWAST with a delay of approx. 2-3 months. GWH check monthly for the latest figures to be provided to women). All documentation provided to parents during a home birth consultation is electronically uploaded to BadgerNET. This process is subject to regular audit to provide ongoing assurance of compliance.

- An updated summary position will be reported via the Perinatal Quality Oversight Model Report as detailed below.

July 2026	Current RAG Status /Action No.	Ockenden 2022 (SaTH) Immediate & Essential Action	Number of Actions Under Each Heading Rated		
			RED	AMBER	GREEN
	1	Workforce Planning & Sustainability	0 =	0 =	11 =
	2	Safe Staffing	0 =	1 =	9 =
	3	Escalation & Accountability	0 =	0 =	5 =
	4	Clinical Governance - Leadership	0 =	0 =	7 =
	5	Clinical Governance - Incident Investigation & Complaints	0 =	1 =	6 =
	6	Learning From Maternal Deaths	0 =	0 =	3 =
	7	Multidisciplinary Training	0 =	0 =	7 =
	8	Complex Antenatal Care	0 =	0 =	5 =
	9	Preterm Birth	0 =	0 =	4 =
	10	Labour and Birth	0 =	0 ↓	6 ↑
	11	Obstetric Anaesthesia	0 =	2 =	6 =
	12	Postnatal Care	0 =	2 =	2 =
	13	Bereavement Care	0 =	0 =	4 =
	14	Neonatal Care	0 =	3 =	5 =
	15	Supporting Families	0 =	0 =	3 =
		TOTAL	0 =	9 ↓	83 ↑

- A summary of the consistent progress across all the Immediate and Essential Actions detailed below



- The Trust have 9 AMBER actions across the IEAs remaining which all have anticipated timescales for completion alongside detailed action plans. Please see below for a summary position of the remaining 9 AMBER actions.
- No operational risks identified within the remaining amber actions.

- **IEA 2.18 (Clinical Skills Facilitators)**
    - A gap analysis of skills facilitator provision has been completed as part of a broader workforce planning exercise. The review identified a small shortfall in supernumerary provision, the associated risks and mitigations have been acknowledged and formally added to the Trusts risk register in September 2025. These mitigations are regularly reviewed as part of the service risk register reviews. The Trust Practice Development & Education midwifery team have taken steps to ensure visibility and support for clinical midwives throughout the service. This will continue to be reviewed at the Perinatal Senior Meetings to monitor progress and explore long term sustainable solutions. This proactive risk management approach demonstrates the Trust's commitment to maintaining safe and supportive clinical environments for midwives, in line with national expectations. The lack of skills facilitators across all practice settings has not been identified as contributing to patient safety events and learning and it has not been voiced as an area of concern by staff. The Trust can demonstrate good retention rates with the Newly Qualified Midwives (NQM) and the Trust are not seeing any delays in advanced skills (e.g. suturing) as a theme through incident reports. Target completion date – April 2027.
- **IEA 5.37 (Six Month Timeframe for Change in Practice)**
- Following a robust action plan to deliver timely changes in practice and provide assurance of embedded governance monitoring processes, there are no outstanding actions associated with a serious incident. Action can be updated and closed.
- **IEA 11.68 (Reviewing Adequacy of Documents in an Anaesthetic Patient Records)**
    - Anaesthetic documentation audit completed. Awaiting presentation at Perinatal Governance. Target completion date - May 2026
- **IEA 11.69 (Core Datasets Within Anaesthetic Records)**
    - Continued engagement with national professional bodies to ensure our documentation remains in line with all guidance from Anaesthetic regulatory bodies. System benchmarking undertaken to ensure aligned compliance across the Trusts. Update due to be presented in Perinatal Governance in July. Target completion date – May 2026.
- **IEA 12.75 (PNC Consultants Involved Daily as Minimum) & IEA 12.76 (PNC Readmissions Seen Within 14 Hours)**
    - Embedded PSIRF learning culture has enabled the service to monitor this theme through patient safety reviews to ensure it is an emerging safety theme. Timely consultant involvement and readmissions being seen daily as a minimum has not been identified as contributing to patient safety events and learning. Postnatal readmission audit recently completed which demonstrated improved compliance rates for being seen daily by a consultant and readmissions being seen within 14 hours, but they do not yet meet the required standard for the action to be moved to GREEN. Supporting improvement actions detailed within clinical audit plan with a reaudit to be conducted in a timely manner to monitor progress. New timescale for completion assigned in line with updated audit schedule. Target completion date – November 2026.
- **IEA 14.85 (Neonatal Network Supporting Supernumerary Secondments) & IEA 14.86 (Neonatal Networks Providing Annual Reporting)**
    - Action improvement plans owned and led by South-West Operational Delivery Network for Neonatal Care with ongoing Trust engagement contributing to planning and delivery. Network action plans extend throughout 2026. Trust to update risk register to reflect IEA action 85 and 86 to ensure mitigations are reviewed and managed. Target completion date - ongoing throughout 2026
- **IEA 14.89 (Neonatal Workforce Compliant to BAPM Standards (Medical & Nursing))**
    - Trust completed final phase of recruitment strategy to ensure the consultant workforce was fully aligned with BAPM standards and national service specification throughout 2025. MIS Y7 compliance declared with action plan approved by Operational Delivery Network for both Neonatal Medical & Neonatal Nursing action standards. Tier 2 gaps now identified due to updated BAPM guidance released in 2025. BAPM standards working group established to monitor progress against implementation of nursing, ANNP & medical BAPM

	workforce standards. Business cases under development for progressions through Trust governance channels. Target completion date – ongoing throughout 2026.
Ockenden 2026 (NUH)	• The Independent Review of Maternity and Neonatal Services at Nottingham University Hospitals NHS Trust, led by Donna Ockenden, was published on 24 June 2026. • The review examined more than 2,500 family cases and identified significant failings in maternity and neonatal care, leadership, governance, culture and organisational learning. • Subsequently, NHS England wrote to all provider organisations highlighting that the findings are relevant across the NHS and requiring boards to reflect on the implications for their own services. • Following publication of the report, the Trust commenced a structured review process involving maternity, neonatal, governance, patient experience and quality teams. The local review includes: o Assessment against the Ockenden 2026 Immediate and Essential Actions. o Review of NHS England priorities outlined in the national letter. o Consideration of local governance and assurance arrangements. o Review of patient feedback and engagement mechanisms. o Assessment of leadership, culture and speaking-up arrangements. o Review of equity and inequalities data. o Assessment of bereavement and mortuary governance processes. o Evaluation of preparedness for implementation of Martha's Rule. • A comprehensive gap analysis is currently underway and will be completed for reporting to Board in August 2026. • This work will provide a detailed assessment of current compliance, identify areas for improvement and inform a comprehensive local action plan.
Amos Report (2026)	• The publication of Baroness Amos' Independent Investigation into Maternity and Neonatal Services in England has highlighted the need for sustained national focus on safety, culture, workforce, governance, equity and the experience of women and families. The report emphasises the importance of listening to women, strengthening accountability, and ensuring robust oversight of maternity and neonatal services. • The recommendations and associated NHS England 10-Point Plan are currently being reviewed to assess local compliance and identify any gaps requiring further action. Existing maternity governance arrangements, quality surveillance processes and ongoing improvement programmes provide a strong foundation against the themes identified within the report. • A detailed gap analysis and implementation plan will be developed to ensure local services are aligned with emerging national requirements and to support continued improvement in the safety, quality and experience of care provided to women, babies and families.
Maternal Care Bundle (MCB)	• Maternal Care Bundle was released nationally in Q4 2025/26 with the aim to improve maternal and neonatal outcomes by ensuring consistent delivery of evidence-based maternity care, reducing unwarranted variation, and supporting early identification and effective management of clinical risk. • Key areas of focus within the bundle are, venous thromboembolism, pre-hospital & acute care, epilepsy in pregnancy, maternal mental health and obstetric haemorrhage. • A briefing paper was taken to Quality & Safety Committee in January 2026 for senior oversight. • High level gap analysis has been completed within Q1, led by a multi-disciplinary team across the service. • Overview summary position for all elements from the gap analysis was included within May 2026 Perinatal Quality Oversight Model report. • The national implementation tool for the Maternal Care Bundle was released to Trusts on 2nd June 2026. • Focussed time with element leads planned to ensure Trust actions plans align with expected national measures. • Full detailed update including projected implementation timeframes, initial compliance position and all improvement actions to be provided during Q2 PQOM slides.

Avoiding Term Admissions into Neonatal Units ATAIN

Do you know where you are in achieving the maternity safety ambition?

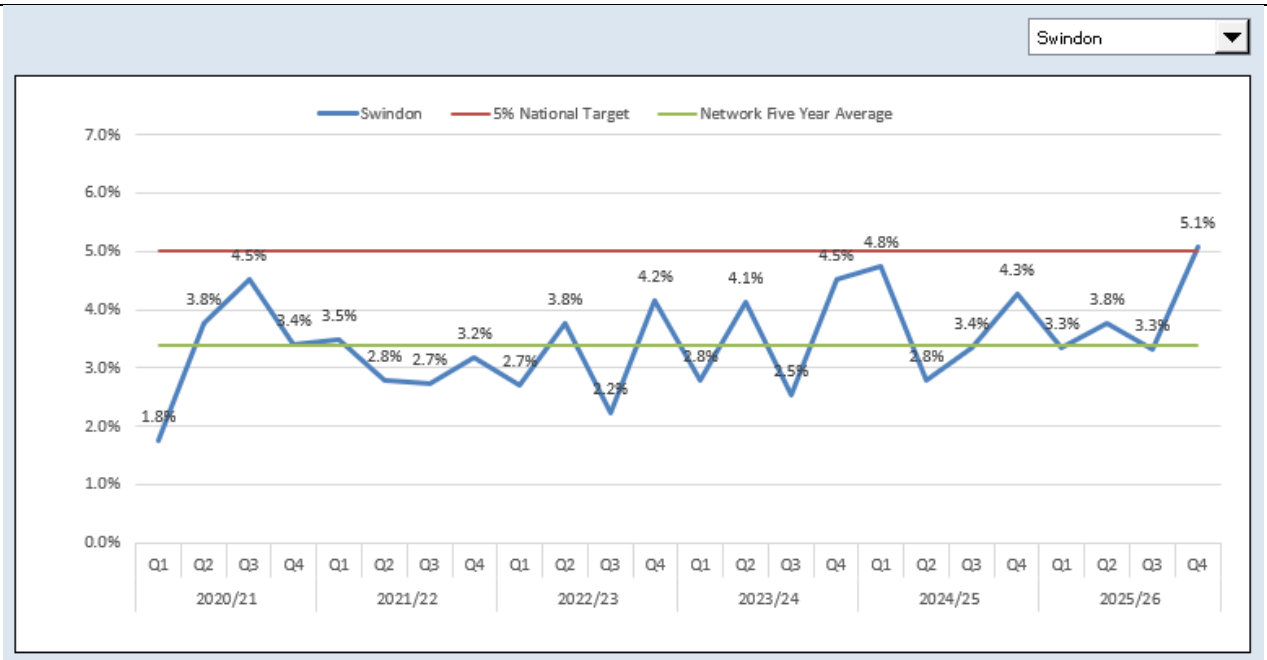
- Results from the Q4 Avoiding Term Admissions into Neonatal Units (ATAIN) audit demonstrated an improvement in overall compliance from 90.61% to 92.98% overall with all audit parameters.
- Ten of the audit standards achieved 100% compliance, demonstrating sustained adherence across the majority of assessed criteria. Cardiotocography (CTG) hourly review compliance remains an area for improvement. Review of audit findings identified that, whilst CTGs were frequently reviewed, the required peer review was not consistently documented, resulting in non-compliance against the audit standard.
- Targeted actions remain in place to improve compliance, including focused education, visual prompts, weekly clinical walk-rounds, and ongoing support to strengthen documentation and peer-review processes.
- The Improving Together A3 methodology is being utilised to better understand contributory factors and implement targeted, measurable improvement actions.
- The introduction of a CTG peer-review buddy system in February has been associated with early improvements in compliance. Improvements have also been observed within the separate CTG audit programme, and early Q1 data suggest a positive impact on ATAIN performance.
- A robust process for the timely multidisciplinary review of term neonatal admissions continues to support organisational learning and quality improvement, with findings reviewed through established governance arrangements.

During Q4, the term admission rate exceeded the national target of 5% for the first time. At present, no definitive themes or learning have been identified through the audit process to explain the increase in term admissions. A detailed review of all term admissions during Q4 is underway to determine whether there are any contributory factors, including changes in mode of birth (e.g. LSCS rates), gestational age at delivery, respiratory morbidity, or other clinical indications for admission. Ongoing monitoring and review processes remain in place to support improvements in performance, with findings from the review and any associated learning or actions to be reported in Q2.

ATAIN Q4 (Jan-Mar 2026) Return

Term Admissions to NNU:

Unit Level	Unit	live births (all)	Term admissions	
			n	% live births
LNU	Gloucester	1,251	50	4.0%
	Great Western Swindon	886	45	5.1%
	Royal Cornwall, Truro	833	55	6.6%
	Royal Devon and Exeter	869	51	5.9%
	Royal United Bath	1,057	53	5.0%
	Taunton	861	39	4.5%



Maternity (Perinatal) Incentive Scheme (MIS)

Do you know where you are in achieving the maternity safety ambition?

- **MIS Year 7**
- Following external validation, the Trust received preliminary confirmation of success in achieving compliance in all ten safety actions for CNST Year 7 on 25th March 2026.
- Year 7 results were published nationally on 13th April 2026 confirming full compliance for GWH.
- Funds were projected to be received into the Trust during Q1 2026/27.

- **MIS Year 8**
- Summary overview received from NHS Resolution in February 2026 with full guidance released on 31st March 2026.
- Attendees from Trusts attended national virtual launch event on 23rd April 2026.
- Ongoing focus from service level action leads to progress detailed improvement plans working towards compliance across all six safety actions.
- Year 8 marks a significant reset, streamlining the scheme to focus on what most improves safety, and acting as a transitional year ahead of wider national maternity reform.
- The scheme has been reduced to six core actions, covering workforce and capacity, training, learning from investigations, service-user voice and equity, evidence-based care bundles, and Board leadership and governance.
- There is a shift from process compliance to outcomes, with greater emphasis on demonstrating real improvements in safety, preparedness, and quality of care for women and babies.
- Equity and service-user experience are central, requiring trusts to show how learning and safety improvements address variation in outcomes and incorporate women and families' voices.
- Trust safety action leads assigned with an initial overview summary undertaken.
- Ongoing focus from service level action leads to progress detailed improvement plans working towards compliance across all six safety actions
- Mid-year training compliance checkpoint declared as 31st July 2026.
- MOSS signal drill undertaken in June 2026 as part of MIS evidence assurance for Safety Action F.
- Monthly summary position reported via the Perinatal Quality Oversight Model report to senior oversight and assurance.
- Summary position of projected submission RAG ratings below,

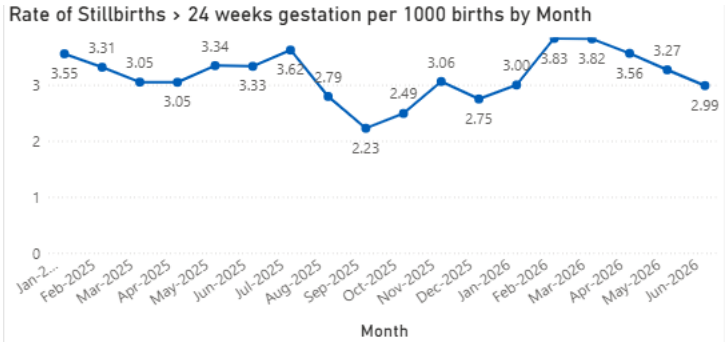
	CNST Y8 Safety Action Detail	RAG (April 2026)	Projected Submission RAG
A	**Workforce & Capacity** Board oversight of effective multidisciplinary (MDT) workforce and capacity planning. Ensuring the maternity and neonatal service have funded establishments for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams meeting nationally recognised workforce standards.		
B	**Training** Effective Board oversight of maternity and neonatal MDT training and competency. Ensuring all maternity, neonatal and anaesthetic staff are trained, assessed and supported to maintain the knowledge, skills and behaviours required for safe, high quality multidisciplinary care.		
C	**Learning from Reviews & Investigations** Effective Board oversight of thematic learning and progress with actions arising from local and national reviews of adverse incidents.		
D	**Service User Voice & Equity** The voices and experiences of all women accessing maternity and neonatal services are used to drive local improvements, using local population demographics to understand and target efforts to support a reduction in inequities in experience and outcomes.		
E	**Care Bundles** Board oversight of progress with implementation of Saving Babies' Lives Care Bundle (SBLCBv3.2), a plan to implement the Maternal Care Bundle by March 2027, and assurance that a guideline for neonatal pulse oximetry testing has been developed in line with national guidance.		
F	**Board Oversight, Governance, Culture & Leadership** The Trust Board has effective oversight of the quality and safety of their maternity and neonatal services.		

Maternity and Neonatal National Ambition

Do you know where you are in achieving the maternity safety ambition?

- There have been no stillbirths recorded in Q1
- There have been 5 pregnancy losses in Q1 reported to MBRRACE via Submit a Perinatal Event Notification (SPEN) by GWH. 0 losses require review using the Perinatal Mortality Review Tool (PMRT)
- There continues to be external scrutiny at the PMRT review meetings with other local providers.
- Parents are actively encouraged to contribute their comments, questions, and concerns through the PMRT process.
- Inclusion of the Maternity and Neonatal Voices Partnership at PMRT meetings commenced in Q2 2024-25 in line with CNST standards.
- All reported cases have been declared and reviewed within the specified timeframe in Q1. Learning from these deaths is captured within the mortality report.
- A quarterly report of all PMRT reported cases is submitted for Trust oversight which provides case level detail.

The stillbirth rate for the financial year to date is 2.99 per 1000 births as of 30th June 2026 (National ambition 2.6 per 1000 births by 2025). This is the crude rate which includes medical terminations of pregnancy and will be adjusted by the national team.



- GWH has seen an increase in stillbirth rate above the national target of 2.6 per 1000 births for the rolling 12-month period; All stillbirths are reviewed in line with PMRT.
- Whilst there were no themes identified during the reviews, high quality bereavement care is accessible to all service users, using patient feedback on lived experience to inform service improvement
- Monthly multidisciplinary Perinatal Review Meetings continue with the attendance of panel members from outside the organisation who contribute to the discussions and reviews of all stillbirths and labour ward neonatal deaths. The input from external reviewers ensures objectivity is maintained. Inclusion of the Maternity and Neonatal Voices Partnership at PMRT meetings continues from Q1 in line with CNST standards.

	All relevant perinatal events continue to be reported via the SPEN portal. To provide assurance against national maternity safety priorities, it is recommended that key outcome measures including maternal mortality, stillbirth, neonatal mortality and pre-term birth are reported alongside the NHS England National Maternity Safety Ambitions. These ambitions seek a 50% reduction in maternal mortality, stillbirths, neonatal deaths and brain injuries from 2010 baseline rates, with a target maternal mortality rate of ≤5.3 deaths per 100,000 maternities and a pre-term birth rate of 6%
LMNS What is the culture in your maternity services?	• Following ICB restructuring, the Local Maternity and Neonatal System (LMNS) has been dis-established and its functions have transitioned into revised system governance arrangements. To maintain a shared approach to learning and improvement, governance leads from across the provider collaborative now meet bimonthly to review incidents, share learning, and discuss common themes, supporting the original intent of the LMNS safety forums. • Whilst guidance on this new direction is pending, the services is supported by the Somerset and Dorset LMNS.
Risk and Compliance	• The Perinatal Risk Register currently contains 25 active risks, all of which undergo monthly review to ensure appropriate oversight, progress against action plans, and effective implementation of mitigating controls. Risk status and key developments are reported through the Perinatal Governance framework monthly. • During Q1, ten risks were identified as suitable for closure following review of controls and mitigations achieved. These are progressing through the appropriate governance approval process. • An increase in proposed risks for inclusion on the Perinatal Risk Register has been observed during Q1. In response, the service has undertaken a review of the risk escalation and registration process to strengthen consistency and ensure a proportionate approach based on risk severity. Opportunities for improvement have been escalated for divisional consideration, and the team continues to work collaboratively with risk owners to facilitate timely assessment and inclusion where appropriate. • The Trust is currently transitioning to a revised 5+5+5 risk scoring methodology. As part of this process, all existing perinatal risks with a score of 12 or above are being reviewed to ensure alignment with the new framework, supported by the Divisional Governance Team. This will provide greater consistency in risk assessment and reporting across the organisation. **Risks Under Review for Inclusion on the Perinatal Risk Register:** ○ Maternity Day Assessment Scanning Room: Risk that the Antenatal Day Assessment Unit scanning room is not clinically appropriate, potentially compromising patient safety and reducing efficiency of care due to inadequate ventilation. ○ Health Inequalities: Risk of poorer maternal outcomes due to disparities in access to maternity services for ethnic minority groups, socioeconomically disadvantaged women, and those facing language or cultural barriers, potentially leading to adverse outcomes, reputational harm, and regulatory scrutiny. ○ Ockenden IEA 14 Action 85,86,89: Neonatal Care - Neonatal Operational Delivery Networks) are not fully implemented, potentially impacting compliance with national neonatal standards, safety of neonatal pathways, and effectiveness of regional ODN collaboration. ○ Ockenden IEA 5 Action 37: Risk that actions arising from serious incident investigations will not be completed within six months, potentially impacting timely learning, patient safety improvements, and regulatory compliance. ○ Ockenden IEA 12 Action 75,76: Risk that obstetric oversight for unwell or readmitted postnatal women is not consistently provided, potentially leading to delayed escalation, compromised patient safety, and non-compliance with national standards. ○ Ockenden IEA 11 Action 67, 68, 69, 71, 73: Risk that anaesthetic services do not consistently meet the requirements potentially resulting in delays in anaesthetic review,

	compromised intrapartum and operative care, and non-compliance with national safety standards. ○ Neonatal Workforce: There is a risk to patient safety due to Neonatal Nurse Workforce Staffing Model not meeting BAPM Standards ○ Theatre Staffing Hybrid Model: There is a significant risk to safe and timely perioperative maternity care due to inadequate theatre staffing that does not meet Association for Perioperative Practice standards (AfPP). ○ Mat/Neo Substance and Alcohol: There is no single point of clinical or operational oversight for the identification and management of substance misuse in pregnancy within maternity services. ○ Community Estates: Insufficient and unsuitable community estate provision presents a risk to the sustainable delivery of community midwifery services and may result in increased operational costs. ○ Maternity Care Centre: The absence of a telephone call-recording system within the Maternity Care Centre limits the ability to review triage decision-making, support incident investigations, and provide assurance regarding the quality and safety of advice provided. ○ Maternal Red Cell Antibodies: Current reporting functionality within BadgerNet does not reliably identify women with maternal red cell antibodies, creating a risk of ineffective surveillance, delayed follow-up, and reduced assurance regarding compliance with monitoring requirements. ○ Neonatal Services: Medical staffing levels do not fully meet British Association of Perinatal Medicine (BAPM) standards for a Tier 2 neonatal service and are only partially compliant with Tier 1 requirements, presenting a risk to service resilience and delivery of national standards. • Formal addition of the Ockenden IEAs to the Perinatal Risk Register was paused pending publication of recent national maternity reports; however, progress continued to be monitored through established governance arrangements. As several actions remain incomplete years after the original recommendations were issued, inclusion on the Risk Register is now being progressed to recognise the ongoing risk and strengthen oversight of delivery.
Patient Experience What is the culture in your maternity services?	• Patient experience continues to be reviewed bi-monthly with the perinatal leadership team including Maternity and Neonatal Voice Partnership (MNVP) service user representation and consultant and midwifery staff. • Insights from: MNVP, Friends and Family Test (FFT), Complaints, Concerns, Compliments, Neonatal Operational Delivery Network (ODN), Specialist services, Incidents, social media & Safety Champions. Feedback is triangulated to identify any themes and create actions to improve the perinatal service. • January and February feedback reviewed at the March meeting, with the next meeting taking place on 13th July to review May and June insights. • Positive feedback included: ○ Relaxed environment ○ Outstanding care in labour including Theatre ○ Well informed with good advice given in Triage ○ Incredible Midwives ○ Good care in emergency situations ○ Good breastfeeding support on the ward ○ Supportive staff who champion women and their needs ○ Brilliant care both antenatal and postpartum • Themes for improvement included: ○ Poor postnatal care after C section ○ Long waits to be seen my doctors (DAU & Hazel ward) ○ Noisy and bright in TC at night ○ Issues with amenity rooms ○ Missed/delayed pain relief • These patient experience forum improvement actions are captured on a shared action log and reviewed bimonthly. • The triangulation meeting action tracker is monitored through Maternity Governance.

	• In addition to the previously completed engagement with South Asian women, engagement has now been undertaken with the Afghan community to further understand the experiences and needs of women accessing maternity services. Findings from both engagement programmes are being used to inform the health inequalities workstream and service improvement initiatives. • The local MNVP representative continues to attend Safety Champions, Maternity Governance, PMRT and patient safety meetings to ensure the service user voice is represented. • Delays for women undergoing induction of labour (IOL) continue to be actively monitored through the daily SITREP process, with oversight by the perinatal senior team to ensure timely, appropriate and safe escalation where required. During Q1, there were no reported patient safety incidents attributable to delays in IOL, providing assurance regarding current escalation and risk management processes. • Following learning identified through the Maternity Oversight and Safety System (MOSS) drill, further work is being undertaken to strengthen the identification, reporting and review of women experiencing IOL delays of greater than six hours. As current national SITREP reporting does not provide the functionality to retrospectively extract and triangulate this data, a local Datix reporting process is being developed to support enhanced oversight, trend analysis, learning and assurance. An audit of IOL has commenced to review delay timings and associated maternal and neonatal outcomes since the introduction of Cook's balloon IOL (June 2026). This work will support a more detailed understanding of system pressures and pathways of care and will inform any required service improvements. Findings from this audit are planned for presentation in the Q1 report. • The service user voice continues to be embedded within safety and governance structures through regular attendance by the local MNVP representative at Safety Champions, Maternity Governance, PMRT, and patient safety forums. The Patient Experience Co-ordinator has sustained proactive collection of service user feedback across the perinatal pathway, with targeted efforts to improve inclusivity, particularly for service users whose first language is not English. Early involvement of the Patient Experience Co-ordinator has enabled prompt identification and escalation of concerns, facilitated timely senior review and supported responsive, patient-centred care. This approach has contributed to the mitigation of several potential complaints and supports ongoing quality and safety improvement.

Maternity & Neonatal Safety Champions
Do you know where you are in achieving
	• Staff engagement continues through regular face-to-face walkabouts and a reintroduced Microsoft Teams drop-in session, providing opportunities for staff to raise concerns, share learning and contribute to service improvement. Maternity and Neonatal Board Safety Champions maintain active engagement with the perinatal leadership team, MNVP representatives, staff and service users through walkabouts, governance meetings and engagement events, supporting a positive safety culture, influencing improvement priorities and ensuring emerging risks and themes are escalated through Trust governance structures and reported to the Board as appropriate. The Perinatal Quality Surveillance Model (PQSM) is fully embedded across the service, and a monthly data review process is undertaken via the new Perinatal Quality Oversight Model (PQOM) slides launched in March.
	  • Chief nurse safety walkaround – Feedback from service users and staff highlighted concerns regarding the environment on Hazel Ward, including mould and limescale within bathroom facilities, and the suitability of the induction of labour room. Themes identified included patient comfort, dignity, safety, and the potential impact on women's choices regarding induction of labour. These concerns have been escalated through the appropriate governance processes for review.
	  • Safety Champion walkabouts undertaken with the Chief Nursing Officer on Hazel Ward and Labour Ward included discussions with staff and women regarding patient safety, environmental pressures during periods of hot weather, and progress against Ockenden-related improvements.
	  • Concerns regarding perceived staffing pressures on night shifts were raised by frontline staff. Although staffing levels were reported as meeting planned establishment, further review was requested to better understand the impact of high-acuity workload and staff experience. Subsequent engagement during a night shift identified significant service demand and acuity, which continues to be monitored through established workforce and governance arrangements.

	No additional significant safety concerns were identified during Safety Champion engagement activities; however, themes and actions continue to be monitored through existing governance and assurance processes. • BadgerNet support staff are now embedded across maternity and neonatal services, with funding extended; the initiative continues and feedback from staff has been positive. We have also recruited a Band 6 Digital Midwife into the team for 22.5 hours per week. This is allowing more time to focus on training and supporting staff. We are also able to look at auditing data added to BadgerNet. • The Neonatal team escalated concerns that current staffing levels do not meet BAPM standards, alongside sustained and consistently high acuity within the unit; this was formally escalated to QUAD by the Neonatal Consultant, Neonatal Nursing has been added to the Perinatal Risk Register (1627) for ongoing oversight and mitigation.
Improving Together	**Maternity Triage** • The maternity triage unit continues to operate as the 24-hour front door to maternity services. Whilst there have been no reported patient safety incidents associated with the environment, increasing demand and limitations of the current physical space are creating pressure on capacity, privacy and workflow. These challenges have been formally recognised and are being progressed through the Trust risk management process. • A dedicated project group remains in place to explore options for redesign and improvement of the maternity triage environment. Early engagement with Estates colleagues has been undertaken to assess feasibility and identify solutions that support safe, effective and responsive care. • During Q1, the service continued to review maternity triage arrangements, workforce, capacity and patient experience as part of ongoing quality improvement activity. This work aligns with emerging themes from national maternity reviews relating to timely assessment, listening to women and ensuring services have the capacity and infrastructure required to deliver safe care. • A business case submitted to NHS England to support this work was unsuccessful. Alternative options are being explored through the multidisciplinary outpatient and maternity service review to identify sustainable solutions that support future demand and enhance the experience of women and families accessing urgent maternity care. **Completion of elective lists within Maternity theatre** • Elective caesarean section activity continues to experience capacity pressures, resulting in occasional list overruns and impacting patient experience and theatre utilisation. Increased use of full-day elective lists, particularly around bank holiday periods, has supported management of rising demand. Delays exceeding 24 hours continue to be monitored through the SITREP process and are reported through governance and executive oversight arrangements. • A key operational and safety risk remains the sustainability of theatre staffing capacity to support both elective activity and the requirement to maintain timely access to Category 1 emergency obstetric care, both in-hours and out-of-hours. • A comprehensive review programme has been undertaken, including a 12-month review of incident data, a time and motion study, workforce and compliance gap analyses, and a joint obstetric theatre risk assessment. This work has informed the development of proposed workforce, management and service delivery models, which continue to be progressed through multidisciplinary stakeholder engagement and governance processes. • Options under consideration include strengthening theatre workforce capacity to achieve recommended staffing standards, reviewing operational management arrangements, and increasing elective theatre capacity to support current and future demand. A formal risk relating to obstetric theatre staffing sustainability and service resilience is being progressed through the Trust's risk management framework. • The proposed service developments and associated recommendations are currently being considered through the Trust's governance and executive decision-making processes.

	Perinatal Research • GWH is a research active Trust and offers families the opportunity to be a part of research. • There are two research midwives at GWH. • We currently have studies open for recruits and are undertaking feasibility reviews for further studies. • All studies are undertaken within the scope of Good Clinical Practice (GCP) • We are looking at development opportunities for midwives to spend time with the research midwives for ongoing CPD. **Current recruiting studies**: • MAMA: The Monoclonal Antibody Medications in Inflammatory Arthritis: stopping or continuing in pregnancy (MAMA) study. • COMET: The goal of this randomised control trial is to evaluate the safety, efficacy, and cost effectiveness of whole-body hypothermia as a therapy for babies with mild hypoxic ischaemic encephalopathy. • PANDA: PANDA workstream 3 is a large study that will help us to understand all the effects for women and babies if we give low-dose iron supplements during pregnancy to prevent anaemia. **Completed / follow up**: • CaPE: Calcium supplementation for women at high risk of pre-eclampsia. Giant PANDA: Which medication is better for hypertension in pregnancy for mothers and babies, Labetalol or Nifedipine? • SNAP 3 Smoking: Nicotine and Pregnancy. Studying a new way of using NRT to help women to quit. • NeoGASTRIC: This study is for babies born more than 6 weeks early and needing a feeding tube. Which is better? Measuring gastric residual volumes or not? • LTPA_Pregnancy: Exploration of patterns in pregnant women's Leisure-Time physical activity: The role of motivation, fear of foetal harm, and social- environmental characteristics of antenatal care. • MORA: A questionnaire for midwives regarding students / use of MORA
Consultant presence monitoring Do you know where you are in achieving the maternity safety ambition?	• In line with the Maternity (Perinatal) Incentive Scheme and the Ockenden Report, consultant obstetric presence outside resident hours (08:30–22:00) continues to be monitored against Royal College of Obstetricians and Gynaecologists requirements for consultant attendance. • The electronic monitoring process is now fully embedded, providing real-time oversight of consultant attendance and supporting timely escalation where required. • Learning from episodes of non-attendance continues to be reviewed through Maternity Governance and Maternity Incident Review Meetings. There were no recorded instances of consultant non-attendance during Q1 where attendance was required. • Compliance data and associated learning are reviewed monthly through the Perinatal Quality Oversight Meeting (PQOM), providing ongoing assurance, oversight and monitoring of adherence to national standards.
Thematic Review	• Thematic reviews continue to triangulate learning from MNSI, NHS Resolution Early Notification investigations, PMRT, PSIRF reviews, MOSS safety checks, claims data, local incident reporting and national maternity reports, identifying recurrent themes, risks and improvement priorities. • Reports incorporate demographic data to identify potential inequalities in outcomes and experience, ensuring that disparities are recognised and addressed through targeted improvement actions. • While recurrent themes are reviewed through existing governance arrangements, further development is required to formalise routine review with the Perinatal and Board Safety Champions and strengthen Board assurance regarding the delivery and impact of improvement actions.

	• Action plans are monitored using recognised quality improvement approaches, with progress tracked through governance processes to ensure learning is translated into measurable improvements in pathways, practice, workforce and patient safety. • Learning from thematic reviews is shared across maternity and neonatal services through governance meetings, safety communications and multidisciplinary training, supporting the embedding of learning and continuous improvement. **Hypoglycaemia Related Incidents:** • A thematic review of 26 neonatal hypoglycaemia-related incidents reported between November 2023 and January 2026 identified recurring themes across Delivery Suite, Hazel Ward, Transitional Care and the Local Neonatal Unit. • Hypothermia was identified as the most common contributory factor, representing a significant opportunity to reduce preventable neonatal hypoglycaemia and avoidable escalation of care. • Additional themes included variation in the recognition and application of the hypoglycaemia pathway during implementation of updated guidance, delays in paediatric review, digital pathway challenges within BadgerNet, and staff training needs associated with workforce rotation and guideline changes. • The review also identified examples of good practice, including timely escalation, effective multidisciplinary management and appropriate implementation of the hypoglycaemia pathway. • Findings have informed a targeted improvement programme, including enhanced management of neonatal hypothermia, reinforcement of pathway compliance, focused multidisciplinary education, review of digital systems and monitoring of neonatal response times. Progress against these actions will be monitored through established governance arrangements. • Learning from the review has informed development of the proposed FORTRESS (Focus on Room Temperature to Reduce Excess Separation) project, supporting a proactive approach to reducing hypothermia-related neonatal hypoglycaemia and improving neonatal outcomes. • Thematic reviews moving forward will be completed using the template supplies by MIS and shared quarterly.
Communication equity, language support and accessible information	• In line with the Maternity Incentive Scheme requirement to identify and address disparities in outcomes and experience, work continues to improve access to information, communication and support for women and families from diverse communities. • During Q4, the Perinatal Quality Surveillance and Safety Assurance (PQSSA) process identified translation and interpreting services as a recurrent theme. This has been escalated to the Great Western Hospital PALS Team for further review. Staff continue to be encouraged to report concerns relating to language barriers, communication difficulties or access to interpreting services via Datix to support organisational learning. • Community teams are undertaking a review of interpreter service utilisation to better understand current uptake, identify barriers to access and inform targeted improvement actions. • Ongoing work with BadgerNet seeks to improve access to maternity information and patient information leaflets, following audit findings which demonstrated that many women are not accessing available digital resources. • Development of the Healthier Together digital offer continues, supporting women and families to access reliable healthcare information and self-management advice. • A new Family Support Nurse role has been introduced within the Local Neonatal Unit (LNU) to provide additional support to parents and families during their neonatal journey, enhancing patient experience and family-centred care. • The screening team have identified barriers in communication with service users who do not have English as a first language. An improvement plan is in place and an update will be shared in Q2.

Perinatal Culture Improvement Plan

- The Trust Perinatal leadership have established a Perinatal Culture Improvement Plan throughout 2024/25 as part of the ongoing Perinatal Culture & Leadership Programme.
- The purpose was to support perinatal leadership teams develop conditions for a positive culture of safety and continuous improvement. This will drive change with a better understand of the relationship between leadership, safety improvement and safety culture.
- To support the achievement of the Perinatal vision statement there have been three workstream objectives within the culture improvement plan identified,

No.	Workstream Objective	Aim of Objective
1	Workforce Civility, Psychological Safety & Speaking Up	Create an environment where staff can raise concerns about safety, culture and capacity without fear
2	Compassionate & Inclusive Leadership	Develop visible and supportive leadership behaviours that support a positive workforce culture and associated behaviours
3	Service Operational Capacity	To operate a service that has appropriate capacity thresholds to support staff wellbeing alongside delivering outstanding quality of care

- Throughout Q1 work has been ongoing with development of improvement action plans in response to the results of the Staff Survey 2026, the scoping of delivering a training and education programme with Civility Saves Lives, expanding a team of trained culture coaches and continuing with a divisional level A3 focussed on reducing sickness absence.
- Full detailed Perinatal Culture Improvement Action Plan to be brought as an appendix to the Q2 safety report for in depth review and oversight.

Appendix A

Quarterly Overview of Perinatal Claims, Complaints & Incidents

Great Western Hospitals NHS Foundation Trust

Claims Scorecard (01/04/2015 – 31/03/2025) Total 46 claims Neonatal(2)

Top injuries by volume

Psychiatric/psychological damage (7)
Additional/unnecessary surgery (6)
Unnecessary pain (3)
Cerebral Palsy (2)Hypoxia (2)Not Specified (2) Fatality (1) Burns (1)

Top injuries by value

Hypoglycaemia (1)
Brain damage (2)Cerebral palsy (2)
Cosmetic Disfigurement (1)
Erbs Palsy (1)
Fatality (1) Burns (1

Top causes by volume

Fail/delay treatment (9)
Failure/delay to diagnosis (7)
Inappropriate treatment (4)
Inadequate nursing care (3)
Fail to Warn-Informed Consent (4)
Inappropriate Treatment (1)
Operator Error (1)

Top causes by value

Fail/delay treatment (9)
Birth defects (2)
Failure to recognise complication (2)
Inadequate nursing care (2)
Inappropriate Treatment (1)
Operator Error (1)

Complaints Q1 2026-27

Information Governance (1)
- 1 complaint relating to handling of personal data on EPR

Clinical care (6):
- 1 Antenatal care
- 3 complaints birth experience
- 2 Care on Hazel Ward

Experience (1):
- 1 Visitor arrangements

Serious Incidents (SI) Q1 2026-27
- 4 new SI identified in Q1 and 0 incidents Closed in Q1.
- Four new Serious Incidents reported: two following homebirths requiring neonatal transfer for therapeutic cooling (one neonatal death and one baby currently receiving palliative care), one term baby requiring tertiary neonatal transfer for cooling following spontaneous vaginal birth, and one unexpected 21-week MCDA twin delivery at home following discharge from triage.
- 3 cases suitable for MNSI review, 2 cases have been accepted, 1 unable to proceed due to family declining consent, to progress to a PSII.

Triangulation of claims, complaints & SI data to generate themes, learning and actions

Themes Q1 2026-27

- No PSII's or MNSI's closed in Q1
- Thematic review findings have identified key learning related to the management of babies requiring additional care pathways.

Learning Q1 2026-27

- **Informed choice** is critical; women must be provided with clear, accessible, and comprehensive information to make decisions about their care confidently. Emphasis should be placed on personalised communication that respects individual needs, preferences, and cultural considerations – Montgomery Standard = Patient centred decision making.
- **Kind and compassionate care** must remain a central pillar of maternity services, influencing every interaction with women and families.
- **Active listening** is essential; staff must ensure service users feel genuinely heard and understood throughout their care journey. Service user feedback has highlighted multiple instances where individuals did not feel listened to, indicating a need for focused improvement.
- **Individulised Care Planning**: Personalised care planning is essential; staff must ensure care is tailored to each individual, with care plans reflecting their needs, preferences, values and informed choices.

Following New Scorecard data 2015/2025:
- There has been an increase in claims relating to Psychiatric/Psychological Damage and a new cause identified relating to Informed consent, previously identified as learning.
- New claim relating to management of hypoglycaemia contributing to top value claim. Increase in total value of claims relating to Hypoxia, Brain damage and Cerebral Palsy.

Action Plan Q1 2026-27 with continued actions (1) from scorecard 15/25		Not started	In progress	Completed
1	Communication month planned for 2026 to support effective communication between health professionals and women. Action reviewed: the SEIPS framework has been embedded into all incident review processes, including communication as a core component. Learning is identified, shared and applied across the service. Communication is a fundamental thread running through training, escalation, and culture reviews, supporting safe, effective, and patient-centred care.			
2	Introduction of call recording system for maternity triage telephone calls			
3	Perinatal mental health support lead midwife to review events that have led to claims to consider commonality and service level learning focusing on prevention.			
4	To review cases where informed consent has contributed to cause of claim and to provide assurance that changes are embedded in practise			
5	A retrospective thematic review of hypoglycaemia identification processes will be undertaken to explore contributory factors, support learning, and inform targeted improvement actions. The rapid review did not identify any adverse outcomes but highlighted areas where deeper analysis would be beneficial.			
6	Commencement of a QI project following trend of miss opportunities to put babies on the correct care pathways.			

Appendix B

	Appendix A. Area for improvement: Maternity PFD Response Action Plan							
	Safety action description (SMART)	**Safety action owner (role, team directorate)**	**Target date for implementation**	**Date Implemented**	**Tool/measure**	**Measurement frequency (e.g. daily, monthly)**	**Responsibility for monitoring/ oversight (e.g. specific group/ individual, etc)**	**Planned review date (e.g. annually)**
1	The Trust to provide sufficient information to enable service users to make an informed choice regarding their birth options. This must include a description of uterine scar rupture, what the consequences may be including risk of death for the mother and baby.	Digital Team Obstetric Team.	Completed	Completed	A new Birth After Caesarean Section (VBAC) leaflet has been introduced, containing updated mandated information. It is provided during the antenatal period and recorded in the patients electronic.	VBAC audit Frequency increased to quarterly	Audit Lead PQSA Team	Quarterly in line with audit
					The Trust's electronic system includes a prompt for 'VBAC discussion' for patients with a previous caesarean. This supports clinicians in discussing key risks—such as uterine rupture, hypoxia, and fetal injury or death—and ensures consistent documentation.			
					This process standardises information sharing, with the new leaflet central to supporting informed choice			
2	Support clinicians to facilitate and evidence discussions of risks and potential consequences of a uterine rupture, with mothers who have had a previous caesarean birth admitted to the labour ward for induction of labour, to confirm that there has been informed shared decision making.	PQSA Team Obstetric Leads	Completed	Completed	Update PIL and operation consent form	VBAC audit Frequency increased to quarterly	Audit Lead PQSA Team	Quarterly in line with audit
					Importance of informed decision making and discussion format included in mandatory training for midwives and obstetricians	Mandatory training syllabus		
					Information card introduced which outlines risks associated with IOL VBAC and in use on Delivery Suite and Hazel Ward	Card in use, metric to be added to the next VBAC audit		
3	Significant elements of care, as outlined by the coroner are addressed individually within the MNSI action plan (Appendix B) in response to the independent investigation safety recommendations	PQSA Team Obstetric Team Senior Leadership Team	Completed	Completed	Please see Appendix B	Please see Appendix B	Please see Appendix B	Please see Appendix B

4	Review of perinatal PILs governance process to provide assurance of compliance and accessibility. To include both digital and printed. Specific focus on updating the PIL tracker, to reflect the current list of PILs which staff have access to.	Audit Lead PQSA Team Patient Safety Lead	Completed	Completed	PIL tracker to be presented in monthly maternity governance forum to ensure oversight.	Monthly Governance	Audit Lead PQSA Team	June 2026
5	Comprehensive review of current Trust PIL process,	Head of Midwifery & Neonatal Services Patient Safety Lead Deputy Chief Nurse (Assigned to Project)	February 2026	Work on going - Trust wide project updateing and movinf PILs to EOLAS for patient to access through maternity EPR sytem - October 2026	Introduce a digital tracking system that logs timestamps for each stage: draft submission, review, feedback, final approval. Set target turnaround times Automate alerts for overdue reviews or pending approvals. Monitor and report monthly	Annually	Multidisciplinary Trust PILS working group	October 2026
6	Trust must make appropriate changes within a reasonable timeframe following serious clinical incidents. As per Ockenden IEA, 'a change in practice arising from an SI investigation must be seen within 6 months after the incident occurred''.	Head of Midwifery & Neonatal Services Patient Safety Lead	Completed	Completed	Full review of all actions commenced immediately to ascertain current compliance position. Action tracker included in monthly Maternity Governance meeting for oversight of compliance and opportunities for escalation. Outstanding actions added to the electronic database to support automatic reminders and completion. Formal request made to all colleagues to provide evidence of actions and update electronic data base. Weekly meeting in place with PQSA team to review all actions and monitor progress.	Manual tracker Datix electronic tracker Maternity governance meeting minutes Updated position will be shared quarterly via the Perinatal Safety report.	Patient Safety Lead	June 2026

Appendix C:

PERINATAL MORTALITY REVIEW TOOL (PMRT) QUARTERLY REPORT

(QUARTER 1, 2026-2027)

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to GWH Quality and Safety Committee and Board level Safety Champions that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MMBRACE-UK) via the Perinatal Mortality Reporting Tool (PMRT) and that following this referral the review that is undertaken is robust of the quality of care provided. The actions and learning will be identified.

1.1 DEFINITIONS

The following definitions from MMBRACE-UK are used to identify reportable losses:

- **Late fetal losses** – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24^{+0} weeks gestation (or from 500g where an accurate estimate of gestation is not available) showing no signs of life.
- **Neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later, or 400g where an accurate estimate of gestation is not available) occurring up to 28 completed days after birth.

1.1.1 MIS Year 8 requirements to notify:

The following deaths should be reviewed to meet safety action C standards:

- All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
- All stillbirths (from 24+0 weeks' gestation)
- Neonatal death from 20 weeks' gestation (or 400g if gestation unknown) (up to 28 days after birth)

2. STANDARDS

A report has been received by the Trust Executive Board each quarter that includes details of the deaths reviewed alongside any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards have been met.

The MIS Year 8 scheme was released in March 2026 and will apply to babies who died between 1st December 2025 until 30th November 2026. The Trust compliance for Q1 has been achieved (see appendix 3 for breakdown of detail).

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Standard
Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within 7 working days, and surveillance completed.	**100%**
A PMR must be completed	**100%**
All parents will have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**100%**
An external member must be present at the Multidisciplinary review panel meeting and documented within PMRT	**60%**
Quarterly reports will have been submitted to the Trust Board from 1st December 2025 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	**100%**

2. RECOMMENDATIONS

3.1 Eligible Incidents in 2026-2027 (appendix 1)

There have been no eligible incidents for PMRT reported to MBRRACE-UK via the SPEN in Quarter 1, 2026-27.

No concerns have been raised with the notification and surveillance submission, and the current reporting process is to continue.

3.2 Summary of all incidents closed in Quarter 1 (appendix 2)

There have been 3 cases closed in Q1. This is broken down into the care provided to the mother before the birth and before the death of the baby, and the care of the mother after the death and birth of the baby, as applicable.

<u>For Intrauterine death: Grading of care of the mother and baby up to the point that the baby was confirmed as having died:</u>

- 1 case had no issues with care identified from birth up to the point that the baby died
- 1 case had issues with care identified which would have made no difference to the outcome for the baby
- 1 case had issues with care identified which were likely to have made a difference to the outcome for the baby

<u>For Intrauterine Death: Grading of care of the mother following the confirmation of the death of her baby</u>

- 1 case had no issues with care identified for the mother following the death of her baby
- 2 cases had issues with care identified for the mother which would have made no difference to the outcome for the mother

For Neonatal Death: Grading of care of the mother and baby up to the point of birth of the baby

(NOTE: none of the cases reviewed met this criterion for grading as per the PMRT system)

For Neonatal death: Grading of care of the baby from birth up to the death of the baby:

(NOTE: none of the cases reviewed met this criterion for grading as per the PMRT system)

For Neonatal Death: Grading of care of the mother following the birth of her baby

(NOTE: none of the cases reviewed met this criterion for grading as per the PMRT system)

Where actions have been identified, appropriate deadlines have been put in place and can be found in appendix 4.

3.3 CNST Compliance as per MIS Year 8 Standards (appendix 3)

GWH is compliant with all eligible standards for MIS CNST Year 8 safety action C, which provides the requirements for Trusts to use the National Perinatal Mortality Review Tool (PMRT) to review all perinatal deaths and ensure securing family involvement, and ensure feedback is supported and incorporated into the reviews.

The Trust have declared compliance with this safety action with all cases reported and reviewed within the required timescale. This data set is externally verified which has confirmed the Trust position.

3.4 Learning and Action Logs for Outstanding Cases (appendix 4)

Learning and progress against previous actions are included in appendix 4

Appendix 1 – Summary of all Eligible Incidents previously reported and closed in Q1, 2025-26

PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Weight (g)	Location of booking / Primary Antenatal Care	Location of Delivery	Location of Death (reporting hospital)	Parents involved and updated	MNSI Case	PSII	Surveillance < 1mth	Review started < 2mth	Review Publish < 6mth
101034	I/P IUD	29 weeks	5/11/25	5/11/25	1490	GWH	GWH	GWH	7/11/25	N/A	N/A	Yes	Yes	Yes
101327	A/N IUD	39 weeks	22/11/25	18/11/25	1590	GWH	GWH	GWH	18/11/25	N/A	N/A	Yes	Yes	Yes
102057	A/N IUD	28+3 weeks	14/01/26	11/01/26	849	GWH	GWH	GWH	15/01/26	N/A	N/A	Yes	Yes	Yes

Appendix 2 – Summary of all incidents closed in Q1 of 2026-2027

Case	Cause of Death	Grading of Care	Issues Identified	Actions	Responsible/Date	Update
Case no: 101034 **Intrapartum intrauterine death 29/40**	Difficult breech extraction with head entrapment and prematurity	The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	Issues identified related to neonatal resuscitation and smoking in pregnancy	On the basis of this review and the patient safety review that took place at the time, GWH have implemented improvement actions to prevent recurrence of the issues identified. GWH does not provide smoking cessation services to family members under current arrangements. Midwives are to signpost to local authority smoking cessation services/Smoke Free app.	Senior Neonatal team, PD team, PQSA Team 31/7/2026 PQSA team 30/4/2026	2 actions completed, 2 ongoing Completed
Case no: 101327 **Antenatal intrauterine death 39/40**	Trisomy 18 with abnormalities	The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died The review group identified care issues which they considered would have made no difference to the outcome for the mother	This mother had poor/no English and family members were used as interpreters during her labour and birth	Referral made to PALS for investigation/Service improvement	Head of Patient experience and engagement 28/2/2026	Ongoing workstream by PALS service
Case no: 102057 **Antenatal intrauterine death 28+6/40**	Maternal Vascular Malperfusion	The review group identified care issues which they considered would have made no difference to the outcome for the mother or baby	Care issues and actions agreed following receipt of feedback from the family	Supportive conversations with staff involved in antenatal care provision and staff involved in breaking bad news to the family	Community Services Matron / Perinatal Support service team	Completed following receipt o feedback prior to PMR

Appendix 3– Summary of CNST Compliance as per MIS Year 8 Standards

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Standard required %	Q1	Q2	Q3	Q4	Total
Notification of all perinatal deaths eligible to be notified to MBRRACE-UK to take place within 7 working days	100%	0 out of 0				
		100%				
A PMRT review must be commenced following the death of a baby.	100%	3 out of 3				
		100%				
A PMRT must be completed following a baby's death.	100%	3 out of 3				
		100%				
All parents will have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	100%	3 out of 3				
		100%				
An external member must be present at the Multidisciplinary review panel meeting and documented within PMRT	60%	3 out of 3				
		100%				
Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	100%	1				
		100%				

Appendix 4 – Summary of all Leaning and Action Logs for Outstanding Cases

Case IDs	Issue	Action	Responsible / Date	Update / progress
101034	Neonatal Consultant not in attendance for neonatal resuscitation	Policy changes regarding early escalation to consultant for babies <30/40 or proceeding to cardiac compressions.	Neonatal Governance Lead Consultant	In progress
	NLS process not followed	Education to wider team and reminder of NLS algorithm: 1) Discuss in Perinatal Learning Forum. 2) Sims training on the Local Neonatal Unit led by Practice Development Nurse.	Neonatal Governance Lead Consultant PLF Admin team Practice Development Neonatal Nurse	1) Completed April 2026 2) Ongoing
101034	GWH does not provide smoking cessation services to family members under current arrangements. Midwives are to signpost to local authority smoking cessation services/Smoke Free app.	Email to be sent to community midwives as a reminder to signpost to local authority smoking cessation services/Smoke Free app	PQSA Team	Completed
101327	This mother had poor/no English and family members were used as interpreters during her labour and birth	Referral made to PALS for investigation/Service improvement	Head of Patient experience and engagement 28/2/2026	Ongoing workstream by PALS service
102057	Care issues identified following receipt of feedback from the family	Supportive conversations with staff involved in antenatal care provision and staff involved in breaking bad news to the family	Community Services Matron / Perinatal Support service team	Completed following receipt of family feedback prior to PMR

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Report to	BSW Hospital Group Board of Directors. Item 4.3.2 RUH
Committee	*N.A*
Meeting date	3rd September 2026
Author	Jodie DaRosa, Interim Director of Midwifery and Neonates; Jodie Clement, Quality and Patient Safety Lead for Maternity and Neonates
Status	*For Assurance / For Information*
Links to Strategic Priority (s)	Patient safety, quality, workforce sustainability, equity of access and experience, and regulatory compliance across maternity and neonatal services.
Links to Risk Register	Risk 3342; Risk 3308; Risk 3101; Risk 3267; Risk 3182; Risk 2785; Risk 3251; Risk 3013.*
Reporting period	Quarter 1 2026/27

**During the Datix transition for risk management reporting, the full Q1 report continues to use the previous risk methodology. This accounts for differences from the upward reporting sheet, where the 5+5+5 methodology has been applied.*

1. Executive summary

The Committee reviewed the Quarter 1 2026/27 maternity and neonatal safety position, drawing on triangulated intelligence from incidents, complaints, claims, PMRT, workforce metrics, audit, patient and family feedback, and national programme requirements. Appendix 6 is included as supplementary context to provide continuity with the previous reporting position. The Quarter 1 position builds on the insights and improvement work identified in Quarter 4, with evidence of active surveillance and continued progression; however, two material risks require formal escalation: maternity workforce capacity and digital interoperability in fetal growth surveillance. Additional risks below the escalation threshold remain under contextual review, including maternity triage medical review timeliness, perinatal pathology delays, neonatal workforce sustainability and delivery against emerging national maternity and neonatal requirements.

2. Alert, Advise, Assure

2.1 Alert

- **Maternity workforce capacity:** The final Birthrate Plus review confirms a material establishment gap, with Risk 3342 recorded at 16. This is aligned with patient experience themes relating to immediate postnatal inpatient care and staff feedback on redeployment pressures. The bi-annual staffing paper (appendix 1) provides assurance that maternity and neonatal services maintained safe care delivery between January and June 2026 through robust workforce oversight and effective escalation processes. However, this approach limits capacity for service improvement, education and transformation activity and is unlikely to be sustainable in the longer term. Approval

and implementation of the phased workforce mitigation programme remain key to reducing risk.

- **Digital interoperability and fetal growth surveillance:** Risk 3308 has increased from 12 to 16 following audit evidence confirming the scale of manual transcription and interoperability risk between obstetric ultrasound systems and the maternity EPR. Capital funding has been approved for a replacement obstetric ultrasound digital solution, with interim audit, verification and documentation controls in place.
- **Perinatal pathology delays:** National pathology workforce constraints continue to delay postmortem results, affecting PMRT completion and family communication. Risk 3251 has reduced to 10 and is therefore monitored within the contextual risk section, with local safeguards in place to support communication with bereaved families.

2.2 Advise

- **Maternity Incentive Scheme Year 8:** Delivery is progressing, and key dependencies include the revised two-point training compliance requirement, Maternal Care Bundle implementation, workforce alignment and Board reporting requirements. Action plans are in place, and no unmitigable barriers are currently anticipated.
- **Maternal Care Bundle:** Implementation is at an early stage, with delivery dependent on digital changes, ICB and system working, tertiary pathway alignment and wider Trust support. Element 3 is fully implemented; Elements 1, 2 and 4 remain in development and Element 5 is partially implemented.
- **Perinatal Culture and Improvement Plan (PCIP):** MIS8 stipulates providers must have a PCIP using workforce, service user and safety intelligence to understand the cultural factors influencing care. PCIP established (Appendix 2) outlining safety, quality and workforce priorities.
- **National maternity and neonatal requirements:** The Ockenden Nottingham review, Amos National Maternity Care Review, national maternity triage specification and NHS England 10-Point Plan require further benchmarking, gap analysis and Board oversight. Appendix 3 and 4 outline the ongoing benchmarking position for Maternity triage Q1 report (Appendix 3) and initial NHSE 10-point plan benchmarking (appendix 4).

2.3 Assure

- **PMRT process compliance:** PMRT process measures remain at 100% across reported MIS standards, including eligible notifications, external review, family engagement and Board-level reporting.
- **Saving Babies' Lives Care Bundle:** Compliance remains strong at 96%, with four of six elements fully implemented and targeted improvement actions in place for fetal growth surveillance, Doppler compliance and auditability.
- **Training compliance:** Training compliance remains above 90% across most mandatory training requirements, with weekly monitoring and targeted actions in place ahead of the September and November MIS checkpoints.
- **Patient safety learning:** Learning is actively informing improvement activity, including neonatal hypoglycaemia pathways, deterioration recognition, fetal growth surveillance, digital interoperability and consultant escalation.

3. Risk review

The Committee reviewed maternity and neonatal risks in line with governance arrangements. Risks 3342 and 3308 are formally escalated at score 16. Risks below the escalation threshold are retained in this report where they require contextual oversight due to proximity to escalation, patient safety relevance, national dependencies or wider service sustainability implications.

3.1 Risks formally escalated to the Managing Director

Risks scoring 12 or above. Use 5+5+5 methodology and the Group Risk Management Policy categories.

Risk ID & Title	5+5+5 score	Controls assessment	Reason for escalation
3342 – Midwifery workforce deficit impacting safety, quality and service sustainability	16	Partially effective	Birthrate Plus confirms a material establishment gap. Current mitigations remain partial until recurrent funding and substantive recruitment are secured.
3308 – Obstetric ultrasound and fetal growth documentation interoperability	16	Partially effective	Audit evidence confirms systemic manual transcription and interoperability risk. Capital funding is approved, but residual risk remains until the replacement solution is implemented.

3.2 Narrative on escalated risks

Risk 3342 has escalated following the final Birthrate Plus review, which confirmed a deficit of 13.12 WTE clinical staff and 8.61 WTE specialist and leadership roles. Current controls provide partial mitigation only; the risk will remain elevated until recurrent funding, recruitment and the wider perinatal workforce model are progressed.

The associated patient safety and organisational risks extend beyond clinical staffing capacity and include specialist, leadership, governance and data infrastructure requirements. These are reflected in the perinatal business case and will require Board support to ensure effective mitigation.

Risk 3308 has increased from 12 to 16 following audit evidence confirming system-wide vulnerability in fetal growth surveillance documentation and data visibility. Interim audit, verification and documentation controls are in place, but the risk will remain elevated until the replacement obstetric ultrasound digital solution is implemented and embedded.

3.3 Risks reviewed for context below formal escalation threshold

This section provides visibility of risks below the formal escalation threshold where the Committee has identified a need for continued oversight, including risks close to escalation or those with important patient safety, workforce, digital, operational or experience implications.

Risk ID & Title	Category	Score	Controls assessment	Committee view
3013 – Ultrasound service capacity	Operational / Patient safety	9	Partially effective	Score reduced below escalation threshold; manual audit provides assurance while data quality issues continue to be monitored.
3182 – Neonatal cot capacity pressures due to reduced regional tertiary capacity	Operational / Patient safety	12	Partially effective	Workforce countermeasures and capacity safeguards have reduced likelihood; however, regional cot closures are expected to continue into Q2 and require continued oversight.
2785 – Neonatal pharmacist cover below clinical need and BAPM standards	Workforce / Patient safety	12	Partially effective	Neonatal workforce requirements, including pharmacy provision, remain under review against best practice recommendations and benchmarking.
3251 – Perinatal pathology workforce gaps impacting bereaved families	Workforce / Patient experience	10	Partially effective	Score is below formal escalation threshold; national pathology workforce constraints continue to affect PMRT timeliness and communication with bereaved families, with local safeguards in place.
3267 – Maturity of perinatal safety data limits responsiveness to patient safety events	Digital / Patient safety	11	Partially effective	Risk is below formal escalation threshold; dashboard development and drill-down reporting have improved visibility, with further maturity and assurance required.
3101 – Maternity triage urgent medical review compliance	Operational / Patient safety	Below threshold	Partially effective	Urgent medical review compliance improved during Q1 following escalation and transfer controls; continued oversight is required against BSOTS standards.

Risks 3182 and 2785 are being reviewed together to determine whether they should be consolidated into a broader neonatal risk: unsustainable workforce model for high-activity neonatal care. The review will test whether cot capacity, specialist pharmacy provision, activity levels and regional tertiary constraints are better represented as a single workforce sustainability issue with associated patient safety implications.

4. Good practice and innovation

The Committee noted several areas of good practice and innovation that support safety, experience and equity across maternity and neonatal services.

- **Perinatal Culture Improvement Plan:** Annual thematic analysis has translated workforce and safety intelligence into focused priorities for 2026/27, including workforce capacity, wellbeing and support, communication and staff voice, postnatal care, infant feeding and pelvic health.
- **Equity and access:** Progress includes redevelopment of the Maternity Health Inequalities Dashboard, procurement of Pocket Talk translation technology, participation in the Healthy Together App programme and development of the Global Majority Enhanced Care model.
- **Community birth provision:** The Hummingbird Team continued to support homebirth and midwifery-led unit activity, with positive outcomes for women choosing to birth in the community outside standard guidance following personalised assessment and planning.

5. Committee approvals and recommendations

The Committee is asked to note the Q1 position, discuss the areas of alert, and support continued oversight of the key risks and delivery dependencies described below.

5.1 Approved by the Committee

- No specific Committee approvals were identified in the source report. The report asks the Board to discuss the report, note areas of alert and take assurance from the controls and improvement actions described.

5.2 Recommended to the Assurance Committee

- Note the formal escalation of Risks 3342 and 3308 at score 16 and maintain oversight until recurrent workforce investment, recruitment and digital implementation milestones are achieved.
- Support continued scrutiny of MIS Year 8 delivery, including the two training assessment points, Maternal Care Bundle implementation, workforce alignment and Board reporting requirements.

6. Looking ahead

Next cycle scrutiny should focus on delivery of workforce mitigation plans, reduction of digital interoperability risk, MIS Year 8 delivery and benchmarking against new national maternity and neonatal recommendations.

Planned areas for follow-up include: September and November training compliance checkpoints; Maternal Care Bundle delivery dependencies; implementation planning for the obstetric ultrasound digital solution; maternity triage urgent medical review compliance; perinatal pathology delay mitigations; and Quarter 2 progress against equity, access and patient experience priorities.

Appendices

Appendix 1 –Quality Report Q1 26/27

Maternity and Neonatal Quarterly Quality Report Quarter 1 26/27

REPORT OVERVIEW

This report provides the Board with a consolidated view of maternity and neonatal safety, quality, workforce and operational intelligence for Quarter 1 2026/27. It brings together intelligence from incidents, outcomes, complaints, claims, patient and family feedback, workforce data, audit findings and national programme requirements to support oversight of risk, assurance and improvement.

The methodology is informed by the principles of the Perinatal Quality Surveillance Model, PSIRF, the Maternity Incentive Scheme Year 8 standards and current national maternity and neonatal improvement priorities. It uses triangulated intelligence from incidents, outcomes, complaints, claims, patient and family feedback, workforce data, audit findings and national programme requirements to identify themes, emerging risks and areas for targeted improvement. These are monitored through established maternity, neonatal and Trust governance processes.

During Quarter 1, the national maternity and neonatal context changed significantly following publication of the Ockenden Nottingham review, the Amos National Maternity Care Review, updated national triage standards and NHS England's 10-Point Plan for Maternity and Neonatal Services. The service is undertaking benchmarking and gap analysis against these publications to identify any further actions required and to inform future reporting, improvement priorities and Board oversight.

1.0 SAFE MATERNITY AND NEONATAL STAFFING

Perinatal nursing and midwifery staffing metrics are monitored and reported against service key performance indicator targets monthly through governance within the Perinatal Quality Support and Oversight Model (PQSOM). During Quarter 1 2026/27, the service received the final report of the triennial independent workforce establishment review provided by Birthrate Plus. In recognition of the significant impact workforce metrics have on the work system and safety and quality outcomes, the service completes bi-annual deep-dive reports into workforce metrics. See Appendix 1 for review of workforce metrics between December 2025 and June 2026. A new risk assessment has been completed with subsequent Risk Register entry 3342.

While the bi-annual workforce report (Appendix 1) provides the detailed establishment review and staffing metrics, this safety report highlights the associated patient safety and organisational risk. The Birthrate Plus findings, Risk 3342 and wider national review requirements demonstrate that safe and sustainable improvement requires not only clinical staffing capacity, but also specialist, leadership, governance and data infrastructure. These requirements are reflected in the perinatal business case and will require Board support to ensure risks are mitigated effectively.

2.0 TRAINING COMPLIANCE FOR ALL STAFF GROUPS IN MATERNITY RELATED TO THE CORE COMPETENCY FRAMEWORK

The report provides evidence of training compliance, including a response to year 8 of MIS, Safety Action 8. The Core Competency Framework version 2.2 sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment for maternity staffing across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service. Compliance with attendance and demonstrated competence for fetal monitoring, neonatal resuscitation, and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) across all staffing groups (Figure 10).



Figure 1. Maternity Training Line Charts for PROMPT, Fetal Monitoring, Mandatory Training compliance and Adult Basic Life Support compliance Q1 26/27 broken down by staff group.



Figure 2. Maternity Training Line Charts for PROMPT, Fetal Monitoring, Mandatory Training compliance and Adult Basic Life Support compliance Q1 26/27 broken down by staff group.

Education and training compliance across maternity and neonatal services remains above 90% for the majority of mandatory training requirements. Compliance is monitored through established governance processes, with oversight arrangements in place to review performance, identify areas below target, and coordinate remedial actions where required.

The revised Maternity Incentive Scheme (MIS) training standard requires organisations to demonstrate training compliance above 90% across all staff groups at two separate assessment points within a six-month period, replacing the previous single-point assessment requirement. The Trust has established assessment checkpoints for 11 September 2026 and 30 November 2026. Weekly compliance reviews are undertaken to monitor progress against these requirements, with targeted actions implemented for staff groups below threshold. Compliance against the first assessment point and progress towards achievement of the second assessment point will be reported through the Quarter 2 quality report.

Within maternity services, current improvement activity is focused on compliance and stability within safeguarding level 3, manual handling and PROMPT compliance within the ‘other obstetric doctor’ staff group. Safeguarding level 3 compliance remains below the required threshold; however, all but six staff members have been booked onto training and follow-up arrangements remain in place for outstanding staff. Manual handling compliance remains below target. Since June 2026, manual handling training has been incorporated into PROMPT delivery to support improvement in compliance and reduce future training gaps. Compliance data for these training areas continues to be reviewed through regular

monitoring processes.

Neonatal services currently maintain compliance above 90% across all mandatory training subjects. The 2026 training needs analysis is underway and is being used to identify staff requiring refresher training ahead of the September MIS assessment point.

Within neonatal services, education activity is focused on speciality-specific training requirements, including Standard Concentration Infusion (SCI) training and insulin safety education in response to Getting It Right First Time (GIRFT) recommendations. Actions include support from practice education facilitators, development of local training and simulation packages, review of national learning resources, and inclusion of newborn life support (NLS) requirements within professional update study days. Compliance and training uptake continue to be monitored against local and national requirements.

Training compliance across both services remains subject to regular oversight and monitoring, with targeted actions in place to address areas below threshold and support achievement of the revised MIS training standard and associated regulatory requirements.

3.0 BOARD LEVEL SAFETY CHAMPIONS

The Maternity and Neonatal Safety Champions programme continues to provide a structured mechanism for staff engagement and workforce intelligence across the service. Staff are invited to participate in monthly listening events and engagement activities, including walkabouts involving the Chief Nursing Officer, the Non-Executive Director for Maternity and Neonatal Services, and the Obstetric, Neonatal and Maternity Safety Champions.
Feedback obtained through listening events, walkabouts and direct engagement with Safety Champions is reviewed through the Service's Insights Forum and reported monthly to the Perinatal Quality and Safety Oversight Model (PQSOM). This enables timely review of emerging issues, identification of recurring themes, and escalation of matters requiring immediate action or further investigation.

This report provides a quarterly thematic analysis of workforce feedback, bringing together trends and areas of commonality identified across the reporting period. The analysis supports the identification of potential systemic issues, informs areas requiring further consideration and enables targeted improvement activity where required.

In addition, an annual thematic review is undertaken through the Perinatal Culture Improvement Plan (PCIP), providing a comprehensive assessment of workforce intelligence and cultural indicators across maternity and neonatal services (Appendix 2). The PCIP uses these insights to provide focus and clarity on the areas requiring wider structured Quality Improvement focus which is most likely to deliver meaningful improvement in organisational culture, staff wellbeing, teamwork, collaboration and psychological safety, ensuring improvement activity is aligned to workforce need and identified priorities. This approach supports compliance with Maternity Incentive Scheme (MIS) standards and the recommendations arising from the Amos review, while ensuring workforce feedback is

systematically incorporated into quality governance, service development and continuous improvement activities.

During Q1, recurring feedback related to the redeployment of community midwifery staff to support periods of increased acuity and operational pressure within acute maternity services. Staff described the impact of on-shift redeployment on wellbeing and experience, including disruption to planned work, increased travel requirements and environmental factors such as parking. These findings align with the workforce risk described under Risk 3342 and reinforce the importance of delivering the planned workforce expansion and model changes.

4.0 COMPLAINTS, COMPLIMENTS, PATIENT SUPPORT AND COMPLAINTS TEAM (PSCT)

	Apr	May	Jun
Number of Patient Support and Complaints contacts	5	3	4
Number of formal complaints	0	2	1
Number of formally recorded compliments	18	22	22

Table 1. Complaints and compliments Q1 26/27

Compliments continue to be received across all areas of maternity and neonatal care. A consistent theme is the kindness, compassion and positive team working witnessed within the care provided to women, birthing people and their families.
During Q1, three formal complaints were received. Themes identified through complaints, PSCT contacts and informal feedback are reflected within the thematic assessment section of this report and the PCIP. See Appendix 2.

Postnatal Care (Inpatient): Immediate postnatal inpatient care continues to feature as a recurring theme within patient concerns and complaints. Families have described perceived workforce pressure on Mary Ward, which aligns with the workforce risk described under Risk 3342 and the findings of the Birthrate Plus review. See Appendix 1.

A commonality identified in Q4 pertaining to induction of labour was not identified as a continued theme within contacts in Q1.

5.0 PERINATAL PATIENT SAFETY INCIDENT RESPONSE INCLUSIVE OF MATERNITY AND NEONATAL SAFETY INVESTIGATIONS (MNSI) AND MATERNITY PATIENT SAFETY INCIDENT INVESTIGATIONS (PSIIS)

Maternity and Neonatal Safety Investigations (MNSI) undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- Maternal Deaths
- Intrapartum stillbirth
- Early neonatal death
- Severe brain injury following labour diagnosed in the first seven days of life

The service received two completed reports in Q1. Table 7 shows one ongoing MNSI review. No new referrals were made in Q1. Initial findings from multi-professional safety reviews (MPSR) identified learning around neonatal hypoglycaemia risk assessment and care pathways. A local learning response under PSIRF is in progress in view of the learning available to the service alongside the MNSI review of care.

Reference	Event Summary	Investigation Status	External Notifications	Duty Of Candour	Key Learning Identified	Family Meeting Offered
MI-047238	Intrapartum intrauterine death	Accepted	MNSI MBRRACE LFPSE	Yes- Ongoing through PMRT	Ongoing review under the Perinatal Mortality Review Tool (PMRT) framework as agreed with the family.	Yes
MI-049980	Neonatal re-admission on day 5 of life with hypoglycaemia. Subsequent Magnetic Resonance Imagery (MRI) changes.	MNSI review in progress Local learning response completed see section 6.2	MNSI NHS-RENS LFPSE	Completed	Risk assessment, screening and care pathways pertaining to the management of hypoglycaemia- see section 6.2	Yes
MI-050463	Neonatal transfer to tertiary unit for therapeutic cooling. MRI post-cooling was abnormal.	Investigation progressing	MNSI NHS-RENS LFPSE	Completed		Yes

Table 2. Completed MNSI investigations Q1 26/27

Reference	Event Summary	Investigation Status	External Notifications	Duty Of Candour	Key Learning Identified
MI-054870	Neonatal Transfer to tertiary unit for neonatal Seizures	Ongoing	MNSI NHS-R ENS LFPSE	Commenced in Progress	-

Table 3. Ongoing MNSI Referrals Q1 26/27

Reference	Event Summary	Investigation Status	External Notifications	Duty Of Candour	Key Learning Identified
MI-057309	Shoulder Dystocia and Neonatal transfer to tertiary unit for therapeutic cooling – Normal MRI post-cooling.	Investigation progressing as Trust Care concerns identified	MNSI LFPSE	Commenced – in progress	Small for Gestational Age and Fetal Growth Ultrasound Assessments
MI-058075	Readmission on day 2 of life – Hypoglycaemic seizures, congenital hyperinsulinism - hypoglycaemic brain injury	Investigation progressing	MNSI NHS- R ENS LFPSE	Commenced – in progress	Maternity Telephone triage for Neonatal concerns
MI-060259	Neonatal Transfer to tertiary neonatal care for active therapeutic cooling post birth – MRI postnatal neonatal stroke	Rejected – lack of Family Consent	MNSI NHS-R ENS LFPSE	Commenced - In Progress	No immediate care concerns identified
MI-060920	Neonatal Transfer to tertiary neonatal care for active therapeutic cooling – Normal MRI post cooling Congenital structural Airway anomalies	Rejected – Does not meet MNSI criteria	MNSI NHS-R ENS LFPSE	Completed	Unavoidable event – Structural airway anomaly not detectable antenatally

Table 4. 4 New MNSI Referrals Q1 26/27

5.1 CORONER REGULATION 28

Nil.

5.2 MATERNITY PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

The following two events were initially under PSIRF learning response review. Due to the complexity and volume of learning identified, the service has upgraded the level of PSIRF response to PSIIs.

Reference	Event Summary	External Notifications	Duty Of Candour process status	Key Learning Identified
Datix 146425	Maternal Admission to ITU on day postnatal with Invasive Group A Strep Sepsis	Nil	Commenced by Obstetric Consultant	Collaborative care pathways with Emergency Department (ED). Use of Maternity Early Warning Scores within the ED. Identification of the deteriorating patient.
Datix 143919	Baby born in unexpected poor condition with undiagnosed fetal growth restriction.	Discussed with NHS ENS & MNSI	Commenced by Obstetric Consultant	Digital integration of Ultrasound and EPR systems. Transcription risk with current USS and EPR systems. Index case for risk register entry 3308. See section 8.0

Table 5. Ongoing PSIRF Learning Responses Q1 26/27

1 of these reports reached completion in Q1.

Reference	Event Summary	External Notifications	Duty Of Candour process status	Key Learning Identified
Datix 143919	Baby born in unexpected poor condition with undiagnosed fetal growth restriction.	Discussed with NHS ENS & MNSI	Commenced by Obstetric Consultant	See below

Table 6. Completed PSIRF Learning responses Q1 26/27

Datix 143919 identified system-level vulnerabilities in the interoperability between obstetric ultrasound systems and the maternity EPR, requiring manual transcription of key ultrasound findings. Independent external scrutiny supported the local investigation findings and confirmed that the learning identified was robust.

The review concluded that current digital arrangements create a wider system risk, including potential transcription errors, incomplete documentation and reduced visibility of important fetal growth surveillance information at the point of review. This has been captured through Risk Register entry 3308, which increased to a risk rating of 16 following audit evidence confirming the scale and systemic nature of the issue.

Capital funding has been approved for procurement of a replacement obstetric ultrasound digital solution during Q1, which is expected to provide the long-term mitigation by improving interoperability and reducing reliance on manual transcription. In the interim, strengthened audit, verification, documentation and surveillance processes are in place and continue to be monitored through established governance routes.These controls have been further

strengthened through actions taken in response to the NHSE/RCOG safety alert, including transition to WHO-based growth chart methodology, enhanced Doppler documentation requirements, and additional audit and surveillance arrangements.

No new events were identified for PSII review in Q1 26/27

5.3 MATERNITY PSIRF LEARNING RESPONSES

During Q1 3 new PSIRF learning responses were commenced, of which 2 have reached completion. 1 learning response remains in progress.

Reference	Event Summary	External Notifications	Harm	Key Learning Identified
Datix 153618	Major Obstetric Haemorrhage	Nil	Low Harm	Cultural and Cognitive factors identified presenting barriers to effective escalation to the consultant on call – visual aids developed to support identification of triggers for on call consultant, plans for consultant Royal College of Obstetricians and Gynaecologist 'must attend' standards. As part of MIS standards
Datix 146963	Neonatal re-admission on day 5 of life with hypoglycaemia. Subsequent Magnetic Resonance Imagery (MRI) changes.	MNSI	Commenced by Neonatal Consultant	Risk assessment, screening and care pathways pertaining to the management of hypoglycaemia. Accurate documentation of Neonatal observations. Digital/paper interfaces.

Table 7. New and Completed PSIRF Learning Responses Q1 26/27

Reference	Event Summary	External Notifications	Harm Level	Statutory Duty Of Candour	Progress update/ Key Learning Identified
Datix 153258	Neonatal Resuscitation in a Community unit	Nil	Low Harm	-	KLOE: Multidisciplinary communication, Newborn Basic Life Support Out Of Hospital, supporting teamwork and education
Datix 146425	Maternal Admission to ITU on day postnatal with Invasive Group A Strep Sepsis	Nil	Moderate Harm	Commenced by Obstetric Consultant	Collaborative care pathways with Emergency Department (ED). Use of Maternity Early Warning Scores within the ED. Identification of the deteriorating patient.

Table 8. New and Ongoing local PSIRF Learning responses Q1 26/27

2 learning responses were completed during Q1.

6.0 PERINATAL MORTALITY AND MORBIDITY Q1 26/27

The following graphs demonstrate RUH performance against the national ambition to reduce stillbirths in the UK, and the RUH local ambition for continual progression in reducing perinatal mortality.

From June 2026 the national averages have been adjusted to reflect the latest publication of the MBRRACE-UK perinatal mortality revised National average from 2024 births. National 2025 figures are not yet available. MBRRACE-UK collects data on perinatal deaths, defined as stillbirths from 22 weeks' gestation and neonatal deaths up to 28 days of age, excluding terminations. Due to differing definitions (stillbirths recorded from 24 weeks, perinatal deaths from 22 weeks), reported rates may vary.

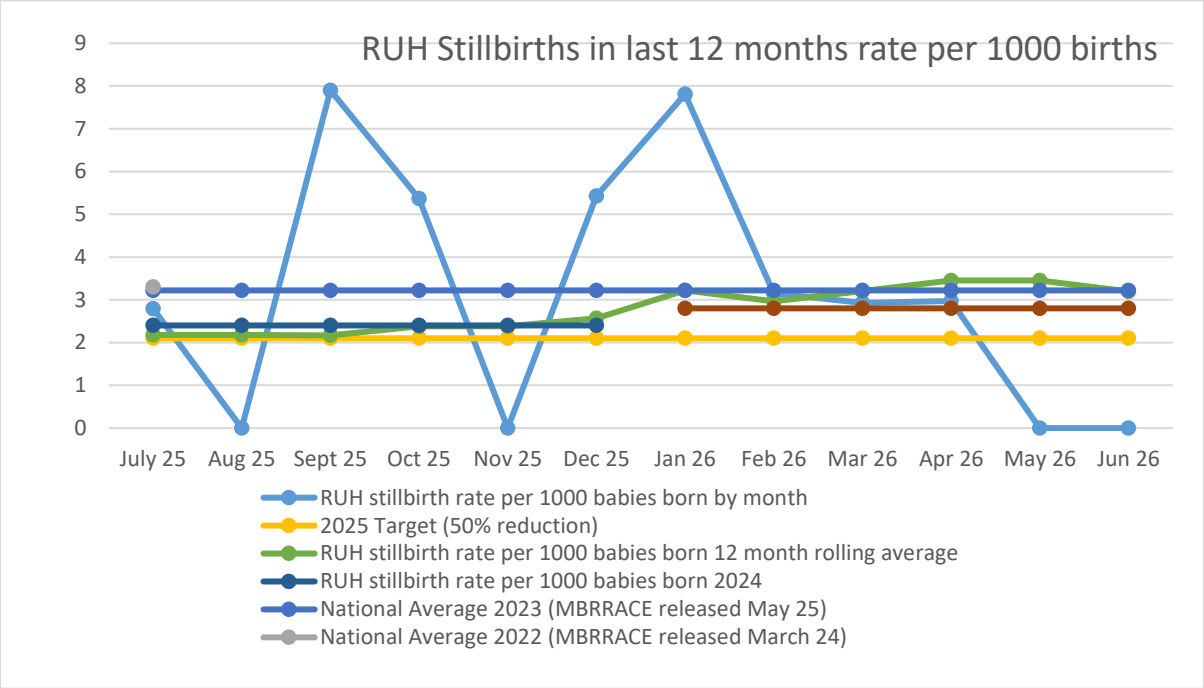


Figure 2: RUH NHS Trust stillbirth rate per 1000 births over last 12 months

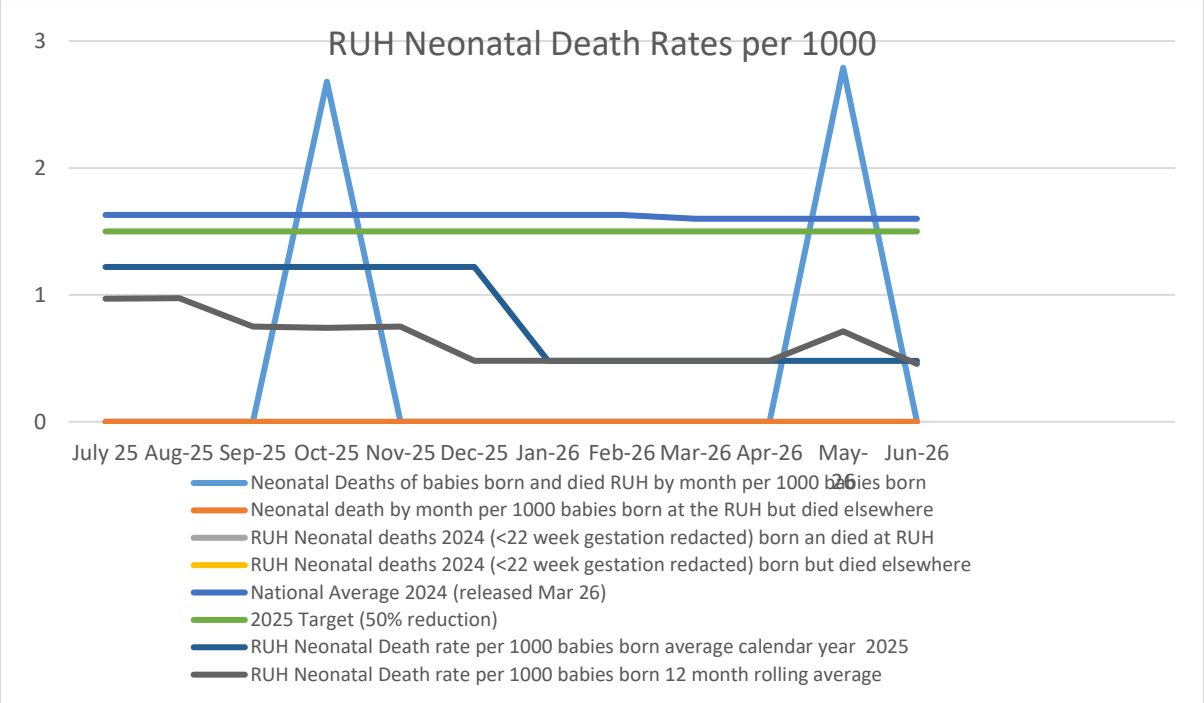


Figure 3: RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

Trusts are provided with initial MBRRACE-UK perinatal mortality rate per 1000 births; results are subsequently stabilised and adjusted to reflect if the RUH statistics were representative of the national socioeconomic demographics. Therefore, the MBRRACE crude, and stabilised and adjusted rates of perinatal mortality for the RUH will be different.

MBRRACE-UK collates the data for those babies who were born at the RUH and subsequently died elsewhere. This report has separated these values to ensure alignment of internal mortality data figures ahead of reported and adjusted MBRRACE-UK figures (Figures 1 and 2).

The RUH annual calendar year stillbirth rate for 2025 was 2.6 per 1000 births. This remains below the national average of 3.18 per 1000 (MBRACE 2024), although is an increase from the local 2024 rate of 2.4 per 1000 births. This exceeds the national ambition of a 50% reduction to 2.4 per 1000 births in 2025 and equates to a crude increase of 1 stillbirth from 2024 – 2025.

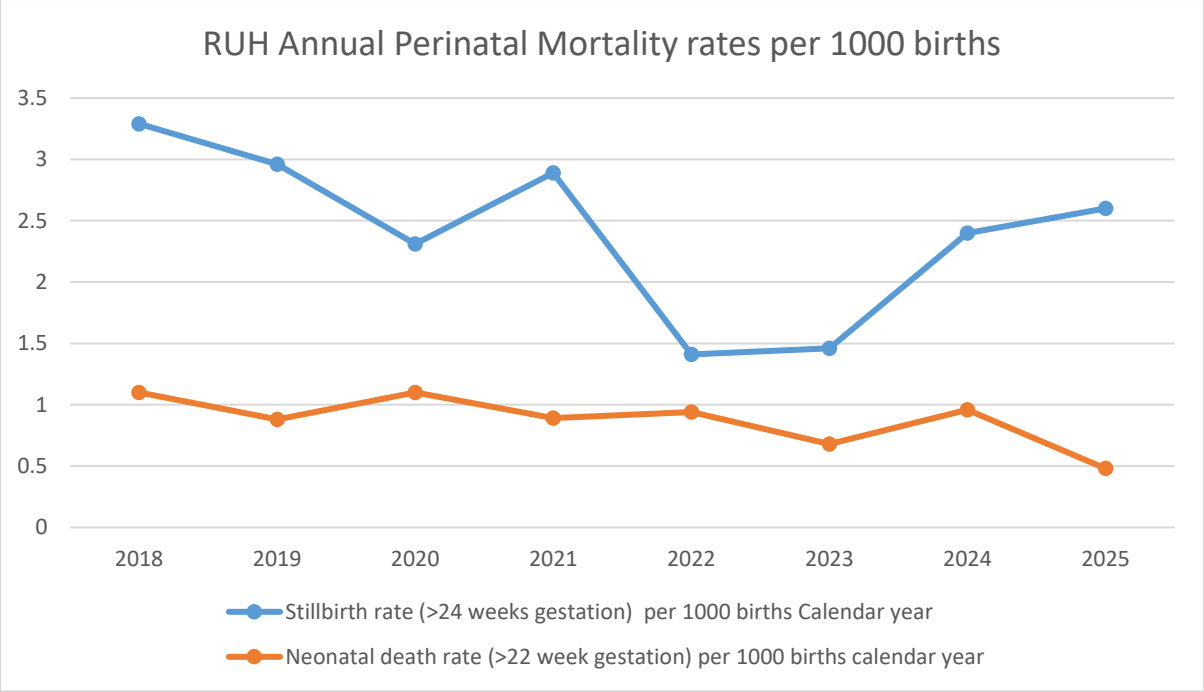


Figure 4: RUH annual Perinatal mortality rate per 1000 births by year

6.1 PERINATAL MORTALITY REVIEW TOOL (PMRT)

There was one antenatal stillbirth eligible for PMRT reporting during Q1 (Table 2).

2025/26 (excluding terminations for abnormalities)	Q1 26/27	Annual total 26/27 (fiscal)	Annual total 2026 (calendar year)
Stillbirths (>37 weeks)	0	0	0
Stillbirths(>24weeks-36+6weeks)	1	1	5
Late miscarriage (22+weeks-23+6weeks)	0	0	2
Neonatal death at the RUH	0	0	0
Neonatal death elsewhere following birth at the RUH	0	0	0
Total	**1**	**1**	**7**

Table 9: Perinatal Mortality summary by number of cases, Quarter 1 2026/27

PMRT reporting is a requirement of Safety Action C of the NHS Resolution Maternity Incentive Scheme Year 8. All eligible perinatal mortality cases are subject to rapid review, where possible within one week, to identify immediate safety concerns or learning under PSIRF. Cases are then reviewed through the monthly multidisciplinary PMRT process, with family perspectives sought and incorporated alongside clinical review. Any concerns or learning identified are escalated through patient safety and governance routes to support service improvement.

Table 4 identifies the service's current PMRT process performance metrics against MIS standards, demonstrating continued compliance, reflective of well embedded and embraced processes in place to deliver the PMRT across perinatal services.

PMRT PROCESS MEASURES

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Q1 26/27	Annual 26/27	MIS Y8 Standard
Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within seven working days	**100%**	**100%**	**100%**
An external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.	**100%**	**100%**	**60%**
All parents will have been informed that a review of their baby's death is taking place and Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have	**100%**	**100%**	**100%**
Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024. (See technical notes 19 to 20)	**100%**	**100%**	**100%**
Parents are offered a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.	100%	100%	**100%**

Table 10: PMRT Process Measures Quarter 1 26/27

Families remain central to the PMRT process. All families are offered a single point of contact, regular updates, the opportunity to share questions or reflections, and an individualised approach to receiving review findings, including the option of an MDT meeting. Where pathology or investigation results are delayed, families may choose whether to receive a draft report reflecting findings to date or await the final PMRT outcome. To protect confidentiality and respect family choice, provisional care gradings will no longer be reported in this public Board report; final gradings will be included once completed and shared with families in line with their wishes.

National perinatal pathology workforce constraints continue to delay postmortem results following stillbirths and neonatal deaths, affecting PMRT timeliness, family communication and the service's ability to identify learning promptly. Local safeguards remain in place to support families and maintain communication; however, this remains a live risk on the maternity and neonatal risk register (Risk 3251). As of June 2026, 12 families are impacted by current delays.

6.2 Q1 2026/27 PMRT INITIAL REVIEW LEARNING OPPORTUNITIES

During Q1, PMRT learning identified a further example of the work-system challenges described under Risk 3308, relating to fragmented fetal growth data across current ultrasound and fetal growth charting systems. This was not

considered contributory to the outcome in this case, but has been incorporated into the Risk 3308 action plan.

6.3 PMRT LEARNING ALIGNED TO SAVING BABIES LIVES CARE BUNDLE 3.2

The Saving Babies Lives Care Bundle v3.2 (SBL) provides evidence-based best practice standards to achieve the national ambition to halve the rate of perinatal mortality by 2025 through innovation and quality improvement in key areas in maternity care. As part of the three-year delivery plan, providers are responsible for fully implementing all interventions of the care bundle. All PMRT cases, inclusive of family feedback of care, are benchmarked against each element of SBL to further focus potential areas of local system and process improvement requirements (Table 4)

April	May	June
Number of perinatal mortality cases where smoking in pregnancy was a relevant issue (Element 1)		
0	0	0
Number of perinatal mortality cases where fetal growth: risk assessment, surveillance or management was an issue (Element 2)		
0	1	0
Number of perinatal mortality cases where raising awareness of reduced fetal movements (RFM) was an issue (Element 3)		
0	0	0
Number of perinatal mortality cases where effective fetal monitoring during labour was an issue (Element 4)		
0	0	0
Number of perinatal mortality cases where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was relevant issue (Element 5)		
0	0	0
Number of perinatal mortality cases where the management of diabetes was an issue (Element 6)		
0	0	0

Table 11: Q1 2026/27 PMRT care concerns triangulated against SBL elements

During Q1 one point of care provision identified though PMRT which presented opportunities for learning under the SBL domains of fetal growth risk assessment, surveillance or management . This was not identified as contributory to the outcome for the mother or baby See Section 5.2.

6.4 Q4 2025/26 LEARNING FROM COMPLETED PMRT REVIEWS

Two PMRT reports were completed in Q4.

No care gradings of C or D were attributed to care provision. All identified actions will be monitored through specialty governance for progression to completion.

PMRT	Grading of care key
Grade A	No issues with care identified that would have impacted on the outcome
Grade B	Care issues which would have made no difference to the outcome
Grade C	Care issues which may have made a difference to the outcome
Grade D	Care issues which were likely to have made a difference to the outcome

Table 12: PMRT grading of care key

7.0 TRUST CLAIMS SCORECARD – OBSTETRICS

The Trust's latest scorecard correlates open and closed claims managed by the Trust's legal team for care provided between April 2015 and March 2025. Obstetric-related claims currently represent around 17% of the total number of Trust claims, yet account for approximately 80% of the overall financial value. This reflects the high-value nature of obstetric claims rather than a high frequency of incidents.

For context, the NHS Resolution (NHSR) Annual Report and Accounts 2024/25 notes that obstetrics represents 11% of clinical claims by volume but 53% by value nationally. While the Trust's profile is above national averages, this pattern is broadly consistent with the complexity and severity associated with obstetric claims across the NHS.

This is further illustrated by the difference between injury types by volume and by financial value, where the most common clinical causes of claims do not correspond to the highest levels of financial damages. This demonstrates that a small number of high-severity cases drive the majority of costs, rather than a wide-spread pattern of incident frequency.

Top 5 injuries by volume for Obstetrics

					% of Specialty	
	Injury	Volume	Value	Ave Claim Value	Volume	Value
1	Unnecessary Pain	9	1,046,326	116,258	18%	1%
2	Psychiatric/Psychological Dmge	9	779,581	86,620	18%	1%
3	Adtnl/unnecessary Operation(s)	6	427,163	71,194	12%	0%
4	Stillborn	3	205,149	68,383	6%	0%
5	Fatality	3	504,775	168,258	6%	0%
Total Top 5 injuries by Volume for Obstetrics		**30**	**2,962,994**	**98,766**	**60%**	**2%**

Table 13. Top 5 injuries by volume for Obstetric legal claims April 2015-Mar 2025

Top 5 injuries by value for Obstetrics

					% of Specialty	
	Injury	Volume	Value	Ave Claim Value	Volume	Value
1	Cerebral Palsy	3	60,118,541	20,039,514	6%	47%
2	Brain Damage	3	44,780,000	14,926,667	6%	35%
3	Hypoxia	2	12,919,089	6,459,544	4%	10%
4	Meningitis	1	2,975,306	2,975,306	2%	2%
5	Erb's Palsy	2	2,215,103	1,107,552	4%	2%
Total Top 5 injuries by Volume for Obstetrics		**11**	**123,008,039**	**11,182,549**	**22%**	**96%**

Table 14. Top 5 injuries by value for Obstetric legal claims April 2015-Mar 2025

Claims intelligence is included within the wider thematic assessment to support identification

of common trends and improvement priorities.

8.0 QUARTER 1 THEMATIC INSIGHT ANALYSIS

Quarter 1 insights were reviewed collectively to identify common themes requiring immediate improvement action and to inform the service's annual safety priorities within the Perinatal Culture Improvement Plan (PCIP).

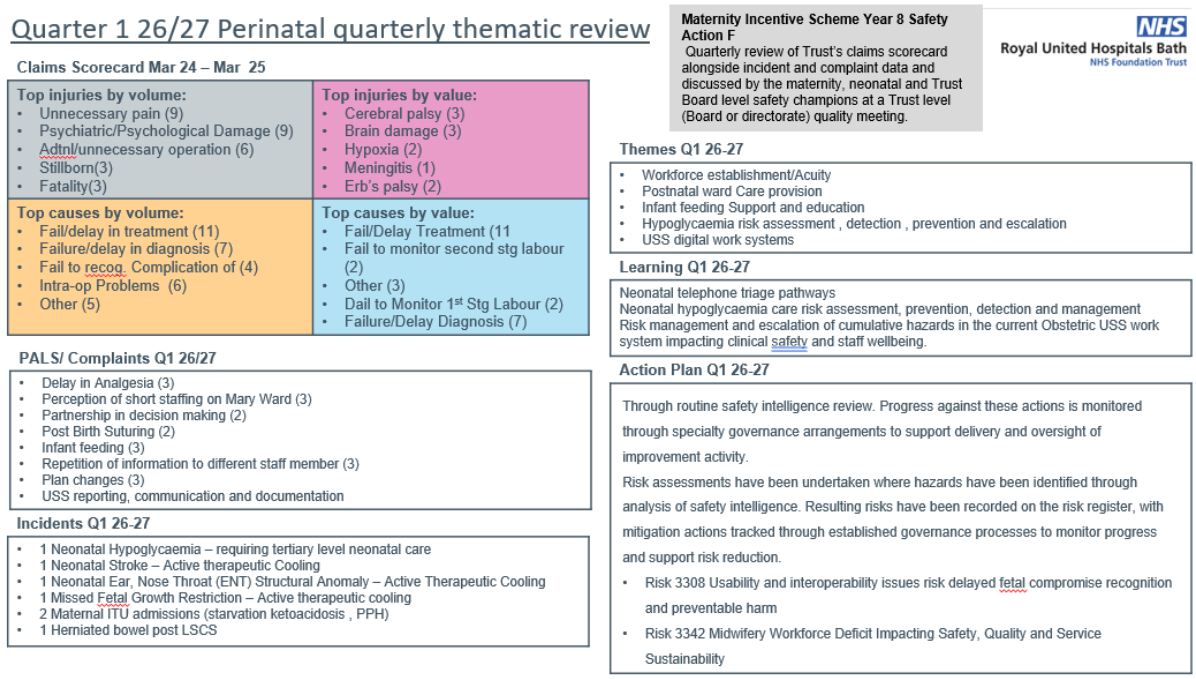


Figure 5 : NHS-R Quarterly Thematic analysis template for Q1 26/27

8.0 Insight to Risk Register

Three new risks were added in Q1. All risks and emerging risks are monitored through Maternity and Neonatal Specialty Governance.

Risk No	Domain of Risk	The Risk	
3306	Patient Safety and Quality	There is a risk that the safety of vulnerable neonates will be comprised due to gaps in supervision provision by Children's Social Care.	6
3307	Patient Safety and Quality	There is a risk that infants will come to harm following a frenulotomy due to gaps in safe service delivery factors.	8
3342	Patient Safety and Quality	Midwifery Workforce Deficit Impacting Safety, Quality and Service Sustainability	16

Table 15. New risk for the Maternity and Neonatal risk register Q1 2026/27

8.1 New High Risks

Risk 3342- Midwifery Workforce Deficit Impacting Safety, Quality and Service Sustainability

The 2026 Birthrate Plus reassessment identified a workforce deficit of 13.12 WTE clinical staff and 8.61 WTE specialist and leadership roles, creating ongoing capacity pressures across maternity services. A phased Perinatal Workforce Risk Mitigation Programme is in place, with approval sought for 15.12 WTE additional posts, including clinical, leadership and patient safety roles. Recruitment planning is underway to enable rapid deployment following approval. Interim mitigation is being provided through bank staffing, workforce reconfiguration and skill mix review; however, these measures remain partial until recurrent establishment funding is secured and substantive recruitment is achieved. Additional transformation work includes redistribution of workforce into acute services and integration of Transitional Care within the maternity workforce model.

The risk will remain elevated until staffing levels are aligned with the validated Birthrate Plus requirement. See Appendix 1.

8.2 Q1 CLOSED RISKS

During Q1 one risk was closed, following mitigating actions taken reducing the risk score to below a the Trust tolerance threshold. Risk 3307.

Risk 3101 evolved during Q1 following review of service audit findings, which identified a shift in the principal risk exposure. The risk has moved from a workforce establishment concern, specifically Senior House Officer staffing levels within Triage not being fully aligned to RCOG Good Practice recommendations, to a realised operational risk relating to the availability of senior obstetric decision-makers to meet the response times required within the Birmingham Symptom Specific Obstetric Triage System (BSOTS). This reflects a transition from a theoretical workforce compliance gap to an evidenced service delivery risk with the potential to impact timely clinical assessment and decision-making. Full details are provided in Appendix 4.

Risk is monitored by the Quality and patient safety lead midwife in conjunction with the service quadrumvirate. All risks rating >12 are reported monthly via Speciality and Divisional governance with Trust Management Executive, oversight to ensure appropriate actions are taken in accordance with the Trust risk framework.

Q1 Risk Register Rating >12 updates

Risk No	Domain of Risk	The Risk	Q4 Score	Q4 Update on Controls Mitigations and Next Steps	Q1 Score
3308	Patient Safety and Quality	There is a risk that usability and interoperability issues across obstetric ultrasound and fetal growth documentation systems lead to incomplete or inaccurate assessment of fetal	12	New Audit information provided context to the frequency/scale of identified incidents therefore likelihood increased	16

		wellbeing, delayed recognition of fetal compromise, and inappropriate care planning;			
3267	Patient Safety and Quality	There is a risk that the Trust is unable to provide timely, robust, and reproducible assurance on maternity safety, performance, and equity.	15	Development of inequalities dashboard , ongoing work to develop drill down reports and breakdown of key clinical process and safety outcome metrics supporting identification of anomalies or disparities.	12
3182	Patient Safety and Quality	There is a risk to neonatal care provision due to service cot capacity pressures impacted by reduced cot capacity within level three tertiary neonatal units	12	Following workforce countermeasures and capacity safeguards the likelihood of the impact has seen a reduction and therefore the overall risk scoring has reduced to 12- however extended works in neighbouring providers will see cot closures extend into Q2 of 26/27	12
3013	Patient Safety & Quality	There is a risk that USS service, provided jointly by maternity and radiology, does not have enough capacity	12	Q1 SBL Element 4 audits have featured a manual small sample cohort to provide assurance after a recognised potential for data discrepancies within the denominator of tehe compliance measurement within the Badger report – the manual audit after excluding women who would not have been applicable (such as IOL within 24 hours, birth within 24 hrs) compliance is recorded at 90%	9
2785	Patient Safety & Quality	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards	12	Work ongoing to review neonatal workforce requirements encompassing neonatal medical nursing, AHP and pharmacy requirements aligned to best practice recommendations. Benchmarking is in progress with anticipated collective risk assessment see appendix 1.	12
3251	Patient Safety and Quality	There is a risk to quality of care and compounded harm to bereaved families due to perinatal pathology	12	Safeguards in place to minimise the emotional and psychological impact on families with ongoing collaboration with the regional	12

		workforce gaps		chief midwife to find mitigations against delays.	

Table 16. Maternity and Neonatal Risk Register rating >12

Moderate and low risks are monitored as per Trust Risk Management policy.

9.0 LOCAL 'INSIGHTS' TO DRIVE IMPROVEMENT: COLLATION, STRUCTURE, AND SAFETY PRIORITIES- THE 'PERINATAL CULTURE IMPROVEMENT PLAN' (PCIP).

Monthly insight review enables timely identification and escalation of themes requiring action through PQSOM, Board-level Safety Champions and the Trust Quality and Safety Group. A structured quarterly assessment then draws together emerging and sustained themes, immediate actions and targeted quality improvement activity.

Annual review of cumulative insights informs the PCIP and supports a targeted focus on areas with the greatest potential to improve outcomes and experience for families and staff. See Appendix 2.

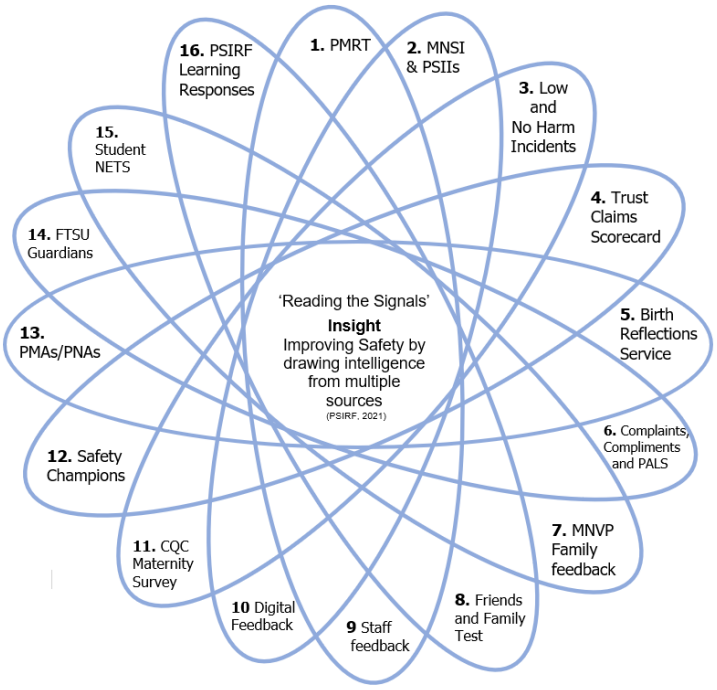


Figure 6. Sources of service 'Insight' analysed monthly via the Maternity and Neonatal Insights Forum

The 2026/27 PCIP has identified three key priorities that support both patient safety and staff wellbeing outcomes. These priorities are aligned with human factors principles and recognise the intrinsic link between workforce culture, staff wellbeing, and the delivery of safe, effective, and high-quality care. By focusing on these areas, the programme aims to strengthen both the conditions in which staff work and the systems that underpin safe service provision for women and families.

Workforce Priorities:

- Workforce Capacity and Sustainable Working
- Wellbeing, Safety and Support.
- Communication, Engagement and Staff Voice



Figure 7. Workforce Safety Intelligence Analysis for PCIP 26/27

Service safety and quality priorities:

- Postnatal Care Pathway
- Infant Feeding Service Provision

- Pelvic Health (including Bladder care, Catheter care, Perineal care)

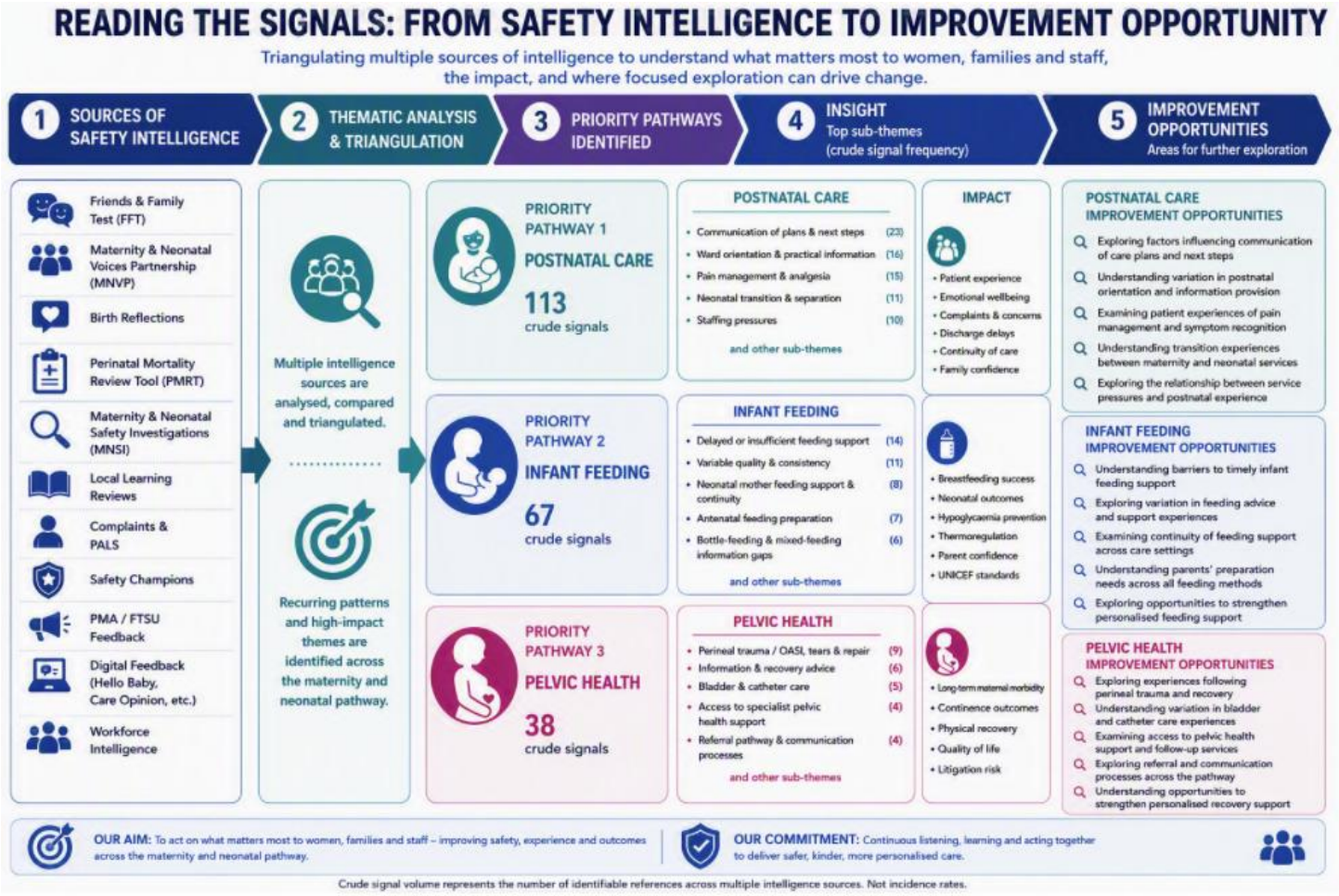


Figure 8. Workforce Safety Intelligence Analysis for PCIP 26/27

10.0 NATIONAL QUALITY IMPROVEMENT INITIATIVES

10.1 NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q1 2026/27

The Clinical Negligence Scheme for Trusts (CNST) released the Maternity (and perinatal)

Incentive Scheme Year 8 on 31st of March 2026. Updates on progress and monitoring towards achievement of the 6 Safety Actions outlined is completed and shared within Maternity and Neonatal Speciality Governance meeting and Board Level Safety Champions monthly.

Overview of progress on MIS year 8 safety action requirements

NHS Resolution

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	0	1	4	2	0	7
B	0	1	3	1	0	5
C	0	0	5	1	0	6
D	0	0	2	0	0	2
E	0	0	2	0	1	3
F	0	0	3	1	0	4
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	0	2	19	5	1	

Table 18: Q1 NHSE MIS year 8 National implementation audit tool Board summary 2026/27

Although the self-assessment tool identifies two areas of non-compliance as at June 2026, this accurately reflects the current position of the service and provides a clear focus for improvement activity. Action plans are in place to address the identified gaps and progress compliance against the relevant standards. At this stage, the service does not anticipate any unmitigable challenges and remains confident that all Maternity Incentive Scheme (MIS) standards will be achieved by March 2027.

Current areas of Focus and progression towards compliance :

- Achieve and sustain 90% compliance with the two-point training checkpoint requirement across all staff groups. *(Safety Action B)*
- Strengthen cross-boundary and system-wide partnership working to support implementation of the Maternal Care Bundle. *(Safety Action E)*
- Review and enhance Board reporting arrangements to strengthen oversight, assurance, and monitoring of programme delivery. *(Safety Action F)*
- Align workforce establishments with Birthrate Plus recommendations and Risk 3342. *(Safety Action A)*
- Undertake elective caesarean birth demand and capacity mapping to support service planning and workforce optimisation. *(Safety Action A)*
- Develop sustainable system arrangements to support a robust offer of postnatal debrief and incident feedback meetings, including dedicated and protected staff time. Current provision is delivered through Consultant Supporting Professional Activities (SPA) time. *(Safety Action D))*

10.2 SAFETY ACTION E - SAVING BABIES LIVES CARE BUNDLE V3.2

The maternity service continues to demonstrate strong overall compliance with the requirements of Saving Babies' Lives Care Bundle Version 3.2 (SBLCBv3.2), with self-assessment indicating 96% compliance across all six care bundle elements. The service

reports full implementation of four of the six elements, with Elements 1 (Smoking in Pregnancy) and 2 (Fetal Growth Restriction) currently assessed as partially implemented.

The areas of partial compliance are concentrated within Element 2: Fetal Growth Restriction (FGR) and Element 4: Fetal Monitoring in Labour. Whilst these findings indicate a high level of implementation, they also highlight specific opportunities for improvement in surveillance pathways, documentation processes, and assurance arrangements associated with fetal wellbeing monitoring.

In line with the governance expectations of SBLCBv3.2, the service has maintained active oversight of compliance through audit, performance review, and maternity governance structures. Recent audit findings have identified three principal challenges impacting full compliance within Element 2:

- Umbilical Artery Doppler (UAD) compliance.
- Rates of declined or non-attended UAD appointments.
- Consistent utilisation and auditability of the BadgerNet FGR/SGA assessment and referral tool for women requiring UAD surveillance.

Recognising the importance of fetal growth surveillance in reducing perinatal morbidity and mortality, the service has developed a targeted improvement plan to address these areas. Actions underway include implementation of routine UAD assessment pathways, exploration of enhanced communication processes with women regarding UAD appointments, review of the functionality and auditability of the BadgerNet FGR/SGA referral tool, and continuation of manual audit processes to ensure reported compliance accurately reflects care delivered in practice. These actions are supported by defined executive and clinical ownership and are monitored through established governance routes.
Improvement actions for Element 2 are aligned with the wider digital interoperability controls and action plan described under Risk 3308.

The service remains assured that the current gaps do not represent systemic failure to deliver SBLCBv3.2 standards; rather, they reflect opportunities to strengthen reliability, documentation, and auditable evidence of compliance. Improvement actions have been incorporated into the maternity quality and safety work programme and will continue to be monitored through divisional and Trust governance processes.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	90%	Fully implemented	100%
Element 2	Fetal growth restriction	Partially implemented	90%	Partially implemented	95%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	80%
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	88%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Partially implemented	96%	Partially implemented	93%

Table 19. RUH Maternity position for implementation of Saving Babies' Lives Care Bundle v3.2 Q1 2026/27

Sustained high compliance with the Saving Babies' Lives Care Bundle (96%) indicates the

service is on track with national safety priorities, with targeted work in place to address remaining gaps

10.3 SAFETY ACTION E - MATERNAL CARE BUNDLE

The maternity service continues to progress implementation of the NHS England Maternal Care Bundle (MCB), with the programme structured to achieve full delivery of all bundle elements by March 2027. Current self-assessment indicates that overall implementation stands at 29%, reflecting the early stage of the implementation programme and the significant system-wide changes required to achieve full compliance across all five bundle elements.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (Trust Board Validated)	% of Interventions Fully Implemented (Trust Board Validated)
Element 1	Venous thromboembolism (VTE)	Not implemented	0%		0%
Element 2	Pre-hospital and acute care	Not implemented	0%		0%
Element 3	Epilepsy in pregnancy	Fully implemented	100%		0%
Element 4	Maternal mental health	Not implemented	0%		0%
Element 5	Obstetric haemorrhage	Partially implemented	67%		0%
All Elements	TOTAL	Partially implemented	29%		0%

Table 20. RUH Maternity position for implementation of the Maternal Care Bundle Q1 2026/27

At the time of reporting, Element 3 (Epilepsy in Pregnancy) is assessed as fully implemented, whilst Element 5 (Obstetric Haemorrhage) is partially implemented. Elements 1 (Venous Thromboembolism), 2 (Pre-hospital and Acute Care) and 4 (Maternal Mental Health) remain in development and are currently assessed as not implemented. This position reflects the maturity of the respective workstreams rather than an inability to deliver the required standards, with implementation plans and executive oversight now established across all elements.

The Maternal Care Bundle requires a significant degree of system-wide collaboration beyond the maternity service itself, involving Integrated Care Board (ICB) partners, tertiary providers, digital suppliers and wider Trust functions. Consistent with the governance expectations of NHS England, the service has undertaken a gap analysis against each care bundle element and identified a number of key dependencies that may influence the pace of implementation. These include:

- Digital system development and supplier updates required to support new pathways and data collection.
- ICB partnership arrangements to support implementation of the Venous Thromboembolism (VTE) pathway.

- Required updates to Severe Maternal Morbidity and Mortality Network (SWMMN) guidance and associated local standards.
- Alignment of referral pathways with tertiary providers to ensure compliance with Maternal Care Bundle requirements.
- Further digitalisation of Modified Early Warning Score (MEWS) processes to improve reliability and auditability of maternal deterioration surveillance.

Recognising these challenges, the service has established a programme of targeted actions to support delivery. Work is underway with the Trust-wide thrombosis group and thrombosis lead to facilitate implementation of the VTE element. Change requests have been submitted to support revised Perinatal Mental Health screening requirements, whilst ongoing engagement with digital providers and NHS England continues to ensure local systems remain aligned with emerging national specifications. In addition, a multidisciplinary Post-Partum Haemorrhage (PPH) forum and associated audit programme have commenced to strengthen implementation of the obstetric haemorrhage element.
The service has also taken a risk-based approach to implementation where infrastructure limitations currently present a significant barrier to safe delivery. Following review of the requirements for Element 4: Maternal Mental Health, progression has been temporarily paused pending resolution of identified infrastructure and system constraints. Current arrangements would require substantial workarounds that could adversely affect the delivery of Perinatal Mental Health services and therefore do not represent a sustainable or safe long-term solution. Alternative approaches are being explored through local and national engagement to support implementation at a later stage.

10.4 OCKENDEN 2026 REPORT, BARONESS AMOS NATIONAL MATERNITY REVIEW, SIR JAMES MACKEY 10 POINT ACTION PLAN FOR MATERNITY AND PERINATAL SERVICES

During June 2026, three national maternity learning reports were published. The service has benchmarked its position and developed structures for ongoing monitoring. The baseline position against the Mackey 10-Point Plan is included in Appendix 4.

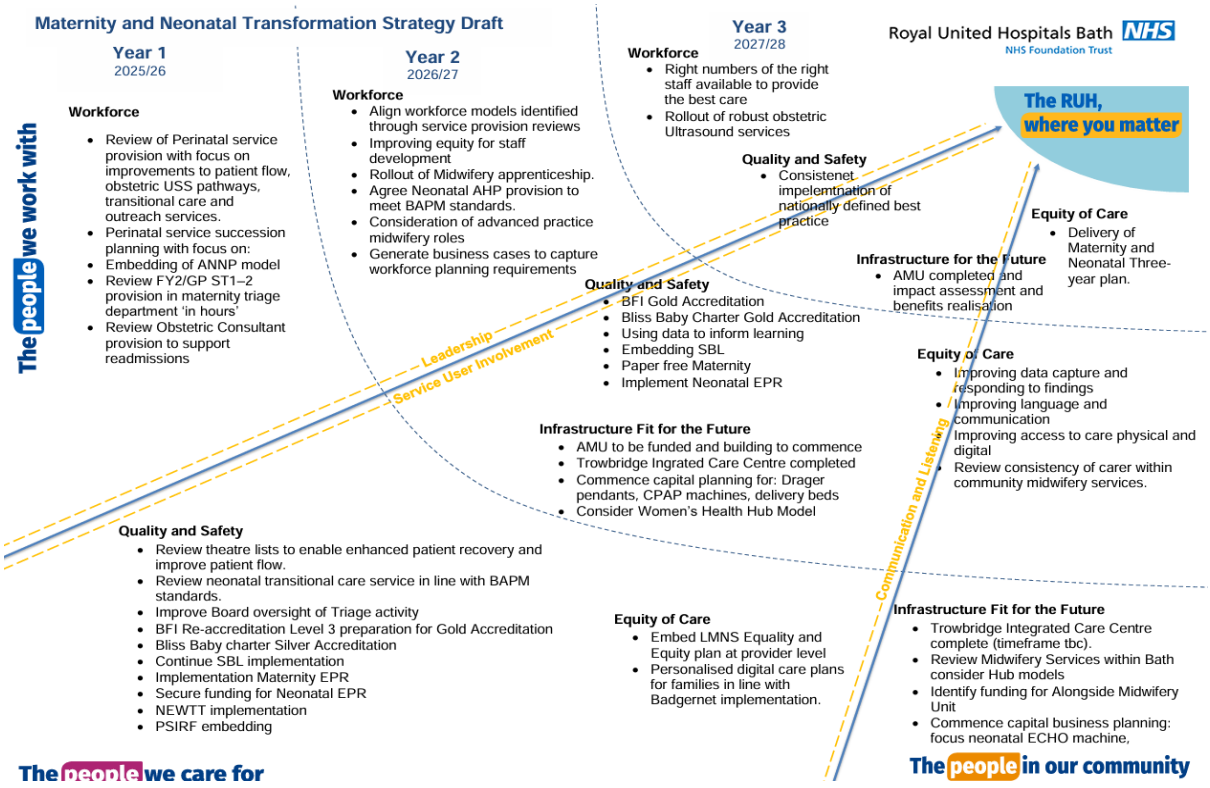
10.3 AVOIDING TERM ADMISSION INTO THE NEONATAL UNIT (ATAIN) & TRANSITIONAL CARE PERFORMANCE INDICATORS

The Avoiding Term Admissions into the Neonatal Unit initiative will continue to be supported through a structured programme of individual case reviews, with each case assessed to identify opportunities for learning, early intervention, and service improvement. Learning from these reviews will be collated and analysed collectively to enable thematic oversight, ensuring that recurrent patterns, system factors, and opportunities for focused improvement are clearly identified and acted upon.

Oversight and performance will be monitored through Specialty Governance Meetings, with outputs informing quarterly thematic assessment and annual improvement priorities within the Perinatal Culture Improvement Plan.

10.4. THREE YEAR MATERNITY AND NEONATAL SERVICES (3YDP)

The Three-Year Delivery Plan has reached the end of its programme period, having supported national improvement priorities and local alignment with the MatNeo Sunray Strategy. In light of the changing national context, including Ockenden, Amos, updated triage standards and the NHSE 10-Point Plan, routine 3YDP reporting will be stood down, with residual priorities monitored through existing governance routes and future reporting reframed once national expectations are confirmed.



10.5 EQUITY AND EQUALITY

The RUH Maternity Equity and Equality Group continues to provide oversight of the service's four strategic priorities: improving data quality and intelligence, enhancing language and communication, improving access to care, and promoting equity amongst staff. This work remains aligned with the BSW Equity and Equality Plan, the Core20PLUS5 Framework, and the Three-Year Delivery Plan. Progress is monitored through established governance arrangements to provide assurance regarding equity of access, experience, workforce opportunities, and outcomes across maternity services.

During Quarter 1, activity has focused on strengthening the foundations required to deliver equitable maternity care. Progress has been made in rebuilding the Maternity Health Inequalities Dashboard following the BadgerNet transition, with priority metrics identified and redevelopment work underway to restore reporting capability and improve oversight of inequalities.

Improving digital access remains a key priority, with RUH maternity services actively participating in the BSW-wide Healthy Together App programme. The app and accompanying

website provides women and families with timely access to trusted, evidence-based information and local support resources, supporting informed decision-making and engagement with care. For the service, it improves the consistency and accessibility of information, supports equity of access, and offers a scalable digital platform for communication and service-user engagement in a variety of languages.

A review of translation support options has now been completed, resulting in the procurement of Pocket Talk technology following a successful trial period. This will enhance real-time communication support for women, birthing people and families with language and communication needs.

The Global Majority Enhanced Care Working Group has been established and has commenced implementation of a targeted improvement programme to address inequalities experienced by Black and Ethnic Minority service users. Work to date has focused on reviewing the current enhanced care pathway, strengthening the collection and analysis of ethnicity and geographical data to better understand local population need, and exploring service-user experience through feedback mechanisms and thematic review of incidents and concerns. Alongside this, actions are underway to enhance staff cultural competence through anti-discrimination and cultural awareness initiatives, improve communication and engagement through co-produced staff and service-user communications, and establish Inclusion Champions across maternity settings to support equitable and inclusive care. This work will inform future service developments and targeted interventions aimed at reducing inequities in access, experience and outcomes.

The service has also continued to promote workforce equity through targeted staff development initiatives. During Quarter 1, two midwives participated in the NHS England Changing and Growing Together Programme and three midwives participated in the RUH Routes to Success Programme, supporting career development and progression opportunities for colleagues from Black and Ethnic Minority backgrounds.

Key priorities for Quarter 2 2026/27 include completion of the next phase of the Maternity Health Inequalities Dashboard redevelopment, implementation of Pocket Talk technology across maternity points of access, progression of the Healthy Together App programme, and further development of the Global Majority Enhanced Care model. This work will support the identification and reduction of inequalities and contribute to measurable improvements in access, experience, workforce equity and outcomes for women, babies and families.

10.6 HOMEBIRTH AND COMMUNITY BIRTH PROVISION

The Hummingbird Team continued to support safe community birth choices during Quarter 1 2026/27, providing planned homebirth services alongside out-of-hours support for Midwifery-Led Unit (MLU) activity. During the quarter, 46 women planned a homebirth, including 21 primiparous and 25 multiparous women. Eighteen homebirths were attended by the Hummingbird Team, with 17 babies born at home, representing a planned homebirth

completion rate of 37% of those planning a homebirth and a homebirth rate of 1.6% of all births. Community birth activity also included 13 births at Chippenham Birth Centre and 12 births at Frome Birth Centre, resulting in an overall community birth rate of 4.0% from a total maternity population of 1,083 births.

The service provided out-of-hours support to Midwifery-Led Units on 14 occasions during the quarter, helping to sustain community birth provision and maximise birth choice for women across the locality. This flexibility continues to support operational capacity across maternity services while enabling women to access community birth settings where clinically appropriate.

Outcomes during the quarter were positive, with five women requesting to birth in the community outside standard guidance. Following personalised assessment and care planning, all five women laboured and birthed within the community setting.

Transfer activity remained within expected levels, with six transfers recorded from planned homebirths and three transfers from MLU settings. Transfer indications included delay in labour progress, fetal concerns, neonatal concerns and requests for additional analgesia. Average ambulance response times were reported as 19 minutes for Category 1 transfers and 40 minutes for Category 2 transfers. Ongoing monitoring of transfer data continues to provide assurance regarding the safety and responsiveness of community birth services.

Five Born Before Arrival (BBA) births were recorded during the quarter, including three planned homebirths. Review identified that most BBAs were associated with rapid labour and were considered unavoidable in retrospect. One freebirth was recorded during the quarter. Detailed review of BBA cases has informed ongoing service learning relating to escalation, workforce availability and communication pathways.

Nineteen women changed their planned place of birth following reassessment of clinical risk, whilst one woman changed her place of birth due to staffing constraints. Five homebirths were unable to proceed as planned because of workforce or acuity pressures. These cases were reviewed through governance processes to identify learning opportunities and inform future workforce planning.

Service development activity during the quarter focused on strengthening governance, improving data quality and reviewing factors influencing community birth access and outcomes. Key areas of focus included transfer performance, BBA reviews, workforce resilience, support for women wishing to birth outside guidance, and continued monitoring of community birth activity. These measures support ongoing service evaluation, strengthen assurance regarding community birth provision and continue to inform families' decision-making about place of birth.

10.7 MATERNITY TRIAGE

The maternity triage service continues to be monitored through the Maternity Governance Framework and RUH Safety Champions, providing oversight of compliance with the CQC

Maternity Triage and NHS England Maternity Triage Standards, patient flow, responsiveness, and patient safety. Regular review of telephone triage performance, in-person triage activity, ongoing care standards, medical review timeliness, and audit findings provides assurance regarding the effectiveness and safety of the service. Progress against identified improvement actions is monitored through established governance arrangements and reported through the Maternity Governance structure.

During Quarter 1 2026/27, the service has continued to embed national maternity triage standards whilst progressing a number of improvement initiatives. Telephone triage demand remained stable, with over 2,000 calls managed each month and call abandonment rates remaining between 6-8%, below the locally agreed threshold of 10%. Audit findings demonstrated high compliance with core telephone triage standards, including confirmation of identity, documentation, and provision of advice in line with BSOTS guidance. Areas for further improvement were identified around standardisation of telephone assessments, neonatal triage questioning, and service-user feedback.

Performance against in-person triage standards demonstrated continued improvement. Compliance with initial midwifery assessment within 15 minutes increased from 75% in April to 80% in June, while compliance with the NICE standard of assessment within 30 minutes remained consistently above 90% throughout the quarter. Review of breaches identified no episodes of patient harm, and work has continued to improve awareness of timely triage assessment and escalation processes.

Performance against ongoing midwifery care standards remained strong, with 96% compliance achieved across Quarter 1. All longest waits were reviewed and no patient harm was identified. Compliance with ongoing medical review standards was 70%, with delays predominantly affecting women requiring urgent (Orange) medical review. Following the introduction of enhanced escalation and transfer processes in June, compliance for urgent medical reviews improved from 22% in April to 53% in June. Thirteen women requiring urgent review were transferred to the Birth Centre to facilitate more timely assessment.

Further achievements during the quarter included completion of the EPRR telephone outage procedure, commencement of NHS England maternity triage benchmarking, achievement of DAU and Maternity Triage Ward Bronze Accreditation, procurement of Pocket Talk translation technology, and preparation for launch of the Healthy Together App and website to support service users with access to information and self-management resources.

Priorities for Quarter 2 2026/27 include implementation of the Healthy Together App and website, introduction of Pocket Talk technology, development and implementation of standardised telephone triage and neonatal assessment scripts, and completion of a service-user survey to better understand caller experience and reasons for call abandonment. Continued focus will also be placed on improving compliance with initial triage assessment standards and reducing delays in urgent medical review through ongoing monitoring of escalation processes, workforce planning, and operational flow. Additional work will progress the review of telephone triage training, development opportunities for preceptorship midwives within triage, and consideration of recommendations arising from the BirthRate Plus review to

strengthen leadership presence within the triage service.

Overall, Quarter 1 demonstrates a sustained improvement trajectory within maternity triage, with strong performance against midwifery assessment standards, effective monitoring of safety indicators, and targeted actions in place to address identified delays in urgent medical review and further enhance service-user experience.

11.0 Recommendations

The Board of Directors is asked to discuss the report, note the areas of alert, and take assurance from the controls and improvement actions described.

12.0 Appendices

- Appendix 1 -Bi-Annual Staffing paper Dec-Jun 25/26
- Appendix 2 -Perinatal Culture Improvement Plan 26/27
- Appendix 3- Maternity Triage Audit report Q1 26/27
- Appendix 4 – RUH Perinatal Services Baseline Mackey 10 point Plan ICB submission report for July 2026.

BSW Hospitals Group Board

Agenda item	Item 4.3.3 Board Assurance Statement - key actions following the Fuller Enquiry
Report title	Board Assurance Statement - key actions following the Fuller Enquiry. Response to NHSE letter dated 26th June 2026.
Date of meeting	3rd September 2026
Sponsor	Luisa Goddard, Chief Nurse, Great Western Hospitals, NHS Foundation Trust Jason Lugg, Chief Nurse, Royal United Hospitals Bath, NHS Foundation Trust Angie Ansell, Interim Chief Nursing Officer, Sailsbury NHS Foundation Trust
Prepared by	
Approval Process: (where has this paper been reviewed and approved)	CEO and Chair sign-off prior to submission on 31st July 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 R8	Reducing avoidable harm

KEY MESSAGES

The Board is asked to receive assurance on the Group's response to the NHS England letter of 26 June 2026 and note the submission of the Board Assurance Statements (see appendices 1-3). 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 assessment identified several areas of good practice, including the establishment of strengthened mortuary governance arrangements, enhanced executive oversight, multidisciplinary involvement in mortuary governance, and ongoing compliance monitoring against Human Tissue Authority standards. Care Organisations have strengthened formal Mortuary Governance arrangements to provide clearer accountability across pathology, estates, safeguarding, bereavement and corporate services.

The review also identified opportunities to strengthen assurance further. These include completing a detailed gap analysis against applicable Fuller Inquiry recommendations, embedding enhanced governance arrangements, reviewing historical HTA-reportable incidents, strengthening audit processes, and completing remaining estates actions, including compliance with the NHS Premises Assurance Model (PAM). Time-bound action plans have been developed to address identified gaps and will be monitored through existing governance and assurance committees.

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.

RECOMMENDATION

The Group Board is asked to:

1. Note the BSW Hospitals Group Board Assurance Statements and actions to achieve full compliance
2. Delegate authority to each Care Organisations Quality and Safety Committee to monitor the action plans and provide updates to the Group board.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix A	GWH Hospitals NHS Foundation Trust Board Assurance Statement
Appendix B	Royal United Hospitals NHS Foundation Trust, Board Assurance Statement
Appendix C	Sailsbury NHS Foundation Trust, Board Assurance Statement

BSW Hospitals Group Board

Agenda item	4.2 Group Director of Infection Prevention and Control reports
Report title	Annual infection Prevention and Control Reports 2025/26
Date of meeting	3rd September 2026
Sponsor	Luisa Goddard, Chief Nurse, Great Western Hospitals, NHS Foundation Trust Jason Lugg, Chief Nurse, Royal United Hospitals Bath, NHS Foundation Trust Angie Ansell, Interim Chief Nursing Officer, Sailsbury NHS Foundation Trust
Prepared by	Connie Timmins, Associate Director of Nursing , Infection Prevention and Control, Great Western Hospitals, NHS Foundation Trust Lisa Hocking-, Deputy Director infection, Prevention and Control and Associate Chief Nurse, Royal United Hospitals Bath, NHS Foundation Trust Fiona McCarthy , Lead Nurse, Infection Prevention and Control, Sailsbury NHS Foundation Trust
Approval Process: (where has this paper been reviewed and approved)	GWH Annual Infection Control Report 2025/26, Quality and safety committee RUH Annual Infection control Report 2025/26, Quality and Safety Committee SFT , Director of infection Prevention and Control Annual Report 2025/26 , 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
BAF R8	Reducing avoidable harm

KEY MESSAGES

These three reports outline the BSW Hospitals Group Trust's performance relating to Infection Prevention and Control activities during the period between 1st April 2025 and 31st March 2026, this included but is not limited to the reportable data, outbreaks and collaborative working for infection, prevention and control as outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2022), the ten criteria outlined in the code are used by the Care Quality Commission (CQC) to judge a registered provider on how it complies with Cleanliness and Infection Prevention & Control requirements detailed in the legislation and also against the National Infection Prevention and Control Board Assurance Framework (2023) which support the compliance to the previously mentioned criterion.

Alert

Key risks, issues and Areas Requiring Attention

HCAI Performance

NB please see Appendix A for associated Data tables

- All three organisations continue to experience challenges in reducing healthcare (HCAI) associated bloodstream infections.
- The Hospitals Group continues to experience infection prevention and control risk, with several nationally monitored HCAI's remaining above threshold or regional benchmark in 2025/26, particularly MRSA, MSSA, *C. difficile*, *E. coli* and *Klebsiella*.
- Gram-negative bloodstream (GNBSI) infections remain a key concern, particularly those with a urinary source, those associated with catheter care, this is alongside contributory factors of hydration and antimicrobial exposure, as well as care pathway variation across the system which continues to drive risks across acute and community-facing pathways.
- Of the GNBSIs, E. coli bacteraemia remains the most consistent area of concern across the Group.
- C. difficile thresholds continue to be a concern across all three organisations.
- MRSA performance is deteriorating at GWH and remains a priority focus

Antimicrobial Resistance

- Increasing prevalence of Gram negative bloodstream infections and rising antimicrobial resistance remain significant clinical risks.
- Antimicrobial stewardship arrangements require continued strengthening, including consistent senior clinical leadership, prescribing governance, shortage management and alignment with national AMR priorities
- Growing CPE activity across the system, region and nationally, alongside the outbreaks identified within two of the Trusts, demonstrate ongoing vulnerability of acute healthcare settings to multi drug restraint organisms (MDRO's).

Workforce & Capacity

- IPC workforce pressures were identified at all three Trusts, notably at GWH and SFT.
- IPC team capacity and resilience remain a risk to sustained delivery of surveillance, outbreak response, audit, training, policy implementation and HCAI reduction priorities
- Reduced surveillance and audit capacity alongside competing operational priorities and growing demand on acute services, present ongoing delivery risks for infection Prevention and control.

Infrastructure

- Environmental and infrastructure risks remain across all three Trusts estates, including isolation capacity, water safety, ventilation, cleaning consistency, local decontamination assurance and ageing estate constraints, which is a particular risk in two of the Trusts.
- The Isolation capacity, patient flow pressures and ageing infrastructure continue to impact infection control risk and resilience.
- Water safety, ventilation and decontamination require sustained investment

Advise

Actions Taken, Improvement Activity and Strategic Response

Group-Level Key Actions Delivered in 2025/26

1. Reduction of Healthcare-Associated Infections

- Targeted programmes to reduce catheter associated infections and invasive device related bloodstream infections.
- Enhanced review of E. coli, Klebsiella, Pseudomonas, MRSA and C. difficile infections.
- Strengthened surveillance, Post Infection Review (PIR) processes and thematic reviews.

2. Outbreak Preparedness and Response

- Effective management of COVID-19, CPE and C. difficile incidents.
- Enhanced isolation, cohorting, environmental cleaning and patient screening processes.
- Improved preparedness for HCIDs and future infectious disease threats.

3. Workforce and Education

- IPC training programmes updated in line with national updates.
- Fit testing compliance improved.
- Staff education delivered on hand hygiene, PPE and outbreak management.
- Link practitioner and specialist training programmes maintained.

4. Antimicrobial Resistance and Stewardship

- Regular multidisciplinary antimicrobial ward rounds.
- Prescribing audits and guideline reviews.
- BSW wide collaborative working and policy alignment.
- Focus on reducing unnecessary antibiotic exposure.

5. Environmental and Infrastructure Improvements

- Investment in ventilation, water safety and decontamination systems.
- Enhanced cleaning and deep clean programmes implemented.
- Improved endoscope storage and decontamination arrangements.
- Ongoing Legionella and Pseudomonas control measures.

Strategic Priorities for 2026/27

- Accelerate reduction of Gram negative bloodstream infections through UTI and catheter programmes.
- Strengthen MRSA screening, decolonisation and invasive device pathways.
- Improve reliability of hand hygiene and IPC training compliance alongside strengthening essential standards of care.
- Continue Group wide antimicrobial stewardship and AMR initiatives.
- Enhance outbreak preparedness, winter planning and High Consequence Infectious Disease (HCID) readiness.
- Develop sustainable IPC workforce capacity and succession planning.

Assure

Evidence of compliance, effectiveness and assurance

The Board can take assurance that:

- Effective IPC governance structures are established across all organisations.
- Mandatory surveillance systems are in place and functioning.
- Significant outbreak events were managed appropriately with learning identified.
- Robust programmes exist for:
    - Antimicrobial stewardship.
    - HCAI surveillance and reduction.
    - Water safety.

- Ventilation management.
- Cleaning and decontamination.

IPC improvement plans are in place across all organisations with monthly oversight arrangements.

ACTIONS

Group Actions for 2026/27

Action	Lead Area
Consider the delivery of a group programme for reduction of UTI related bloodstream infections	IPC / Clinical Divisions
Review MRSA pathways and standardise screening/decolonisation processes across Group	IPC Leads
Consider the development of a Group improvement programme for invasive device management	IPC / Nursing
Strengthen antimicrobial stewardship collaboration across BSW system working with community and primary care partners	Pharmacy / Microbiology
Continue to share learning through the existing system IP&M collaborative for outbreaks and incidents, including but not limited to winter virus, MDRO's e.g. CPE	IPC Governance/ ICB
Review IPC workforce sustainability and succession planning	Chief Nurses / DIPC/ IPC Leads
Continue targeted investment in water, ventilation and decontamination infrastructure	Estates Leads
Improve assurance on hand hygiene, standards of care and mandatory IPC education compliance	IPC Leads/ Divisions / Education Teams

Conclusion

The Group has maintained robust infection prevention and control governance arrangements throughout 2025/26 and has demonstrated effective management of outbreaks, environmental risks and emerging infectious threats. Whilst assurance can be taken regarding governance, surveillance and improvement systems, the group recognises there are areas for improvement relating to some aspects of HCAI prevention such as the link to fundamentals of care.

The main priorities for 2026/27 are:

1. Reduction of Gram negative bloodstream infections.
2. Strengthening the delivery of the MRSA prevention pathways.
3. Improving reliability of invasive device care.

4. Ensuring sustainable IPC workforce capacity across the Group.

RECOMMENDATION

The Group Board is asked to:

1. Approve and note the three BSW Hospitals Group 2025/26 Director of Infection Prevention and Control Annual Report
2. Note the BSW Hospitals Groups continued compliance with the ten IPC criteria.
3. Endorse the improvement priorities identified for 2026/27.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix A	BSW Hospital group HCAI data 2025/26
Appendix B	GWH Hospitals NHS Foundation Trust Infection Prevention and Control Annual report 2025/26
Appendix C	Royal United Hospitals Foundation Trust, Infection Prevention and Control Annual Report 2025/26
Appendix D	Sailsbury Foundation Trust, Director of infection Prevention and Control Annual Report, 2025/26

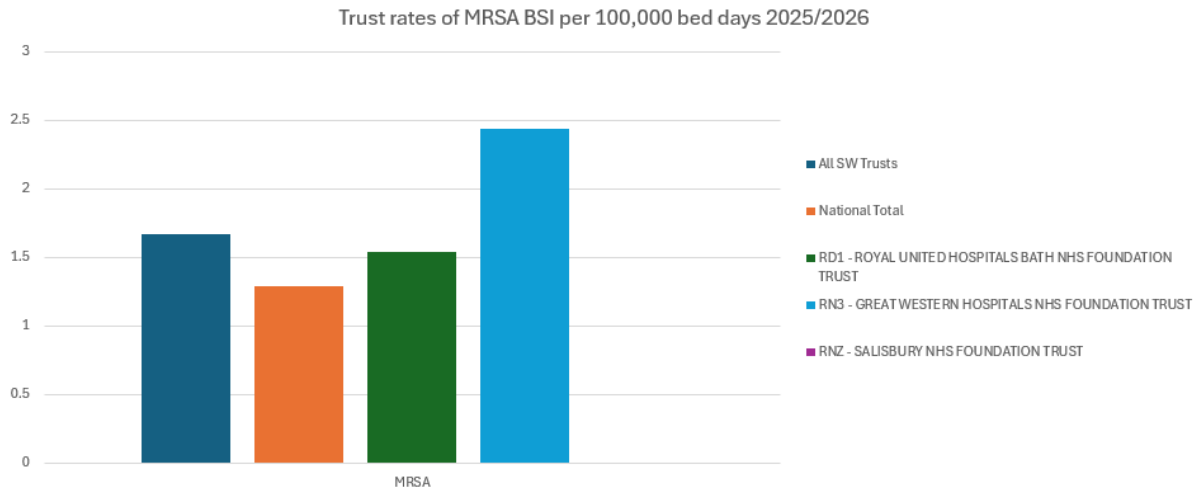
NHSE Thresholds 2025/26					
Organisation	**CDI**	**MRSA**	**E-Coli**	**Pseudomonas**	**Klebsiella**
BSW Integrated Care Board (ICB)	257	0	529	68	158
Great Western Hospital (GWH)	59	0	96	21	26
Royal United Hospital (RUH)	75	0	77	12	24
Salisbury Foundation Trust (SFT)	21	0	29	7	9

MRSA					
Organisation	**NHSE Threshold**	**2025/26 Cases**	**Variance from Threshold**	**Threshold Breached?**	**Change from 2024/25**
Total BSW	0	20	+20	YES	+10
SFT	0	0	0	NO	-1
GWH	0	5	+5	YES	+5
RUH	0	3	+3	YES	+3

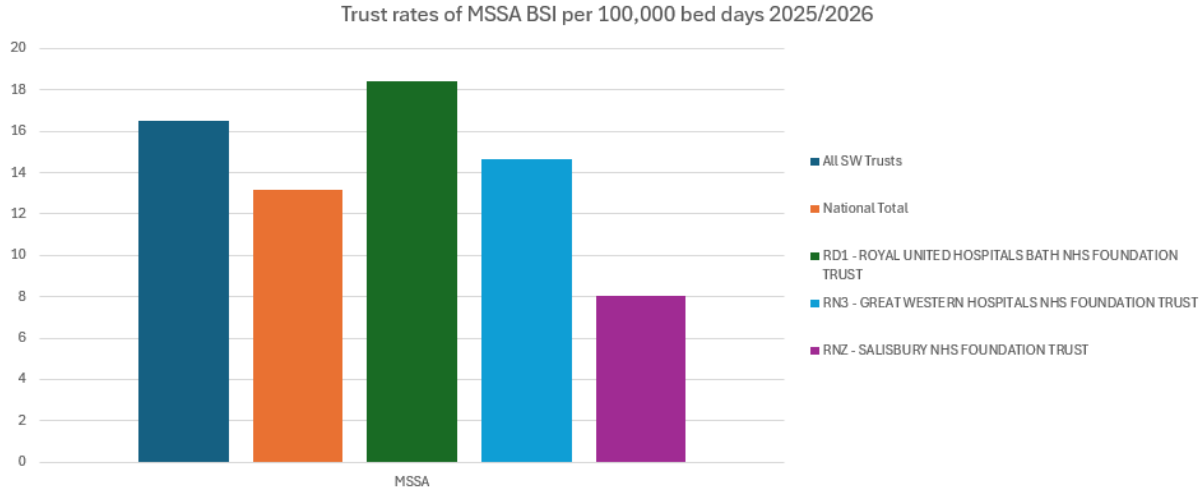
Table 3: NHSE MRSA BSI thresholds - ICB and Acute trust performance

Trust	Metric Value (count)	Metric Score	Segment
SFT	0.00	1.00	1
GWH	5.00	3.12	3
RUH	3.00	2.54	3

Table 4: Acute trust NOF and Segment allocation of MSRA BSI: April 2025 - March 2026



MSSA					
Organisation	**NHSE Threshold**	**2025/26 Cases**	**Variance from Threshold**	**Threshold Breached?**	**Change from 2024/25**
Total BSW	N/A	199	N/A	N/A	-3
SFT	N/A	13	N/A	N/A	-2
GWH	N/A	30	N/A	N/A	-2
RUH	N/A	35	N/A	N/A	+4

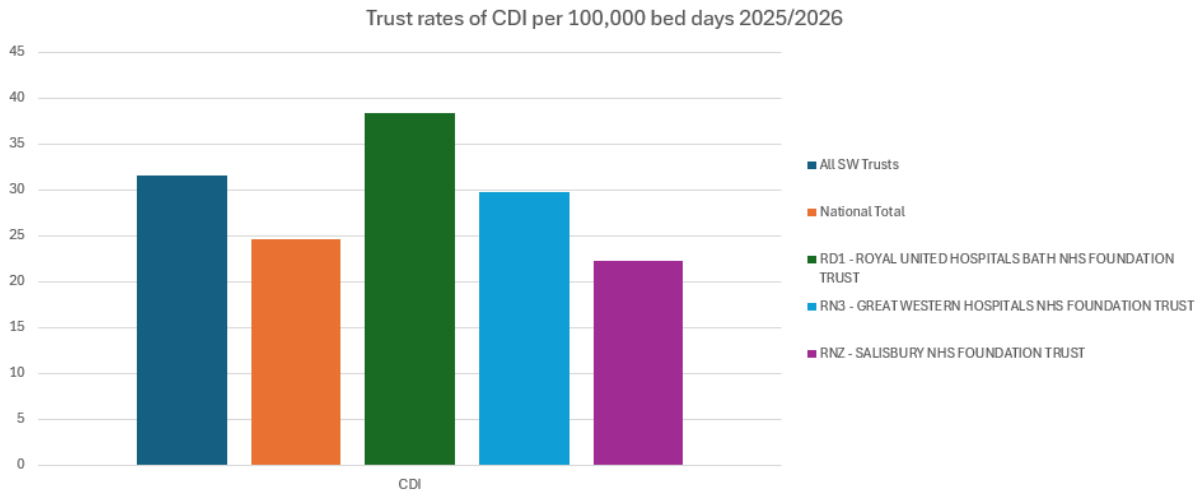


CDI					
Organisation	**NHSE Threshold**	**2025/26 Cases**	**Variance from Threshold**	**Threshold Breached?**	**Change from 2024/25**
Total BSW	257	263	+6	YES	-28
SFT	21	36	+15	YES	+4
GWH	59	61	+2	YES	0
RUH	75	75	0	NO	-28

Table 6: NHSE CDI thresholds - ICB and Acute trust performance

Trust	Rate	Metric Score	Segment
SFT	1.71	3.77	4
GWH	1.03	2.05	2
RUH	1.00	1.00	1

Table 7: Acute trust NOF and Segment allocation of CDI: April 2025 - March 2026



E.coli					
Organisation	**NHSE Threshold**	**2025/26 Cases**	**Variance from Threshold**	**Threshold Breached?**	**Change from 2024/25**
Total BSW	529	626	+97	YES	+49
SFT	29	43	+14	YES	+18
GWH	96	110	+14	YES	+20
RUH	77	104	+27	YES	+5

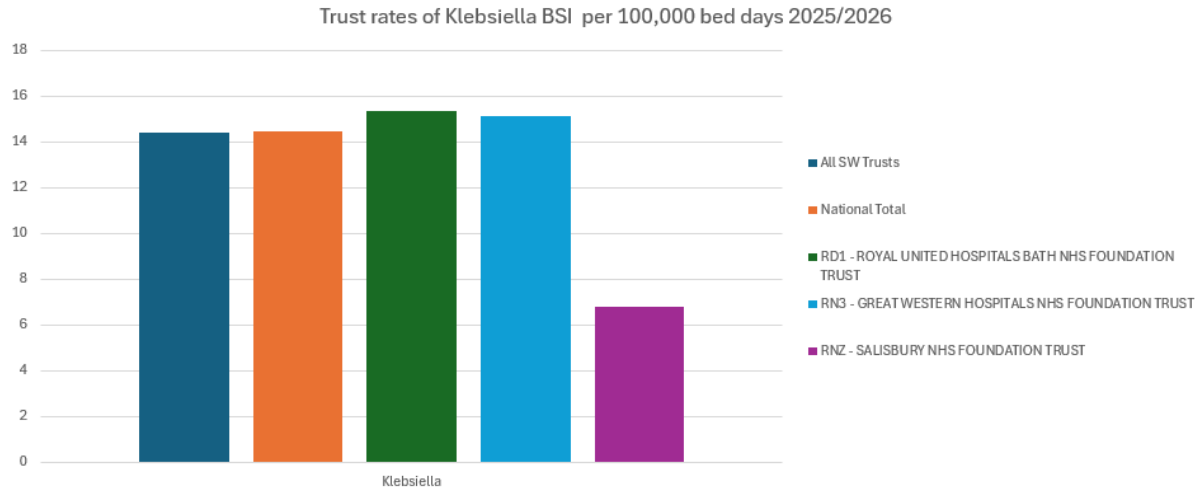
Table 8: NHSE E.Coli BSI thresholds - ICB and Acute trust performance

Trust	Rate	Metric Score	Segment
SFT	1.48	3.68	4
GWH	1.15	2.63	3
RUH	1.35	3.46	3

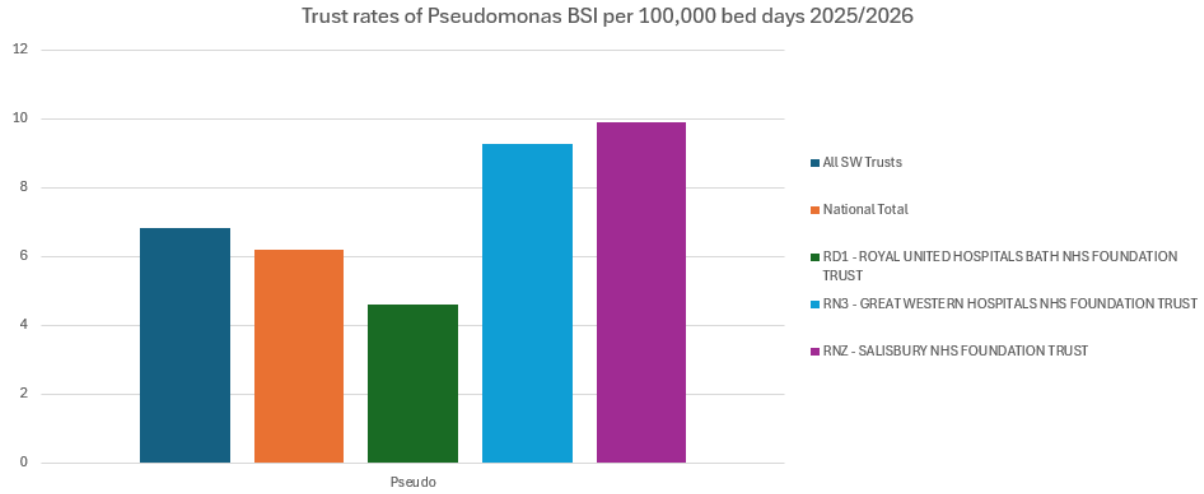
Table 9: Acute trust NOF and Segment allocation of E.coli BSI: April 2025 - March 2026



Klebsiella					
Organisation	**NHSE Threshold**	**2025/26 Cases**	**Variance from Threshold**	**Threshold Breached?**	**Change from 2024/25**
Total BSW	158	179	+21	YES	-1
SFT	9	11	+2	YES	-2
GWH	26	31	+5	YES	-4
RUH	25	30	+5	YES	+9



Pseudomonas					
Organisation	**NHSE Threshold**	**2025/26 Cases**	**Variance from Threshold**	**Threshold Breached?**	**Change from 2024/25**
Total BSW	68	76	+8	YES	+2
SFT	7	16	+8	YES	+3
GWH	21	19	-2	NO	0
RUH	12	9	-3	NO	-5



Appendix B - GWH Hospitals NHS Foundation Trust Infection Prevention and Control Annual report 2025/26

2025-26 IPC Annual Report v0.5.docx

Appendix C- Royal United Hospitals Bath Foundation Trust, Infection Prevention and Control Annual Report 2025/26

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Appendix D - Sailsbury Foundation Trust, Director of infection Prevention and Control Annual Report, 2025/26

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BSW Hospitals Group Board

Agenda item	
Report title	CPO Report July 2026 – Workforce Plan Assurance
Date of meeting	3 September 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

- Workforce plan: workforce is above plan at M03, with the Group 183 WTE above plan and c.£5.7m adverse pay variance. Bank WTE is 129 above plan and remains the principal temporary staffing pressure.
- CIP pay reduction delivery is behind trajectory in Q1, with £4.0m delivered against a £7.1m plan, resulting in £3.1m under-delivery.
- Actual pay spend run rate is broadly stable against an operational environment of increased demand and an operational plan that requires pay spend reduction.
- Temporary staffing costs remain above cap expenditure, with off-framework usage, notably in Medical and Dental, remaining an opportunity for cost reduction.
- The recruitment pipeline indicates variation and opportunity to reduce expenditure.
- Total Group WTE has reduced by 115 WTE from the March 2026 baseline to June 2026 actuals.
- Sickness absence remains variable across the Group. GWH remains below plan; RUH is above trajectory; and SFT has improved but remains above target.
- Staff Survey 2026 plan: COLTS w/c 10 July, including optional local questions and approach to drive completion to 70%.
- People Services Systems: procurement opportunity for further efficiencies, with work commenced with PA Consulting.
- BSW Leadership and Management offer is being developed, with proposal due to P&Cs in January 2027 and incorporating NHS Staff Standards.
- Bank Partners go-live has seen some teething issues, including delays on phone response and responsiveness to short-notice requests. Bank Partners are responding to resolve issues, with daily escalation calls in place and on-site presence at SFT from Monday 10 August.

RECOMMENDATION

The Group Boardis asked to:

1. Note the M03 workforce plan assurance position and the adverse workforce plan variance of 183 WTE and c.£5.7m adverse pay variance. Recovery trajectories for substantive and bank WTE, CIP delivery and temporary staffing are now required.
2. Support the Staff Survey plan to achieve 70% completion
3. Engage with the BSW Leadership and Management offer as it goes through the development cycle

APPENDICES

Appendix 1	M03 WOM

Section 1: Executive Summary

1.1 Alert | Advise | Assure

Alert

• Workforce delivery is above plan at M03, with the Group 183 WTE above plan and c.£5.7m adverse pay variance. Bank WTE is 129 above plan and remains the principal temporary staffing pressure.

• CIP delivery is behind trajectory in Q1, with £4.0m delivered against a £7.1m plan, resulting in £3.1m under-delivery.

• Temporary staffing risk remains material, particularly Medical & Dental agency expenditure and SFT agency usage.

Advise

• Bank Partners go live has experienced some initial teething problems. Daily calls are in place with issues raised being tracked and dealt with promptly. On site presence by Bank Partners at SFT on Monday to resolve concerns and build relationships.

- Staff Survey 2026 plan is being taken through COLTS to seek feedback on Care Organisation local questions and options to deliver 70% completion rate.
- People Services systems efficiency – project to work with PA Consulting to identify further efficiencies from the People Systems contracts.

Assure

- First P&Cs took place, a “Chairs Wash Up” has been set up to capture learning and drive assurance improvements as this new governance model embeds.

1.2 Key achievements and good news

- Bank Partners go-live supported by all three Care Organisations with all indicators RAG rated green at time of delivery.

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	WIT leads CN – Luisa Goddard DCNs Scoping meeting: JG/LG/Simon Fuller SFT Mtgs – 17-18 June GWH & RUH – dates tbc
GWW02	**Fairer Deal For Nurses** **Nursing Profiles – Starting with B5 Registered Nursing**	Taking our workforce with us	Working group in place, and initial benchmarking provided to regional and national teams – updates via P&C in Sept
GWW3	**MARS**	Financial sustainability	Launched 20th July, closes 28 August with central delivery of support to the scheme and Group-level monitoring of applications and benefits reporting
GWW04	**Group Staff Survey Working Group**	Taking our People with Us	Approach for 2026 Survey created, and working group are reviewing detailed action planning and standardised offering for the fieldwork period of the survey
GWW06	**Corporate Services Employer Model**	Becoming an effective Group, enabling shared corporate services	First workshop held 4 Aug 5 potential options being evaluated ranging from “Do nothing” to WOS

Section 4: Risk Escalation

Risk Title	Risk Description	Likelihood (L)	Impact (I)	Inherent Score (L+I)	Description of Controls in Place	Control Score (C)	Residual Score (L+I+C)	Review Date
Workforce plan delivery	At M03 the Group is 183 WTE above plan with c.£5.7m adverse pay variance. Temporary staffing remains above trajectory, with bank utilisation above plan and continuing risks to workforce cost control and delivery of workforce-related savings.	5	4	9	Controls described in the deck: CIP programme; establishment reviews; refreshed Group-level vacancy control process; Corporate Services Transformation Programme; substantive recruitment and retention plans; targeted interventions in hard-to-recruit clinical specialties.	3	12	Monthly through GEC / workforce oversight
Temporary staffing	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 ultimately impact patient care quality and safety. This is also on the Corporate Services Risk Register. Increased public concerns have been raised via MP, Governors and Council.	5	4	9	1. Daily meetings 2. Escalation tracker 3. Daily monitoring of shift fill	3	12	Daily
CST programme risk	Finance tracker: significant effort is required to build and monitor the finance tracker and forecasting tool, with variation in how CST CIP has been incorporated into operational plans.	5	5	10	SROs to take ownership for CST savings delivery. Finance support to the programme is constrained to one day a week.	4	14	Aug 2026 CST Steering Group
CST programme risk	Digital enablement: new models for corporate services require investment in digital enablers to achieve future service states; however, investment is not currently affordable.	5	5	10	Digital enabler task and finish group established. Request at DA 17/12/2025 to capture baseline of the digital ask for services. Digital Enablement paper to Group Board in September. PA Consulting to review designs.	3	13	Aug 2026 CST Steering Group

BSW HOSPITALS GROUP

NHS

Workforce Planning 2026-27

BSW Hospitals Group

M03 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 Unidentified £0.2M	**£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 £	2,140,666	2,442,666	2,521,666	3,529,445	3,574,445	3,492,445	4,185,334	4,380,334	4,405,334	4,584,334	4,683,334	4,741,334	*44,681,337*
		Actual £	**1,240,230**	**1,366,561**	**1,405,288**										*4,012,079*
		Variance £	-900,436	-1,076,105	-1,116,379										*-3,092,919*

CIP delivery improved further in June; however, Q1 savings totalled £4.0m against a £7.1m plan, resulting in a £3.1m under-delivery. This shows that momentum is building, but delivery remains behind the required trajectory.

Plans (see appendix) now show much stronger site-level granularity, with clearer phasing, ownership and quantification of opportunities. This should strengthen visibility of the savings profile and improve confidence in delivery over the next period.

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	66
		Actual WTE	**14,614**	**14,623**	**14,643**										
	Bank	Plan WTE	728	732	720	702	698	693	686	675	674	670	667	647	21
		Actual WTE	**831**	**798**	**849**										
	Agency	Plan WTE	68	66	65	57	56	55	51	48	47	40	36	29	29
		Actual WTE	**68**	**84**	**62**										
	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	115
		Actual WTE	**15,512**	**15,505**	**15,554**										
		Variance WTE	145	148	183										
		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**										
		Variance £	3,150,507	4,444,073	5,696,528										

At month 3 the Group sits 183 WTE above plan, representing an adverse pay variance of c.£5.7m. This is driven by substantive WTE 57 above plan and bank WTE 129 above plan, partially offset by agency WTE 3 below plan.

Bank utilisation remains above planned levels at 849 WTE against a plan of 720 WTE, although agency usage has reduced to 62 WTE against a plan of 65 WTE. This shows progress in reducing agency reliance, but overall temporary staffing remains above trajectory. Bank usage is high and is linked predominantly to sustained site pressures and prolonged time in critical incident.

Workforce controls remain in place, with continued focus through the CIP programme and establishment reviews to reduce reliance on temporary staffing and improve alignment to planned workforce trajectories. The refreshed Group-level vacancy control process continues to progress, with particular focus on Corporate areas through the Corporate Services Transformation Programme.

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**										
	Bank	Plan WTE	198	207	207	191	189	189	189	186	186	185	185	185	-14
		Actual WTE	**238**	**211**	**240**										
	Agency	Plan WTE	36	36	35	28	28	27	23	22	21	14	10	5	-31
		Actual WTE	**38**	**38**	**28**										
	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**										
		Variance WTE	8	2	17										
		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**										
		Variance £	-22,000	206,000	752,000										

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
SFT Total	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**										*1,800,000*
		Variance £	106,000	-49,000	-219,000										*-162,000*

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	**4,963**	**4,965**	**4,984**										
	Bank	Plan WTE	285	280	268	266	264	259	259	251	250	247	245	225	-60
		Actual WTE	**309**	**298**	**306**										
	Agency	Plan WTE	24	24	23	23	22	22	22	21	21	21	21	19	-5
		Actual WTE	**16**	**24**	**23**										
	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	**5,288**	**5,287**	**5,313**										
		Variance WTE	73	88	103										
		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**										
		Variance £	2,040,700	2,398,700	2,905,748										

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
GWH Total	Total	Plan £	1,145,666	1,145,666	1,145,666	1,909,445	1,909,445	1,909,445	2,291,334	2,291,334	2,291,334	2,291,334	2,291,334	2,291,334	*22,913,337*
		Actual £	**346,000**	**469,000**	**652,000**										*1,467,000*
		Variance £	-799,666	-676,666	-493,666										*-1,969,998*

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**										
	Bank	Plan WTE	245	245	245	245	245	245	238	238	238	238	237	237	-8
		Actual WTE	**284**	**289**	**303**										
	Agency	Plan WTE	7	7	7	6	6	6	6	5	5	5	5	5	-2
		Actual WTE	**13**	**21**	**12**										
	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	**5,788**	**5,786**	**5,797**										
		Variance WTE	64	58	64										
		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**										
		Variance £	1,131,807	1,839,373	2,038,780										

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
RUH Total	Total	Plan £	562,000	562,000	582,000	740,000	740,000	740,000	969,000	1,169,000	1,169,000	1,262,000	1,272,000	1,267,000	*11,034,000*
		Actual £	**355,230**	**211,561**	**178,288**										*745,079*
		Variance £	-206,770	-350,439	-403,713										*-960,921*

WTE Performance Against Actuals

Trust	Staff Type	Mar-26 Baseline	Jun-26 Actual	WTE Change M3 vs Mar-26
GWH	Substantive	5,042	4,984	-58
RUH	Substantive	5,484	5,482	-2
SFT	Substantive	4,182	4,176	-5
Group	**Substantive**	**14,708**	**14,643**	**-66**
GWH	Bank	355	306	-49
RUH	Bank	271	303	32
SFT	Bank	245	240	-4
Group	**Bank**	**870**	**849**	**-21**
GWH	Agency	25	23	-3
RUH	Agency	19	12	-7
SFT	Agency	47	28	-19
Group	**Agency**	**91**	**62**	**-29**
GWH	Total	5,422	5,313	-110
RUH	Total	5,773	5,797	24
SFT	Total	4,473	4,444	-29
Group	**Total**	**15,669**	**15,554**	**-115**

Trust	Staff Type	Staff Group	Mar-26 Baseline	Jun-26 Actual	WTE Change M3 vs Mar-26
Group	Total	Clinical Non-Medical	10,410	10,431	21
Group	Total	Clinical Medical	2,260	2,263	3
Group	Total	Non-Clinical	2,999	2,859	-139
Group	Total	Registered Nursing, Midwifery and Health Visiting Staff	4,934	4,909	-25
Group	Total	Registered/ Qualified Scientific, Therapeutic and Technical staff	1,750	1,752	2
Group	Total	Support to Clinical Staff	3,705	3,749	44
Group	Total	Total NHS Infrastructure support	2,999	2,859	-139
Group	Total	Medical and Dental	2,260	2,263	3
Group	Total	Any other Staff	20	20	0

Workforce levels show a net reduction of 115 WTE since the March baseline. Reductions have been achieved primarily through non-clinical workforce controls and lower agency utilisation, while clinical workforce numbers have remained largely stable. The most notable change is a 139 WTE reduction in non-clinical infrastructure support roles, alongside a 29 WTE reduction in agency staffing. While registered nursing staffing has reduced by 25 WTE, this has been partially offset by increases in clinical support roles. The impact of reductions in non-clinical capacity remain a concern in some areas, as they represent key elements of support to clinical provision. Nursing vacancies remain subject to active recruitment and retention plans

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	7,131	5,775	321	347	60	21	77%
RUH	Total	8,359	6,131	84	91	29	43	21%
SFT	Total	7,713	5,217	54	523	340	14	32%
Group	Administration & Estates	4,961	4,606	22	22	0	0	100%
	Healthcare Assistants & Other Support	6,038	4,809	0	0	0	0	-
	Healthcare Science	478	444	0	0	0	0	-
	Medical & Dental	3,815	1,981	437	349	309	22	5%
	Nursing, Midwifery & Health Visiting	6,792	4,627	0	405	41	46	79%
	Scientific, Therapeutic & Technical	1,119	656	0	185	79	10	52%
	Total	23,203	17,123	459	961	429	78	47%
Previous month		22,402	17,085	446	1,195	562	89	46%
Variance to previous month		+801	+38	+13	-234	-133	-11	+1%

Compliance with agency spend controls has improved during the month, with reductions in agency utilisation, above-cap expenditure and off-framework usage.

Bank staffing continues to meet the majority of temporary workforce demand. However, Medical & Dental staffing remains a significant challenge, with high levels of above-cap agency expenditure, and Salisbury continues to account for a substantial proportion of Group agency usage. Continued focus on substantive recruitment, bank fill rates and targeted interventions in hard-to-recruit clinical specialties will be required to sustain progress and reduce expenditure risk.

Job Planning and Rostering

Job Planning

Trust	Metric	Consultants	SAS Doctors
GWH	Headcount	278	115
	# with a signed off job plan	244	100
	% signed off	**87.8%**	**87.0%**
RUH	Headcount	321	63
	# with a signed off job plan	315	61
	% signed off	**98.1%**	**96.8%**
SFT	Headcount	251	52
	# with a signed off job plan	188	28
	% signed off	**74.9%**	**53.8%**
Group	Headcount	850	230
	# with a signed off job plan	747	189
	% signed off	**87.9%**	**82.2%**

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

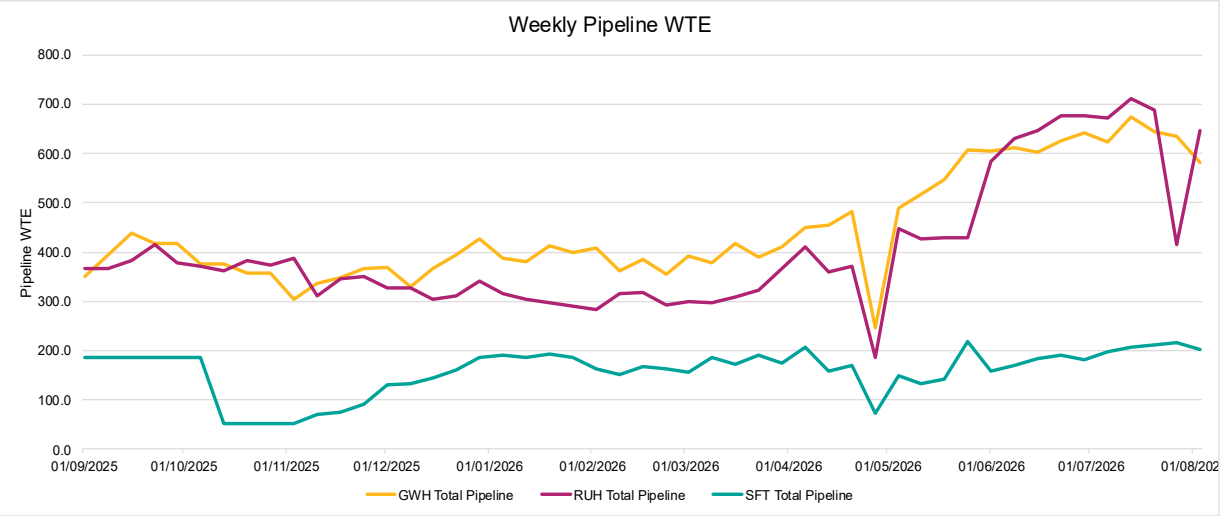
Trust	M01 Apr-26	M02 May-26	M03 Jun-26	M04 Jul-26	M05 Aug-26	M06 Sep-26	M07 Oct-26	M08 Nov-26	M09 Dec-26	M10 Jan-27	M11 Feb-27	M12 Mar-27
GWH Plan	4.41%	4.39%	4.36%	4.34%	4.32%	4.30%	4.28%	4.26%	4.24%	4.22%	4.20%	4.17%
GWH Actual	4.25%	4.28%	4.25%									
RUH Plan	5.37%	5.40%	5.41%	5.38%	5.34%	5.26%	5.15%	5.08%	5.02%	4.98%	4.93%	4.90%
RUH Actual	5.55%	5.60%	5.65%									
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	4.21%	4.19%	4.04%									

Sickness absence performance remains variable across the Group. GWH continues to deliver absence levels below plan and demonstrates sustained performance. In contrast, RUH's sickness absence has increased during the first quarter and remains above trajectory, whilst SFT, although showing encouraging improvement, continues to operate significantly above target. Continued focus on attendance management, wellbeing interventions, and targeted support for areas with persistent absence will be important to ensure delivery of the planned year-end reduction in sickness levels across the Group.

The impact of increased heat levels alongside additional operational pressures is having an impact on sickness at what would ordinarily be a reduced sickness period. Anxiety and Stress generated by the uncertainty of the Corporate Services review is an added pressure on the number this year.

Recruitment pipeline

	Stages	GWH WTE			RUH WTE			SFT WTE		
		Clinical	Non-Clinical	Total	Clinical	Non-Clinical	Total	Clinical	Non-Clinical	Total
Average 20-week Advert to Start	Advertising	18.4	11.4	**29.8**	31.5	14.2	**45.7**	44.8	8.6	**53.3**
	Shortlisting	36.5	13.0	**49.5**	49.9	13.2	**63.8**	10.0	3.0	**13.0**
	Interviews	44.4	19.8	**64.2**	73.4	18.6	**92.0**	29.7	6.8	**36.5**
	Offer & Planned Start Date	415.1	22.8	**437.9**	401.9	43.8	**445.6**	80.9	20.8	**99.2**
	Total Pipeline	**514.4**	**67.0**	**581.4**	**556.6**	**89.8**	**647.0**	**165.4**	**39.1**	**202.0**
	of which Resident Doctors	194.1	0.0	**194.1**	166.6	0.0	**166.6**	0.0	0.0	**0.0**
	of which EPR	3.0	17.1	**20.1**	1.3	0.0	**1.3**	0.0	2.5	**2.5**
	Influenceable Pipeline	317.3	49.9	**367.2**	388.7	89.8	**479.2**	165.4	36.6	**199.5**
	Average 20-week leaver FTE	107.5	48.2	**155.7**	85.8	58.3	**144.0**	99.1	85.6	**184.7**
	Net FTE Impact	209.8	1.6	**211.4**	302.9	31.5	**335.1**	66.3	-49.0	**14.8**



•**Workforce instability is material:** 13% turnover—around 2,200 leavers annually—creates persistent recruitment pressure.

•**Operational risk remains:** vacancies may affect capacity, waiting times, continuity of care, staff wellbeing and agency reliance.

•**Pipeline figures need qualification:** candidates in the pipeline do not necessarily translate into timely starters or hard-to-fill roles.

Annual planning adjust numbers of staff required, which accounts for the reduction in recruitment pipeline in April, and the subsequent increase in May, as recruitment activity catches up with the newly agreed planned numbers.

Service design and anticipated changes in service delivery as a result of the Op Plan generate the increase in numbers in the pipeline.

Appendix – CIP scheme delivery

SFT Pay Efficiency Schemes

			M01 Apr-26	M02 May-26	M03 Jun-26
SFT Total	Total	Plan £	433,000	735,000	794,000
		Actual £	**539,000**	**686,000**	**575,000**
		Variance £	106,000	-49,000	-219,000
Corporate services transformation	Total	Plan £	138,000	138,000	138,000
		Actual £	**135,000**	**141,000**	**131,000**
		Variance £	-3,000	3,000	-7,000
Clinical services redesign - Outpatient	Total	Plan £	0	0	0
		Actual £	**0**	**0**	**0**
		Variance £	0	0	0
E-roster, sickness management and ATOP	Total	Plan £	116,000	198,000	203,000
		Actual £	**31,000**	**62,000**	**47,000**
		Variance £	-85,000	-136,000	-156,000
Agency reduction	Total	Plan £	74,000	210,000	239,000
		Actual £	**144,000**	**129,000**	**121,000**
		Variance £	70,000	-81,000	-118,000
Bed rationalisation - Medicine schemes	Total	Plan £	2,000	50,000	75,000
		Actual £	**122,000**	**176,000**	**113,000**
		Variance £	120,000	126,000	38,000
Specialty challenges - establishment reviews	Total	Plan £	103,000	109,000	109,000
		Actual £	**91,000**	**167,000**	**144,000**
		Variance £	-12,000	58,000	35,000
Bed rationalisation - Surgery schemes	Total	Plan £	0	30,000	30,000
		Actual £	**16,000**	**11,000**	**19,000**
		Variance £	16,000	-19,000	-11,000
Temporary staffing model	Total	Plan £	0	0	0
		Actual £	**0**	**0**	**0**
		Variance £	0	0	0

GWH Pay Efficiency Schemes

			M01 Apr-26	M02 May-26	M03 Jun-26
GWH Total	Total	Plan £	1,145,666	1,145,666	1,145,666
		Actual £	**346,000**	**469,000**	**652,000**
		Variance £	-799,666	-676,666	-493,666
Outpatient productivity	Total	Plan £	136,500	136,500	136,500
		Actual £	**0**	**0**	**0**
		Variance £	-136,500	-136,500	-136,500
Non-elective LOS reduction (Right care)	Total	Plan £	86,000	86,000	86,000
		Actual £	**0**	**0**	**0**
		Variance £	-86,000	-86,000	-86,000
Agency reduction	Total	Plan £	15,000	15,000	15,000
		Actual £	**0**	**0**	**65,000**
		Variance £	-15,000	-15,000	50,000
Bank reduction	Total	Plan £	60,000	60,000	60,000
		Actual £	**0**	**0**	**0**
		Variance £	-60,000	-60,000	-60,000
Workforce optimisation	Total	Plan £	62,500	62,500	62,500
		Actual £	**0**	**0**	**0**
		Variance £	-62,500	-62,500	-62,500
Clinical services redesign	Total	Plan £	33,333	33,333	33,333
		Actual £	**0**	**0**	**0**
		Variance £	-33,333	-33,333	-33,333
Corporate group efficiencies	Total	Plan £	140,000	140,000	140,000
		Actual £	**0**	**270,000**	**0**
		Variance £	-140,000	130,000	-140,000
1% reduction in divisional expenditure over and above schemes listed	Total	Plan £	170,000	170,000	170,000
		Actual £	**346,000**	**199,000**	**587,000**
		Variance £	176,000	29,000	417,000
Pathology related savings	Total	Plan £	12,333	12,333	12,333
		Actual £	**0**	**0**	**0**
		Variance £	-12,333	-12,333	-12,333
Unidentified	Total	Plan £	430,000	430,000	430,000
		Actual £	**0**	**0**	**0**
		Variance £	-430,000	-430,000	-430,000

RUH Pay Efficiency Schemes

			M01 Apr-26	M02 May-26	M03 Jun-26
RUH Total	Total	Plan £	562,000	562,000	582,000
		Actual £	**355,230**	**211,561**	**178,288**
		Variance £	-206,770	-350,439	-403,713
CDC	Total	Plan £	83,000	83,000	83,000
		Actual £	**0**	**0**	**0**
		Variance £	-83,000	-83,000	-83,000
Corporate Services Redesign	Total	Plan £	119,000	119,000	119,000
		Actual £	0	0	0
		Variance £	-119,000	-119,000	-119,000
Divisional & E&F run rate reductions	Total	Plan £	29,000	29,000	29,000
		Actual £	**355,230**	**211,561**	**178,288**
		Variance £	326,230	182,561	149,288
Productivity & invest to save	Total	Plan £	221,000	221,000	221,000
		Actual £	**0**	**0**	**0**
		Variance £	-221,000	-221,000	-221,000
Workforce - Rostering , sickness, pay reward & recruitment	Total	Plan £	110,000	110,000	130,000
		Actual £	**0**	**0**	**0**
		Variance £	-110,000	-110,000	-130,000

BSW Hospitals Group Board

Agenda item	
Report title	GWH: Illustrative Designated Body Annual Board Report and Statement of Compliance Medical Revalidation and Appraisal
Date of meeting	3rd September 2026
Sponsor	Dr Kathryn Bateman, Chief Medical Officer & Responsible Officer, GWH
Prepared by	Amy Smith, Medical Revalidation & Job Planning Specialist
Approval Process: (where has this paper been reviewed and approved)	Medical Staff Support Group, GWH, 1st July 2026 GWH People & Culture Committee, 28th July 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

KEY MESSAGES

ALERT	ADVISE	ASSURE
Nil	Next steps: maximise the value of SARD and workforce data by strengthening links between job planning, capacity, productivity, workforce sustainability and service delivery.	GWH remains compliant with Responsible Officer (RO) Regulations and has effective governance, systems and resources in place to support the RO function.

		Appraisal, revalidation, job planning and associated quality assurance processes are embedded and operating effectively.

Key Messages

The Annual Organisational Assessment (AOA) provides assurance that Great Western Hospitals NHS Foundation Trust remains compliant with Responsible Officer Regulations and has effective arrangements in place to support appraisal, revalidation, job planning, medical governance and workforce assurance.

The Trust continues to demonstrate strong governance through established oversight mechanisms, including the Medical Staff Support Group (MSSG) and Medical Workforce, Consistency and Advisory Group. Together with the Chief Medical Officer and Deputy Chief Medical Officers, these arrangements provide effective leadership, scrutiny and assurance of medical professional standards.

During 2025/26, the focus has shifted from implementation and compliance to optimisation and strategic use of workforce data. Following successful implementation of SARD as the Trust's core appraisal and job planning system, attention is now focused on:

- Improving data quality and reporting capability.
- Enhancing visibility of medical workforce information.
- Supporting workforce planning and sustainability.
- Strengthening links between job planning, productivity, capacity and operational delivery.

Appraisal, revalidation and job planning processes remain well embedded, with robust quality assurance arrangements and regular monitoring through established governance structures.

Overall, the AOA confirms that GWH has effective systems, governance arrangements and resources in place to support the Responsible Officer function and meet national requirements. The key opportunity for the coming year is to maximise the value of these mature processes and workforce insights to support operational performance, workforce sustainability, productivity improvement and organisational transformation.

RECOMMENDATION

The Group Board is asked to: approve and sign off the report for submission to NHSE by 30th September 2026.

The report is for assurance on compliance with the requirements of the Responsible Officer Regulations and the effective delivery of medical professional standards processes, including appraisal, revalidation, job planning, medical governance, and workforce assurance.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
A	Annex A – Illustrative Designated Body Annual Board Report and Statement of Compliance

BSW Hospitals Group Board

Agenda item	4.5
Report title	Responsible Officer Annual Report and Statement of Compliance 2025/26
Date of meeting	3rd September 2026
Sponsor	Rebecca Maxwell, Chief Medical Officer, Royal United Hospital, Bath
Prepared by	Stewart Redman, Associate Medical Director for Appraisal and Revalidation Alison Stead, Medical Workforce Business Partner Debbie Scoplin, Appraisal Administrator Lucy Tainton, Appraisal Administrator
Approval Process: (where has this paper been reviewed and approved)	Reviewed through the Responsible Officer Advisory Group (ROAG) and approved for submission to NHS England through the Responsible Officer governance process Care Organisation Leadership Team. People Committee September

☒ **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 report provides annual assurance that the Trust remains compliant with the requirements of the Medical Profession (Responsible Officers) Regulations 2010.
- During 2025/26, 553 doctors held a prescribed connection to the Trust, with 453 appraisals completed and 87 revalidation recommendations made.
- No doctors were referred to the GMC and no doctors were excluded or suspended during the reporting period.
- Key developments included the introduction of an appraiser allocation process, strengthened appraiser training, and continued collaboration across the BSW Hospitals Group.
- The report identifies priorities for 2026/27 focused on appraisal quality, compliance, governance oversight and system-wide learning.

RECOMMENDATION

The Group Board is asked to:

1. Note the Responsible Officer Annual Report and Statement of Compliance 2025/26.
2. Receive assurance that robust arrangements are in place to support medical appraisal, revalidation and professional standards across the Group's providers.
3. Note the priorities identified for continued improvement during 2026/27.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix 1	Responsible Officer Annual Report and Statement of Compliance 2025/26

BSW Group Board

Agenda item	4.5.1.1_SFT
Report title	**Annual Organisational Audit of Medical Workforce Governance 2025/26**
Date of meeting	03 September 2026
Sponsor	Duncan Murray, CMO/RO SFT
Prepared by	Duncan Murray, CMO/RO SFT
Approval Process: (where has this paper been reviewed and approved)	Salisbury care organisation governance processes; submitted to the BSW Hospitals Group Board for annual assurance.

☐ 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	This is an annual statutory and professional standards assurance report. Findings inform relevant care organisation risks relating to workforce, culture, quality and patient safety.

KEY MESSAGES

- SFT reports overall compliance with the Medical Profession (Responsible Officers) Regulations 2010, as amended, for 1 April 2025 to 31 March 2026. The Board is invited to review the audit and support the Statement of Compliance.
- There is positive assurance regarding Responsible Officer capacity, appraisal and revalidation arrangements, trained appraisers, employment checks, established clinical governance and fair processes for responding to concerns. Medical appraisal compliance consistently exceeds the Trust internal target of 90%.
- At 31 March 2026, 377 doctors had a prescribed connection. During the year, 283 appraisals were completed; 31 revalidation recommendations were submitted, including 27 positive recommendations and four deferrals. There were no non-engagement referrals and no doctors failed to revalidate.
- Five concerns were received by the Responsible Officer; two processes were completed, one doctor was excluded or suspended and one was referred to the GMC. The MHPS consistency panel is established and provides senior multidisciplinary review, supported by regular triangulation with the GMC Employment Liaison Adviser and Practitioner Performance Advice Service.
- The principal assurance gaps are: no external peer review of appraisal and revalidation; delayed ratification of the updated appraisal and revalidation policy; incomplete structured Board reporting from the MHPS consistency panel, including analysis by protected characteristics and country of primary medical qualification; incomplete audit of Medical Practice Information Transfer processes; and the need to strengthen oversight and onboarding of bank doctors engaged through Locums Nest.
- Priority actions for 2026/27 are to establish Group-level ASPAT peer review, progress a common digital appraisal platform, ratify the appraisal and revalidation policy, standardise confidential professional standards reporting across the Group, complete the MPIT audit, and strengthen governance of collaborative bank doctors.

RECOMMENDATION

The Group Board is asked to:

- Receive and note the Salisbury NHS Foundation Trust Annual Organisational Audit of Medical Workforce Governance for 2025/26.
- Take assurance that SFT is compliant overall with the Medical Profession (Responsible Officers) Regulations 2010, as amended, while noting the identified gaps and planned mitigating actions.
- Endorse the proposed Group-wide actions on appraisal peer review, digital appraisal systems, professional standards reporting and oversight of collaborative bank doctors.
- Support signature of the Statement of Compliance on behalf of the designated body.

APPENDICES

Appendix A: SFT Annual Organisational Audit and Statement of Compliance 2025/26, providing qualitative assurance, metrics, actions and the formal compliance statement.

BSW Hospitals Group Board

Agenda item	
Report title	BSW Hospitals Group Digital Service Report
Date of meeting	3rd September 2026
Sponsor	Jonathan Hinchliffe, Group Chief Digital and Information Officer
Prepared by	Julie Parish, Senior Digital Business Manager Graeme Temblett–Willis, Head of Information Governance (DPO) Glyn Rowe, Senior Cyber Security Manager
Approval Process: (where has this paper been reviewed and approved)	Approved by Jonathan Hinchliffe, Group Chief Digital and Information 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
BAF R03	Delivering Digital Maturity
BAF R10	Cyber security

KEY MESSAGES

Cyber security remains a principal strategic risk and a critical enabler of safe patient care, service continuity and the protection of information. The Group maintains a managed cyber risk position through established governance, risk management, technical safeguards, staff awareness, incident response and resilience arrangements aligned with national health-sector requirements; however

Cyber risk remains elevated, with further assurance and resilience work ongoing across the Group to maintain protection and vigilance.

During the reporting period, there were no cyber security incidents resulting in significant patient safety concerns, sustained disruption to clinical services or material compromise of information assets. National alerts and emerging threats continue to be assessed and managed through established processes.

Data Protection Officer assurance for the BSW Hospital Group, covering the effectiveness, maturity and proportionality of arrangements for information governance, data protection and confidentiality across Royal United Hospitals Bath (RUH), Great Western Hospitals (GWH) and Salisbury NHS Foundation Trust (SFT), draws on annual DSPT and CAF-aligned assurance activity, local governance reporting, incident learning, policy assurance, individual rights performance such as DSAR (Data Subject Access Requests), DPIA (Data Protection Impact Assessments) and data sharing oversight, and the developing BSW Group Information Governance Framework.

The overall assurance position is positive. The Group demonstrates established leadership, clear statutory accountability and active management of information risk. The independent CAF-aligned DSPT reviews conducted by KPMG at each of the care Organisations confirm significant assurance, with variation in residual risk and evidence maturity between organisations. It should be noted that cyber security is addressed separately through the Group cyber assurance route as this report focuses on data protection, information governance, confidentiality, lawful processing, individual rights, transparency, records and information security and risk.

RECOMMENDATION

The Group Board is asked to:

1. Note the content of this report and associated appendices.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix A1	BSW Group - Group Board (Public) - Cyber Annual Report - August 2026
Appendix A2	BSW Group - Group Board (Public) - Group Cyber Report Summary - August 26
Appendix B	BSW Group – Group Board (Public) - SIRO Annual Data Security and Data Protection Report

BSW Hospitals Group Board

Agenda item	GWH Managing Director's Report. Item 5.1
Report title	GWH Managing Director's Report: June 2026 Update
Date of meeting	3rd September 2026
Sponsor	Lisa Thomas, Managing Director
Prepared by	Lisa Thomas, Managing Director
Approval Process: (where has this paper been reviewed and approved)	Reviewed through Group Executive Committee. Assurance content informed by Finance, Performance & Infrastructure Committee, Quality & Safety Committee, People & Culture Committee and Senior Leadership Team / TMC reporting.

☐ **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 / principal risk area	Relevance to paper
	UEC pressure, patient flow, corridor care, delayed care, maternity triage, neonatal staffing, stroke and Interventional Radiology service fragility.
Multiple: workforce and culture	Workforce affordability, sickness absence, staff experience, training, clinical leadership capacity and safe staffing requirements.
Multiple: financial sustainability	Month 3 adverse financial position, recurrent savings delivery, productivity, cash risk and recovery plan delivery.
Multiple: estate, infrastructure and digital resilience	PFI handback readiness, capital constraints, Building Safety Act dependencies, utilities resilience and EPR readiness.

KEY MESSAGES

The Group Board is asked to:

- Note that June 2026 represented a materially pressured operating environment for GWH, with sustained emergency demand, high occupancy, critical incident status, corridor care, and consequential impacts on access, quality, workforce and finance.
- Receive assurance that governance and recovery controls are in place across UEC, RTT, cancer, finance, workforce, quality, maternity/neonatal services and estates, while recognising that assurance remains partial where controls have not yet delivered sustained impact.
- Note the principal areas requiring continued Board visibility: UEC and flow recovery, recurrent financial delivery, workforce affordability and safe staffing, maternity triage estate constraints, neonatal workforce compliance, service sustainability and PFI hand back readiness.
- Recognise that recovery is dependent on both internal delivery and external dependencies, including system demand management, discharge capacity, capital availability, corporate support functions, transformation capacity and EPR readiness.
- Maintain oversight of the measurable recovery milestones, control gaps, quality impact and risk movement through the Group governance framework.

RECOMMENDATION

- Receive the Managing Director's report for assurance.
- Note the areas of escalation, partial assurance, and residual risk outlined in the report.
- Support continued scrutiny through Group governance of UEC and flow, RTT and cancer recovery, financial recovery, workforce delivery, estates/PFI, maternity/neonatal services and challenged services.
- Note that no formal decision is requested within this cover sheet, but several issues require continued Board visibility and strategic oversight.

APPENDICES

Appendix A	Quality and Safety Committee escalation report:
Appendix B	People and Culture Committee escalation report:
Appendix C	Finance, Performance & Infrastructure Committee escalation report:
Appendix D	Senior Leadership Team / TMC escalation report:

Great Western Hospitals NHS Foundation Trust

Managing Director's Report: June 2026 GWH

Report field	Detail
Report Title	June 2026 GWH update
Date of meeting	Group Board of Directors : 3rd September 2026
MD / Lead	Lisa Thomas, Managing Director
Purpose	☑ FOR ASSURANCE

Executive Summary

June was dominated by sustained acute operational pressure, with high emergency demand (June having the highest ED attendances this year related to the heat wave), critical incident status, high occupancy and increased corridor care. These pressures constrained UEC recovery, affected patient experience and quality metrics, and increased the difficulty of delivering financial and workforce reductions.

The Month three financial position remains materially adverse to plan £6.3m variance, this is driven by unidentified CIP in the first two months of the year £2.5m, shortfall against income £1m in first two months (on plan for month 3), cost pressures associated with urgent and emergency care demand £1.3m and non-recurrent costs associated with Hunter support and strike actions £1.3m. There were some positive messages within the June position, elective income and activity showed a marked improvement in month with activity levels closer to planned levels.

GWH received a letter from NHSE Jim Mackey and Penny Dash on the 26th of June, reflecting under performance against plan in both operational and financial metrics. As part of the response to NHSE, recovery actions were outlined (and considered at an extraordinary Board meeting in July) delivery is dependent on sustained delivery through specialty-level RTT recovery plans, financial delivery through enhanced financial oversight in financial improvement board and Hunter healthcare support and for UEC both internal improvements through the Right Care Board and combined with system demand management reductions.

To make sustained improvements at pace there is a need for improvements in underlying capacity and capability this includes rapid improvement in Business intelligence, financial analysis to support recovery, the need to ensure recruitment to key transformation roles supporting improvement, and a really focused resourced team responding to recovery. This is all being developed into a comprehensive recovery plan for oversight through group governance mechanisms.

1.1 Alert | Advise | Assure

ALERT

Issue	Board-level narrative
Urgent and emergency care / corridor care	June was materially pressured. GWH operated at Critical Incident level for much of the month, experienced its busiest ever front-door day on 29 June with 518 attendances, and bed occupancy peaked at 580 patients at midnight against a core stock of 509. Corridor care increased to 1,224 episodes, 70 more than May. The Right Care programme is in place, but delivery remains dependent on internal flow improvement and partner demand-management actions. A UEC recovery plan is in place with actions covering UTC streaming, UTC capacity, ED staffing and process, diagnostics at the front door, patient flow and children's emergency pathways.
RTT performance	RTT 18-week performance reported 56.6% in June, remaining below plan. The overall PTL position was broadly stable and better than plan, but the long-wait tail deteriorated, with 1,250 patients

Issue	Board-level narrative
	waiting over 52 weeks in FP&I reporting and five patients reportable at 65 weeks against a plan of zero. Oversight, validation and specialty recovery actions continue, with recovery dependent on investment and delivery through 2026/27. Whilst the waiting list has stabilised the lag in RTT % performance will take longer to recover as patients are seen and treated.
Financial recovery and cash position	The Month three position is a £10.9m deficit, £6.3m adverse to plan. The middle-case forecast of a a £25m deficit, indicates £30.7m savings delivery in year, the full £47m has been identified which improves the underlying deficit by c£10m. However ongoing urgent care activity being above plan continues to place the organisational under capacity constraints, both in terms of management time in responding but also resource inefficiency. The cash flow forecast shows significant risk related to the forecast shortfall against plan – with projected shortfalls in Q4 of 2026/27.
Capital constraint	The 2026/27 capital programme remains constrained. Month 03 capital spend was £561k against a plan of £1.3m and the Trust is reporting a forecast capital funding pressure of approximately £3.7m after committed unavoidable costs, contingency requests and available offsets. Delivery remains dependent on national, regional and external funding opportunities.
Maternity triage	National guidance on maternity triage has been released which the maternity team are reviewing. This combined with the CQC inspection highlighting the triage service is capacity constrained and does not fully support the requirements of NHSE service specification. SLT is due to receive some options from the estates team in August to review how quickly this risk can be resolved.
Challenged services	Stroke services remain a focus of improvement area and scores high on the risk register. The service remains staffed by Locum Consultants which is unsustainable model for the future. SSNAP data shows the service is underdelivering. Focus has been on improving the CT perfusion pathway, with support from the RUH Clinical lead. To address the SSNAP further will require investment in alternative workforce models. Interventional Radiology remains a high-risk service. Ongoing discussions are in place with Gloucestershire about a model of care. From September without an agreement in place there is no Interventional Radiology service at GWH. The model is likely to lead to a forecast cost pressure.
Neonatal staffing	The Committee also noted that neonatal medical staffing does not meet BAPM standards for dedicated Tier 2 overnight LNU cover, although no direct harm had been identified and ANNP day cover has been confirmed from September. A case for recruitment is currently being finalised to be considered in July.
EPR Readiness	EPR readiness was an ongoing discussion at SLT ensuring that the planning from a Care Organisational perspective is clear and robust. Risks are being identified and mitigation plans developed for loss of productivity, training requirements and workforce implications of training, reporting and data quality and opportunities to embed improvements.
Mortuary – Fuller Report	GWH have been reviewing the board assurance required in line with the Fuller report. This has identified some immediate actions required by estates team to ensure the physical environment is fully compliant with the expectations. It is anticipated (but awaiting further information from the estates team) that this will require a small amount of additional capital funding.

ADVISE

Issue	Board-level narrative
Quality and patient experience	Total reported harms increased in June to 123 from 112 in May, driven by falls and pressure ulcers, although no falls resulted in moderate harm or above. Complaint response performance improved to 57% but remained below the 80% KPI, with 90 complaints received in June and operational pressure continuing to affect timeliness. Section 2.1 below outlines in more detail actions.
Cancer performance	May cancer performance remained below plan. The 28-day faster diagnosis standard reduced to 67.3%; 31-day treatment improved to 87.0%; and 62-day performance improved to 64.5%, with material breach contribution from Urology and Colorectal pathways. Recovery actions are pathway-specific and include diagnostic, outpatient, reporting, workforce and treatment capacity interventions. Forecast performance improvements are expected by September reporting.
Workforce and culture	Q1 Pulse Survey results show deterioration in recommend as a place to work and care as top priority measures. June sickness absence was 4.39% against a 3.5% target. Workforce was 104 WTE above plan at Month 3, driven by substantive and temporary staffing pressures linked to operational escalation and sickness cover alongside the plan assuming reductions in staffing related to transformation. The impact of significant demand, recovery actions in UEC and planned care and financial recovery are having an impact on staff morale.
Delivery capacity	ORBIT and SLT reporting highlight organisational capacity as a finite resource. Shared EPR readiness is now the dominant programme dependency and is likely to influence transformation delivery, benefits realisation and programme sequencing over the next 12-18 months. This must be balanced alongside the expectation of significant recovery improvements across GWH. Resourcing is being reviewed to ensure the appropriate level of transformation resource to support those balancing operational delivery with longer term improvement schemes. There are ongoing demand placed on corporate functions to support recovery at the pace expected with further support required in Business intelligence, estates planning, Financial recovery and transformation support.
Governance	The new governance framework started this month with all Executive led assurance committee having their first cycle. Adoption of the Advise/Assure/Alert mechanism is now in place. Learning has been captured including ensuring upward reporting into committee assurance includes the AAA model. Looking for areas where duplication in reporting can be eliminated. Strengthening relationship between corporate functions and delivery of key GWH priorities as enablers e.g. corporate functions supporting recovery at pace.
Nursing fairer deal	All job evaluations for the Band 5 nursing are required to be completed by October 2028, there are risks to capacity for evaluation, project management resource and unclear funding route for any significant changes to profiles of band 5/6 across the Trust. Any cost pressures associated with the change have not been built into the financial forecast. This has Governance
Improvements in pathways	There are new models of care required in both frailty and Surgical admissions pathway which are underway, both are material to sustainable improvements in UEC and to ensure the hospital is fit for future population changes. The capacity for clinical leadership to achieve the change is limited with current workforce and demand pressures. Plans are being developed to identify additional resource to expedite development of new models of care.
Sterile Services	The sterile services department has been identified as physically too small for some years with identification of the adjacent land as an opportunity to re-provide. This work has not progressed in recent times however this has now been reprioritised in recognition of the impact on service provision and staff morale. There is a risk it will be identified as part of the upcoming JAG accreditation with risk to material improvement notices.

ASSURE

Issue	Board-level narrative
Maternity and neonatal governance	Q1 maternity and neonatal safety reporting provides good assurance on governance and oversight. Training compliance remains strong across most staff groups, the Tier 2 MOSS signal drill was completed during the week commencing 22 June 2026, and patient safety incident review arrangements continue through multidisciplinary huddles and formal governance routes.
Estates, PFI and ward decant	The Modular Short Stay Unit opened as planned and enabled the decant of Kingfisher Ward, Ampney Ward and Trauma services. Phase 1 remains on track for completion in September 2026. Estates reporting provides good assurance on governance while noting continuing risks on PFI expiry, utilities, Building Safety Act dependencies and capital availability.

Key Achievements and Good News

- The modular Short Stay Unit (MSU) opened as planned, enabling safe decant of Kingfisher, Ampney and Trauma services and commencement of refurbishment works. This is new model of working with the specific aim of improving patient flow has commenced with rapid improvement cycle learning in place as it starts to establish. This is part of the Right Care Programme improving UEC flow.

- Cancer 31-day and 62-day performance improved in May, although both remain below plan and require continued pathway recovery. GWH is establishing a new Cancer Committee to ensure that the oversight of cancer delivery alongside cancer outcomes and patient experience becomes more central to improving services. This is expected to start in late September.

- Quality Committee papers noted improvement in the proportion of patients receiving NEWS2 observations within one hour of transfer from ED to a ward, increasing from 53% to 72.4%. While further improvement is required, the trajectory demonstrates successful focus on patient safety.

- The Group Employee Relations report highlighted GWH's achievement of 3.9% sickness absence, ranking 2nd regionally and 4th nationally, demonstrating strong workforce wellbeing support and attendance management despite ongoing operational pressures.

Section 2: Performance Triangulation

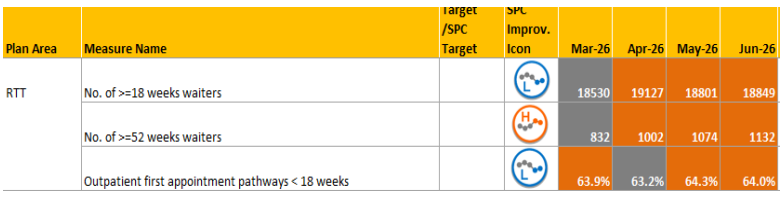
2.1 SPC variation

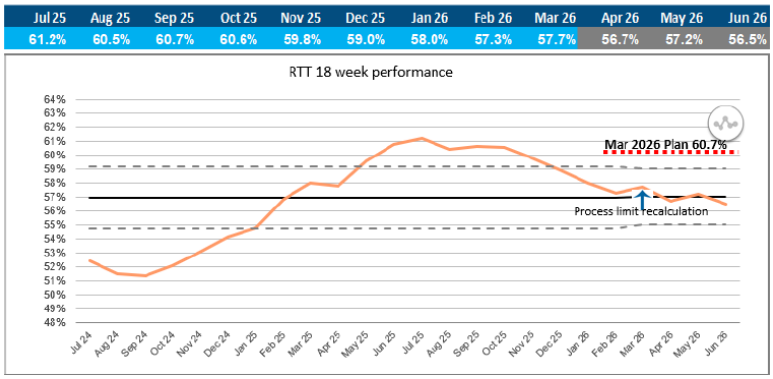
The June position demonstrates increased emergency demand and bed occupancy are challenging recovery, worsening corridor care, increasing escalation staffing costs and reducing capacity to deliver financial recovery. Quality, workforce and patient experience indicators show the consequences of the same operating context, while recovery controls are in place but require sustained delivery to improve the position.

New breakthrough objectives have been adopted for 2025/26 therefore the improvements are in the early phases; a summary is included below for information.

Breakthrough objective / metric	June position	Action
Reducing deconditioning in acute care	June performance was 43% against the aim for 75% of patients to be appropriately dressed and sat out of bed for lunch. Early-phase work continues through ward-level education, engagement and Improving Together routines.	Maintain visibility through ward reviews and Go and See's; strengthen evidence of impact over coming months. Improvement work on Teal, Saturn and Trauma wards continues to progress positively through weekly *Improving Together* meetings, enabling teams to identify barriers and test local solutions.
Reducing corridor care	June corridor care increased to 1,224 episodes, with Critical Incident status during much of the month and occupancy peaking at 580 patients.	Changes to medical rotas in Ed and Acute Medicine to ensure they are aligned with peaks in attendance peaks Comprehensive review commenced of the first assessment processes across all ambulatory patients that present to ED and UTC. New Medical short Stay Unit to open early July. To support management of medical patients within a >72 hour stay. New ward daily processes implemented to ensure consistency for board rounds, earlier declaration of next day discharges and clarity on next steps for each patient
RTT 18-week performance	Performance deteriorated to 56.6% in June and remains below the operating plan. PTL size was broadly stable but long waits worsened, with 1,250 patients over 52 weeks reported in FP&I materials	Continue corporate PTL grip, specialty recovery plans, validation, investment tracking and Elective Performance Group (EPAG) oversight.
Staff survey: care as top priority	Q1 Pulse Survey reported 66.2% against a 77% target, down from Q4 68.5%.	Countermeasures targeted corporate and divisional work, with impact reviewed through pulse data and staff survey planning.
Improving productivity	Financial and operational reports identify lower planned care income, high operational escalation and workforce above plan as constraints on productivity, the plan assumed 6.3% productivity, the Trust is currently 1.9% in June.	Focus on theatre/clinic productivity, cancellations, start times, activity within existing resources and reduction in premium temporary staffing.

2.2 Alerting Metrics

Metric	June / latest reported position	Action / response
RTT performance	 RTT performance reduced to 56.6% against plan of 61.3%, with 1,250 patients waiting over 52 weeks and five remaining 65-week breaches. The greatest contributors continue to be ENT, Gastroenterology and Gynaecology, where	Specialty-specific recovery plans are being overseen through EPAG, including additional clinic and theatre capacity, waiting list validation using the Patient-Led Validation programme, strengthened booking controls and increased use of independent sector capacity. Weekly executive review of 52-week waiters has been implemented to accelerate

	demand is exceeding available outpatient and treatment capacity and pathway validation has identified longstanding data quality issues. **RTT 18-week performance**  	reduction of the longest waiting patients. 5 patients were waiting longer than 65 weeks, against a target of zero. Whilst this remains a material variance from plan, it represents a positive improvement, with 7 fewer 65 week breaches than reported in May.

Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26
61.2%	60.5%	60.7%	60.6%	59.8%	59.0%	58.0%	57.3%	57.7%	56.7%	57.2%	56.5%

Complaint response	Performance improved to 57% in June but remained below the 80% KPI and below the six-month average; 90 complaints were received in June. The overall number of complaints has increased in month. This was discussed at Senior Leadership Committee this month as a priority not only to respond to complaints in a timely way, but ensure that all actions were being undertaken to reduce concerns escalating into complaints.	Weekly divisional oversight and early complainant contact expectations continue. A3 working group in place, with countermeasures. Top complaint theme is waiting times. Process improvements for outpatient waiting times incorporated into the outpatient transformation group.

Plan Area	Measure Name	Target	SPC Improv. Icon	Mar-26	Apr-26	May-26	Jun-26
Concerns and Complaints	No. of complaints received	SPC		81	94	73	90
	Number of reopened complaints	SPC		5	5	6	3

Cancer standards	Faster Diagnosis Standard (67.3%) and 62-day performance (64.5%) remain below trajectory. The principal areas driving underperformance are: Urology due to MRI and diagnostic reporting delays. Colorectal due to diagnostic and workforce constraints. Skin due to outpatient and treatment capacity pressures. Breast due to clinic capacity constraints and pathway delays. Gynaecology due to administration and booking delays	Additional TVCA-funded clinics have commenced in Skin and Breast services. Urology capacity has been increased through additional MRI and LATP activity. Colorectal services are being supported through registrar and CNS workforce development. Monthly pathway reviews are tracking delivery against tumour-specific recovery trajectories

Plan Area	Measure Name	Target /SPC Target	SPC Improv. Icon	Mar-26	Apr-26	May-26
Cancer	% Cancer 62 day performance	85% (Nat)		72.0%	62.2%	64.5%
	% Cancer 31 day performance	96% (Nat)		89.7%	80.0%	87.0%
	% Cancer 2 week wait	93% (Nat)		67.4%	56.0%	46.4%
	% 28 day faster diagnosis			80.7%	72.1%	67.3%

Emergency Department standards		Operational response is focussed on reducing length of stay and improving discharge flow. This is being driven through the Right Care Board as the overarching improvement group. The key areas for the next month include:

Plan Area	Measure Name	Target /SPC Target	SPC Improv. Icon	Mar-26	Apr-26	May-26	Jun-26	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)		68.6%	67.6%	66.0%	65.1%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)		8.5%	7.8%	9.0%	9.8%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)		47.9%	54.6%	54.5%	54.1%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)		16.1%	13.2%	14.0%	15.4%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)		90.8%	87.0%	87.3%	84.1%	
	Total ED Type 1 Attendances (all arrival methods)	SPC		6241	7093	7856	7816	
	Emergency Care - AED - Median Stay	240 (Int)		296	238	238	239	

Four-hour performance remained at 65.1%, significantly below trajectory. June saw record ED attendances, ambulance handovers averaging 68 minutes and 1,224 episodes of corridor care. The principal driver is continued high occupancy from increased patient demand, with midnight occupancy reaching 114% of core bed capacity.

The Medical short stay unit opening in July is focusing on improving reduced length of stay and increasing flow from ED to reduce waiting times.

Other schemes include enhanced discharge coordination, daily review of patients increased consultant presence in the acute pathway,
improved escalation processes and system-wide discharge events with community partners.

GWH is over planned activity levels for UEC, particularly ED and whilst despite an increase in patients being discharged, this pressure remains significant in both direct costs but also opportunity cost of not being able to deliver improved efficiencies and reduce expenditure.

Finance

Month 3 deficit was £10.9m, £6.3m adverse to plan, with CIP under-delivery and operational escalation as key drivers.

For Period Ended - 30th June 2026											
Financial Position	In Month				YTD				2026/27 Plan vs Middle Case FoT		
	Plan	Actual	Variance		Plan	Actual	Variance		Plan	FoT	Variance
	£000	£000	£000		£000	£000	£000		£000	£000	£000
Income	46,001	46,192	192		134,382	133,238	(1,144)		539,984	542,428	2,444
Pay	(29,081)	(29,772)	(691)		(83,387)	(87,589)	(4,202)		(325,241)	(342,934)	(17,693)
Non Pay	(14,751)	(16,943)	(2,192)		(46,539)	(48,594)	(2,055)		(178,758)	(193,069)	(14,311)
Total Expenditure	**(43,832)**	**(46,715)**	**(2,883)**		**(129,926)**	**(136,183)**	**(6,257)**		**(503,999)**	**(536,003)**	**(32,004)**
EBITDA	**2,169**	**(523)**	**(2,692)**		**4,456**	**(2,945)**	**(7,401)**		**35,985**	**6,425**	**(29,560)**
Depreciation & Finance Charges	(2,999)	(2,624)	375		(8,996)	(7,934)	1,062		(35,984)	(31,737)	**4,248**
Surplus/(Deficit) incl deficit support	**(830)**	**(3,147)**	**(2,317)**		**(4,540)**	**(10,879)**	**(6,339)**		**0**	**(25,312)**	**(25,312)**
Less: Deficit Funding	**(564)**	**(564)**	**(0)**		**(1,691)**	**(1,692)**	**(0)**		**(6,782)**	**(6,782)**	**0**
Adjusted Surplus/(Deficit) excl Deficit Funding	**(1,394)**	**(3,711)**	**(2,317)**		**(6,232)**	**(12,571)**	**(6,339)**		**(6,782)**	**(32,094)**	**(25,312)**
Capital	1,500	561	(939)		4,033	2,062	(1,971)		16,789	16,789	0
Cash & Cash Equivalents	33,015	33,320	305		33,015	33,320	305				
Efficiencies	2,360	1,434	(926)		7,080	3,535	(3,545)		47,200	30,700	(16,500)
Headcount (funded vs worked)	5,103	5,312	(210)						5,078		

Schemes totalling £46.9m (99% of target) have been identified, with governance now focused on accelerating implementation and increasing recurrent savings delivery

External turnaround support from Hunter Healthcare has been deployed to challenge delivery assumptions, support divisional recovery plans and strengthen implementation of high-value schemes.

A significant component of the recovery programme is workforce cost reduction. Delivery plans include a 30% reduction in agency expenditure, 10% reduction in bank utilisation, active recruitment to reduce medical locum dependency, weekly scrutiny of temporary staffing requests and conversion of recurring temporary staffing demand into substantive staffing models where appropriate. Workforce reduction trajectories are being monitored through divisional reviews, supported by Quality Impact Assessments to ensure financial savings do not adversely affect patient care.

Corporate expenditure controls remain in place, including enhanced approval processes for discretionary spend, non-pay expenditure scrutiny, vacancy controls and monthly review of underperforming savings schemes through the Financial Improvement Programme Board and divisional recovery meetings.

The Theatres Transformation Programme is focused on increasing elective productivity through reduction of on-the-day cancellations, increasing day-case rates, improving theatre utilisation and strengthening scheduling processes. Particular attention is being given to variation within General Surgery, Urology and Ophthalmology, supported by specialty-level productivity reviews and expanded use of the Surgical Elective Hub.

The Outpatients Transformation Programme is redesigning referral and follow-up pathways through implementation of a Single Point of Access model, expansion of straight-to-test pathways, digital booking processes, standardised follow-up arrangements and specialty-specific pathway reviews to reduce avoidable activity and improve productivity.

Income generation initiatives are also being progressed. These include pharmacy automation and medicines optimisation, expansion of private patient activity, pricing reviews, enhanced debt recovery processes, development of opportunities linked to contracted theatre services and a review of commercial income streams across support services. A proposal to revise staff parking

	The principal challenge remains converting identified opportunities into recurrent delivery. Whilst virtually all savings have now been identified, delivery remains behind plan, particularly within workforce and transformation programmes. Sustained operational pressures, high demand, use of escalation capacity and continued reliance on temporary staffing continue to constrain the speed at which financial benefits can be realised	charges for the first time since 2017 is also being considered

2.3 Cross-Domain Analysis

Operational demand is the central triangulating theme for June. High Bed occupancy, increased corridor care and high ED length of stay align with financial reporting showing escalation beds, additional staffing as material contributors to the adverse June position. The Trust has been in critical incident more than not since January 2026 reflecting the underlying pressure on capacity. Whilst the organisation remains focused on internal actions to improve flow and financial recovery there are further support actions required by system partners to ensure GWH has the ability find a sustainable recovery position.

Planned care recovery remains constrained by the same operational context. RTT% performance deteriorated while the total PTL remained broadly stable. Therefore, focus is ongoing to ensure the overall list size does not increase and more focus to ensure the recovery of waits through specialty-level plans. Due to the calculation the RTT% will lag in terms of reporting whilst improvements overall are shown in the overall waiting list size.

Workforce indicators show both control and pressure. Agency utilisation is reported as broadly in line with plan, but bank usage and substantive workforce variance are above plan, sickness absence remains above target, and financial plans require workforce reduction. This creates a continuing need to balance financial recovery with safe staffing, staff experience and retention.

Quality and safety reporting provides assurance that oversight is being actively maintained, particularly in maternity, safe staffing, complaints and incident review. However, harms and complaints data suggest that the broader operational environment continues to affect patient experience and safety-related metrics.

Capital and estates risks remain strategic constraints. The capital funding pressure, PFI expiry requirements, Building Safety Act delays and infrastructure risks have direct implications for operational resilience, service continuity and future transformation delivery. Car parking is raising a concern for local residents to the hospital and for local councillors, further work is required from the group estate and facilities function on the car parking/travel plan to meet increased staff and patient demand.

Section 3: Assurance Committee Summary

Committee / route	Key focus	Assurance received	Escalations / Board visibility
Finance, Performance & Infrastructure Committee	The Committee focused on delivery of the 2026/27 recovery plan, emerging financial forecast risks, urgent and emergency care performance, elective recovery, cancer standards, workforce productivity, agency expenditure and delivery of cost improvement programmes. Particular attention was given to the sustainability of current trajectories and the degree of confidence in achieving in-year financial and operational objectives.	The Committee received assurance on strengthened programme management and executive oversight supporting delivery of recovery priorities. Improvement has continued in a number of key operational areas, including elective waiting list management and elements of scheduled care productivity. The Committee noted actions underway to address areas of variance from plan, including enhanced scrutiny of divisional financial performance, further controls on temporary staffing expenditure and focused interventions within urgent and emergency care pathways. Assurance was also received that risks are being actively monitored through established reporting mechanisms and that mitigating actions are identified for all materially adverse variances.	The Committee highlighted that the overall financial position remains challenging and that significant delivery risk persists against efficiency and productivity assumptions. Continued pressure within urgent and emergency care, sustained levels of demand above historical norms and ongoing workforce cost pressures present a risk to delivery of plan. The Board is asked to maintain visibility of forecast performance against control totals, trajectory delivery within recovery programmes and the potential impact of operational pressures on both financial sustainability and quality outcomes.
Quality & Safety Committee	The main areas of scrutiny were maternity and neonatal front-door standards and workforce resilience; deteriorating infection metrics, particularly E. coli; stroke performance. Emergency Department governance; overdue incidents across divisions; complaints response performance. Speaking-up culture- FTSUP report. Quality consequences of high occupancy and flow pressure particularly through ED. The Committee also considered the wider quality impact of UEC pressure, with related Board-	The Committee received good assurance in several areas, while recognising that outcome metrics remain under pressure. Maternity and neonatal reporting showed strong governance and oversight, including 98.5% one-to-one care in labour in June, 100% supernumerary labour ward coordinator status, obstetric consultant presence at 74.5 hours, most maternity/neonatal training groups above the 90% MIS standard in June. Assurance was also received that PMRT	Maternity/neonatal capacity and compliance risks. The need to align triage standards to the NHSE service specification and neonatal staffing to BAPM standards, The detailed maternity data reinforces the risk: neonatal nurse-in-charge supernumerary cover was 51.6% in June against a 100% target, neonatal nursing shifts filled to BAPM QIS standard were 83.3% against a >90% green threshold, cot-occupancy-based staffing was 65% against a 90% target, and neonatal QIS-trained staff were 62.7% against a >70% target. The Committee also noted that neonatal medical staffing does not meet BAPM standards for dedicated Tier 2 overnight LNU cover, although

Committee / route	Key focus	Assurance received	Escalations / Board visibility
	report material noting 1,224 corridor-care episodes in June, 518 attendances on the busiest front-door day, 114% midnight occupancy, four-hour performance at 65.1%, and complaint response performance at 57% against an 80% KPI with 90 complaints received in June	reporting is embedded, with all perinatal deaths reported through PMRT since 2018, no reportable PMRT cases in June, and a MOSS signal drill completed in June with an Amber assurance rating and action plan to strengthen compliance The IPC annual report evidenced active surveillance and control systems, including CPE screening. Antimicrobial stewardship provided additional assurance, with 934 prescriptions audited, 93% reviewed within 24–72 hours, 99% having an indication recorded and 95% guideline adherence; however, antibiotic usage was 8% above baseline and narrow-spectrum access antibiotics accounted for 56% against a 61% acute-trust target. The new head of infection control demonstrated a clear plan	no direct harm had been identified and ANNP day cover has been confirmed from September. A case for recruitment is currently being finalised to be considered in July. Services which remain a challenge include Stroke, where ongoing support from the regional clinical lead is helping improve key front door metrics. Interventional Radiology: ongoing work with GHFT to ensure clear pathway for patients is in place by September when remaining consultant retires. Discussions are ongoing and progress is being made.
People & Culture Committee	The Committee focused on • workforce sustainability, organisational culture and delivery • confidence against the workforce recovery plan. • workforce affordability and delivery of the £23.9m pay savings requirement, • staff survey action plans, workforce experience, • Education and training compliance, medical workforce governance, employee relations, • and the Trust's highest-rated workforce risks. • The Committee also reviewed progress on the Fairer Deal for Nurses programme, Fit and Proper Person arrangements, Guardian of Safe Working reporting and workforce implications arising from delivery of the wider £47m recovery programme.	Assurance was received that employee relations governance remains robust and is increasingly standardised across the Group. GWH maintained sickness absence at 3.9%, ranking 2nd regionally and 4th nationally, whilst conduct cases reduced by 33% (73 to 49) and dismissals reduced by 60% (10 to 4), indicating positive impact from restorative and just culture approaches. The Committee received assurance regarding medical governance, appraisal and revalidation processes, with established governance through the Medical Staff Support Group, continued optimisation of the SARD system and ongoing compliance with Responsible Officer requirements	Delivery of the workforce component of the recovery plan remains the most significant people risk. The workforce plan requires delivery of £23.9m pay savings, including a 30% reduction in agency spend, 10% reduction in bank use, and an estimated workforce reduction of approximately 217 WTE, whilst £8.9m of savings remain unidentified. Detailed workforce delivery plans continue to be developed. Workforce performance remains above plan. At Month 3 the Trust was 104 WTE above plan and continued to experience higher-than-planned bank usage driven by sickness absence, critical incident pressures, front-door demand and patient flow challenges. National Education and Training Survey results identified continuing concerns regarding organisational culture in acute clinical environments. 13% of trainees reported discrimination from patients, 16% reported sexual safety concerns arising from patients, and ongoing themes of bullying, undermining and reluctance to raise

Committee / route	Key focus	Assurance received	Escalations / Board visibility
		Significant improvements were noted within Guardian of Safe Working metrics, with exception reports in General Medicine reducing from 411 to 100 over three years and Paediatrics reducing from 207 to 10, demonstrating improvement in working patterns and workforce management. Mandatory training compliance requires continued scrutiny, particularly Patient Safety Level 2 and Oliver McGowan training, where performance remains below target and operational pressures continue to impact release of staff for training. The Committee noted that full assurance cannot yet be provided on Fit and Proper Person compliance until planned audit activity is completed and historic records are fully validated under the new Group arrangements.	concerns were identified. The Committee requested clearer action plans and strengthened oversight of hotspot areas. Workforce capacity concerns remain within General Surgery, Geriatric Medicine and Stroke Medicine, which continue to generate higher levels of exception reporting and safe working concerns compared with other specialties. Consultant locum expenditure has also increased significantly year-on-year, requiring ongoing monitoring these are predominately related to hard to recruit specialties e.g. stroke.
Senior Leadership Team / TMC	The main areas of focus where progress against • Pillar metrics, • breakthrough objectives, • ORBIT, • corporate projects, • capital, • estates, • modular unit/decant works • AI transformation, • EPR readiness • risks.	Breakthrough objectives are early in the year, assurance provided in actions being taken for Reducing deconditioning, reducing corridor care, Elective performance, patient care our priority and improving productivity. The committee considered an update on the behaviours work to embed within the senior leadership team and wider. Update on AI and the potential benefits of Copilot to efficiency and effectiveness of processes. Update on the recovery plan/delivery plan in year, focus on RTT, UEC, Cancer and diagnostics delivery.	Key issues for board visibility includes Access target performance, both RTT and Cancer performance shows early signs of improved performance, but sustained focus required to ensure progress continues. June was unprecedented ED demand which in turn put significant pressure on flow through out the hospital. Demand management shows no signs of impacting GWH activity and remains a key risk. Financial forecast including cash position, capital forecast over plan c£3m and the need to identify further savings to mitigate the part year impact of schemes identified. Capacity for change was escalated in terms of responding to recovery pace, particularly the impact of financial recovery alongside EPR

Committee / route	Key focus	Assurance received	Escalations / Board visibility
		Progress on health and safety fire risk – completion of health and safety audits.	readiness. Transformation schemes are deep rooted and require significant management intervention to achieve.

Section 4: Deep Dive / Other Business

4.1 PFI expiry and estates resilience at GWH

The Finance, Performance & Infrastructure Committee and Senior Leadership Team reviewed the long-term risks associated with the Trust's PFI estate, future lifecycle requirements, infrastructure resilience and preparation for PFI contract expiry. Particular attention was given to the condition of core infrastructure, backlog maintenance requirements, ward refurbishment programmes and the organisational capacity required to manage PFI hand back and estate transition activity.

Assurance was received that a structured programme of work is underway to prepare for future PFI contract expiry and manage associated estate risks. Detailed planning is being undertaken across maintenance, lifecycle replacement and infrastructure works, supported by development of longer-term utilities and estate strategies. Live utility monitoring dashboards are now being used to improve oversight of electricity, heating and water capacity, with capacity reviews embedded within future capital planning processes. The Committee also received assurance that refurbishment and lifecycle planning is progressing for key clinical areas, including Trauma and Kingfisher wards, and that estate requirements are increasingly being incorporated into wider operational and transformation planning.

The Committee highlighted a significant medium-term risk associated with the scale of work required to support PFI expiry and lifecycle management. Current assessments indicate that additional dedicated resource will be required to deliver the volume of contract, technical, surveying and project management activity associated with hand back preparations, with proposals identifying a requirement for approximately 11-15 WTE specialist capacity. An investment request of c£3.6m was presented to Orbit, this was a new request not previously raised through planning process due to the national guidance from NHSE not being issued until January 2026. This pressure is not in the financial plan for this financial year.

Due attention should be paid to resourcing the exit appropriately as infrastructure constraints, backlog maintenance requirements and utilities resilience remain key risks which could affect future service development, site reconfiguration if not addressed early. The risk to the capital spend of the Group is significant if sufficient maintenance work is not undertaken whilst still in the PFI contract, the liability transfers to GWH. Similarly preparing for the revised soft FM service contract post PFI is of significance importance to ensure a service that meets the hospitals need but also one that achieves maximum value for money. These risks are reflected in the risk register and ongoing oversight is being overseen through finance, performance and infrastructure committee.

Continued Board visibility is therefore required on PFI hand back readiness, estate investment requirements, infrastructure resilience and the financial implications of managing the transition from the current PFI arrangements.

Section 5: Maternity

Maternity and neonatal services remain an area of Board visibility, with Quarter 1 reporting providing assurance that governance, safety oversight and quality surveillance arrangements remain robust. Training compliance remains strong across all staff groups, a Tier 2 MOSS signal drill was successfully completed with an agreed improvement plan, and incident reporting levels remain stable, providing assurance of a positive safety culture and continued staff willingness to raise concerns. Patient experience feedback continues to highlight compassionate care, strong teamwork and positive outcomes, supported by achievement of UNICEF Baby Friendly Gold accreditation and full compliance with CNST Year 7 requirements.

Neonatal workforce capacity remains the most significant risk. Current nursing and medical staffing do not fully meet revised BAPM standards, particularly for Tier 2 overnight cover, against a backdrop of sustained acuity and demand. A business case to strengthen neonatal nursing, medical and ANNP capacity is progressing through governance routes, with 12-hour, 7-day ANNP day cover commencing from September 2026. Increasing maternity activity is also placing pressure on elective theatre capacity and workforce resilience, although no related patient safety incidents have been identified.

The service continues to respond proactively to learning identified through thematic reviews, national reports and local surveillance. A review of neonatal hypoglycaemia incidents identified hypothermia and pathway compliance as key improvement themes, informing development of the FORTRESS quality improvement project. Postpartum haemorrhage rates remain stable and within expected variation, while ongoing work continues to strengthen equity, interpretation services, patient experience and implementation of recommendations arising from the Ockenden, Amos and CQC reviews.

Strong governance arrangements remain in place to support delivery of MIS Year 8 requirements, PMRT compliance, safety learning, and implementation of national safety programmes. There were no stillbirths reported in Quarter 1, all eligible perinatal losses were reviewed within required timescales, and no new significant safety themes were identified through incident surveillance.

Section 6: Risk Escalation

This section presents significant GWH risks using the 5+5+5 methodology. The highest scoring GWH risk in the June Group Risk Register is GWH-1576 at residual score 13. All other risks below are shown as residual score 12 and require continued executive oversight, with controls and actions routed through the relevant assurance committees, Divisional governance and Group risk processes.

Category	Risk ID & title	5+5+5 score	Controls / route
Operational / financial	GWH-1576 - There is a risk GWH does not have the capacity or capability to achieve the scale of the improvements to achieve the plan.	5+4+4 = 13	Financial governance oversight; financial performance reporting; Hunter Healthcare support; corporate project oversight; monthly ERMs linked to breakthrough objectives.

Category	Risk ID & title	5+5+5 score	Controls / route
Operational / flow	GWH-1085 - There is a risk that the high hospital occupancy leads to poor patient flow through the hospital affecting the delivery of safe care	5+4+3 = 12	Breakthrough objective, corridor care monitoring, emergency zone operational group, escalation policy, handover improvement group, safety checks, NCTR improvement plan, UEC and Flow Programme, Nerve centre.
Quality / stroke	GWH-1267 - There is a risk that stroke patients will not receive quality care and timely interventions required to aid their recovery which can be evidenced SSNAP performance.	4+5+4 = 13	Stroke Unit SOP amendment, Bournemouth predictor tool, visual field assessment, dedicated stroke bed safeguarding, divisional oversight and weekly performance oversight.
Quality / service continuity	GWH-1382 - There is a risk to service provision & patient safety due to Interventional Radiologist shortage.	4+4+4 = 12	Case triage, transfer arrangements, urgent tertiary referral, bank IR support, third-party SLA, agency cover, NHSE hub-and-spoke support and emergency IR support arrangements.
Infrastructure / compliance	GWH-1401 - Building Safety Act	5+3+4 = 12	Estates & Facilities Board, EFM monthly risk review, legal advice, BSR submissions, building control engagement and competence checks.
Leadership capacity	GWH-1493 - Insufficient Clinical (Medical) leadership capacity and training.	4+4+4 = 12	New CMO appointment, AMD and executive support, and new clinical leadership training commenced May 2026.
Clinical environment	GWH-1577 - There is a risk that suboptimal clinical environment is impacting patient experience and effectiveness of clinical care.	4+4+4 = 12	IPC measures and audit, duty of candour, health and safety assessments, divisional environmental risk reviews, capital bids and Way Forward Programme masterplan.
Surgical assessment capacity	GWH-570 - There is a risk to patient safety at times of pressure due to the increasing demand of patients who attend the Surgical Assessment Unit	5+4+3 = 12	Daily divisional huddle three times daily, daily safety and quality meeting, and Matron of the Day escalation role. Business case going through governance to increase ACP capacity
PFI / capital funding	GWH-1608 - Insufficient capital funding for estate betterment and PFI hand back readiness	4+4+4 = 12	PFI Expiry Capital & Betterment Plan, resourced PFI Expiry Programme Plan and charitable funds application for betterment works.
Quality/Maternity	GWH – 1560 The footprint of the Maternity Care Centre and Day Assessment Unit is not adequate to fulfil the demand.	4+4+4 =12	Risk assessment, emergency buzzers, records of routine emergency drills and incident reviews learning.

6.2 Risk narrative

Risk reporting identifies a material concentration of significant risks related to financial recovery, high hospital occupancy, specialist workforce fragility, clinical leadership capacity, estates infrastructure and PFI expiry. These risks are interdependent: operational pressure is increasing staffing requirements and affecting elective recovery; workforce constraints limit recovery pace; and capital, estates and EPR dependencies constrain transformation capacity.

The most significant escalation is GWH-1576, relating to capacity and capability to deliver the financial plan. This should be considered alongside June's financial performance, CIP under-delivery, workforce above plan and the continuing need to maintain safe operational delivery.

GWH-1085 remains the clearest operational risk link between flow, corridor care, patient safety, ED performance and financial recovery. Current mitigations include Right Care, UEC and Flow Programme actions, escalation controls, NCTR improvement plans with system partners and additional capacity enabled by MSSU.

A further risk theme is specialist workforce capacity. GWH-1314, GWH-1382 and GWH-1493 demonstrate the effect of workforce fragility on timely diagnosis, service provision, patient safety and the organisation's ability to deliver major clinical and transformation priorities.

Estate and infrastructure risks GWH-286, GWH-299, GWH-1401, GWH-1608 and GWH-1613 require continued Board visibility because they directly affect service resilience, future development, PFI expiry planning and capital availability. These risks should remain visible alongside the capital funding pressure and the sequencing of major programmes.

Section 7: Care Organisation Context

June was dominated by acute operational pressure, with high demand, leading to Critical Incident status. The subsequent high occupancy and corridor care materially affected GWH's ability to deliver access, productivity and financial recovery plans.

The Board should note that controls and governance arrangements are in place for oversight, including elective recovery EPAG, financial oversight through (FIPB, financial controls, discretionary spend panel, workforce controls) the governance is under continual review as the move to Group assurance and oversight embeds. However, the degree of interdependency between urgent care, planned care recovery, workforce controls, patient experience, capital constraints and financial recovery means that improvement in one domain is unlikely to be sustainable without system-wide delivery.

The immediate Board emphasis should remain on UEC and flow recovery, RTT long wait reduction, financial and workforce control, and assurance that capital, estates, PFI and EPR dependencies are sequenced in a way that protects operational delivery.

Appendix A: Escalation reports to Management Committee

- Quality and safety committee escalation report
- People and culture committee escalation report
- Finance, performance and infrastructure escalation report
- Senior Leadership Committee (TMC) escalation report.

BSW Hospitals Group Executive Committee

Agenda item	Managing Directors Report – Salisbury NHS FT
Report title	Managing Directors Report – Salisbury NHS FT
Date of meeting	11th August 2026
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
BAF 1 -10	This report covers issues related to all BAF Risks.

KEY MESSAGES

The Trust continues to deliver predominantly safe care and maintain positive momentum in elective recovery, cancer performance and organisational improvement. However, operational delivery remains constrained by sustained urgent care pressures, high bed occupancy, workforce availability challenges and the scale of the financial recovery programme. While the organisation remains broadly on plan at the end of Quarter 1, delivery risk increases through the remainder of the year and will require continued focus on flow, workforce, productivity and transformation delivery and Group and System dependencies to materialise.

RECOMMENDATION

The Group Executive Committee is asked to:

1. Note the report and raise any issues arising as a result
2. Identify where further Group support or action is required to support delivery at Care Organisation level

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Quality and Safety Committee Escalation Report	Appendix A
Finance and Performance Committee Escalation Report	Appendix B
People and Culture Committee Escalation Report	Appendix C

1.1 Alert | Advise | Assure

ALERT

Urgent Care Flow and Operational Pressure - Urgent and emergency care remains the principal operational challenge. June saw continued deterioration in flow metrics, with ED performance reducing to 66.3%, ambulance handovers increasing to an average of 37 minutes, NCTR rising to 77 patients and continued reliance on escalation capacity. The Trust experienced sustained operational pressure throughout the month, including periods of critical incident escalation.

In response, reducing non-elective length of stay has been established as a new breakthrough objective, an integrated discharge programme has been created following an external analysis from Health Integration Partners, an enhanced SDEC will open on 2nd September and preparation for the opening of the Urgent Treatment Centre remains on track for Autumn. Work also continues through the UEC Board on flow redesign, and ward processes.

SFT will continue to focus on internal improvements, however, UEC performance and the consequential financial cost will continue to affect plan delivery until there is a significant step-change in the out of hospital environment. In the absence of assurance from the ICB and partners on this a Group H@H service would be such a step-change.

Group CMOs and CNOs recently wrote to the ICB raising concerns about the impacts of HCRG's service provision and the impact on quality, patient experience and the extra burden being placed back on to group clinicians.

Financial Sustainability and Cash - The Trust remains on plan at Quarter 1 but delivery of the full-year position remains highly dependent on achievement of the £32.5m efficiency programme, delivery of productivity improvements, workforce reductions and clinical transformation schemes. Cash remains the most significant financial risk, with forecasts indicating increasing pressure during the second half of the year.

Actions underway include strengthened oversight through the CIP Delivery Cell, dedicated turnaround arrangements, enhanced workforce and productivity governance, and establishment of the Group Cash Management Committee. Work also continues to proactively progress key dependencies including coding improvements and the key worker accommodation programme.

Workforce Availability - Staff unavailability remains at 21.2%, significantly above the breakthrough objective target of 16%, whilst sickness absence increased to 4.23%. Workforce availability continues to impact productivity, temporary staffing expenditure and operational resilience.

Targeted interventions continue through the Steering Group, attendance management initiatives, reductions in time-to-hire, team-based rostering and focused action within high-absence areas. Workforce availability remains a core organisational priority.

Care Quality Commission Rating - The Care Quality Commission (CQC) published its report on Thursday 30th relating to Surgical Services and has adjusted our overall location rating to Requires Improvement.

This reflects both the surgery inspection undertaken in September 2025 and a correction by the CQC to how historical inspection ratings were previously aggregated. In effect, the CQC has advised that our overall location rating should have been Requires Improvement since 2021.

The surgery service was rated Good for being effective, caring and responsive, and Requires Improvement for being safe and well-led. We are already addressing the areas identified for improvement and will continue to focus relentlessly on the things we need to do better, while building on the many strengths that colleagues demonstrate every day.

The CQC recognised that the rating was based on a number of aged inspections (back to 2016) and it needed to review its inspection pipeline accordingly. On Tuesday 4th August the CQC attended for an unannounced inspection of spinal rehabilitation services.

Whilst disappointing, the publication does not reflect the current position in many areas and the Trust's focus remains on delivering the required improvements, maintaining strong governance oversight and ensuring readiness for future inspection activity

ADVISE

Staff Pulse - July Pulse Survey results present a mixed picture. Response rates reduced to 14%, continuing a recent downward trend and highlighting the importance of maintaining meaningful engagement with colleagues. While overall staff engagement, advocacy and organisational confidence indicators have softened since their peak in 2024/25, there are some encouraging signs, including a small improvement in colleagues reporting that they look forward to coming to work and increasing awareness and engagement with the BSW Hospitals Group. Around 30% of respondents now report being aware and engaged with the Group, although many colleagues remain uncertain about what this means for their role. The results suggest that the cumulative impact of sustained operational pressure and organisational change is being felt by staff and reinforce the importance of continuing to invest in communication, leadership visibility, career development and colleague support. The findings will help inform local action planning and may provide an early indication of themes likely to emerge in the forthcoming National Staff Survey.

Delivery Capacity - The cumulative impact of EPR implementation, Corporate Services Review, financial turnaround programmes, Group transition and national improvement requirements continues to create pressure on organisational capacity. Transformation delivery and HR/change management capacity therefore remain areas requiring close executive oversight.

SFT has a mature EPR Organisational Readiness Committee. Increasingly the committee is identifying 'out-of-scope' resource requirements which is increasing the burden on the care organisation. A request to the EPR programme team to review the scope has been initiated and a date is awaited.

Delivery of the coding improvement programme has not progressed at the pace required due to insufficient capacity within the Digital portfolio, arising from Corporate Services Review savings requirement. As a result, the digital enablement necessary to realise the £10m coding opportunity identified in the SFT business plan has not been delivered. A business case to invest in dedicated coding resource has now been developed and, in the interim, SFT is deploying turnaround support and exploring alternative routes to accelerate improvement. Whilst the opportunity was not assumed to generate additional income or cash,

delivery remains critical. Firstly, further block contract unwinding will influence future system settlements and accurate coding is therefore increasingly important. Secondly, improved coding will provide a more accurate reflection of clinical activity and productivity, strengthening discussions regarding organisational performance, Group sustainability and the underlying deficit position.

Business cases - Business cases for UTC and Stroke, both of which were included in the annual plan have been approved at Care Organisation level. The DASH business case has been submitted with a £6m capital gap. Value engineering and alternative sources of funding will continue to be explored, however, the project will need to be the first priority for on Group capital in 28/29 if the affordability can not be bridged.

In July, the NHSE Regional CFO stated in a Provider Oversight meeting that SFT should not enter into the KWA agreement without HMT approval. Further positive written auditor opinion has been provided and direct discussions with NHSE regional colleagues have proven helpful in clarify their misunderstandings which prompted the referral. Nevertheless, we await HMT review of the business case and there are currently no timescales for that. It is certain that our M4 plan position will be missed as a result.

ASSURE

Elective recovery continues to perform strongly. RTT performance improved to 72.5% and remains ahead of plan, whilst average waiting time to first outpatient appointment reduced to 101 days, the best position achieved to date. Validation programmes, specialty recovery actions and outpatient transformation continue to deliver measurable benefits.

Cancer performance continues to recover. The 62-day standard improved to 75.1%, achieving plan, whilst the backlog reduced to 76 patients, its lowest level since April 2025. Improvement work through the Cancer Improvement Group and pathway redesign continues to strengthen performance.

Improving Together remains an area of organisational strength, with improvement methodology increasingly embedded within clinical, corporate and turnaround programmes. Leadership development, research governance, patient experience and maternity training compliance all received positive assurance during the month

1.2 Key Achievements

- The SFT leadership development programme is comprehensive, mature, closely aligned to national aspirations and demonstrates strong evidence of impact. The capacity of the team responsible is being reduced as a result of CSR.
- AVT Licences secured by the Group are being rolled-out
- RTT performance improved to 72.5% and remains ahead of plan.
- Time to first outpatient appointment reduced further to 101 days, the best position on record.
- Cancer 62-day performance achieved 75.1% and the backlog reduced to its lowest level since April 25.
- Staff vacancy levels remain low, sustaining a positive net position.
- CNST training compliance achieved at the first national reporting point.
- Regional recognition received for Retinopathy of Prematurity improvements.
- Improving Together continues to expand, with 153 teams having completed Improver training and 50 active improvement huddles in place.

- Research activity remains strong, with more than 115 active studies and over £1m of research funding.

Section 2: Performance Triangulation

2.1 Plan Position

Metric	Standard / Plan	Current Performance	Status	Commentary
RTT	70.2% plan	**72.5%**	🟢 Above plan	Continues to improve and remains ahead of trajectory.
Total RTT waiting list	Reduce / manage within trajectory	**29,733 patients**	🟢 Improving	Waiting list size continues to reduce, although long waits require continued focus.
Cancer 62 Day	75%	**75.1%**	🟢 Achieved	Standard achieved in May reporting, with performance at its highest point since December 2024.
Cancer 28 Day Faster Diagnosis	80%	**78.7%**	🟠 Below standard	Slightly below standard, with ongoing challenges in Lower GI, Urology, Haematology and Lung.
Diagnostics	89% local plan / 95% national standard	**86.2%**	🟠 Below plan	Below plan, driven mainly by Audiology, CT and Urodynamics capacity constraints.
ED 4 Hour	78.3% local plan / 82% March 2027 ambition	**66.3%**	🔴 Significantly below plan	Principal operational challenge, with special cause concern linked to sustained flow pressure.
ED 12 Hour	Reduce / minimise	**794 breaches**	🔴 Off track	Increased from 702, reflecting sustained crowding and flow constraints.
Ambulance handover	20 mins plan / <15 mins national ambition	**37 mins average**	🔴 Off track	Poorest level in over two years and a key indicator of front-door pressure.
Bed occupancy	96% target	**97.0%**	🔴 Above target	Remains above target and continues to constrain flow.
NCTR	45 patients / 9% plan	**77 patients**	🔴 Off track	Remains materially above plan and is a key driver of occupancy and escalation capacity.
Staff Unavailability	<16%	**21.2%**	🔴 Off track but improving	Improved from 22.8%, but remains significantly above target.
Productivity	-5.33% target	**-11.16%**	🟠 Improving but off target	Continues to improve from baseline, supported by activity gains, but remains below target.
Financial Position	Break-even plan	**On plan at M3**	🟡 Delivered to date	On plan at Quarter 1, but delivery risk increases in H2.
CIP Programme	£32.5m delivery requirement	**£85k ahead of plan**	🟢 Currently on track	On trajectory, although workforce and service transformation schemes remain high risk.
Total WTE	Reduction trajectory from 4,430 WTE M1 to 4,287 WTE M12	**4 WTE over establishment at M3**	🟡 Watch	WTE trajectory requires continued reduction through the year; current position is close to plan but delivery remains dependent on workforce controls.

2.2 SPC Variation

Sustained improvement:

Elective Recovery

- RTT Performance improved to 72.5%, continuing a sustained upward trajectory and remaining ahead of plan. Waiting list size is also reducing, suggesting genuine improvement rather than short-term fluctuation.
- Time to First Outpatient Appointment (TT1OPA) reduced to 101 days, the lowest position recorded since the breakthrough objective was established. SPC identifies this as Special Cause Improvement.
- Patient-led validation continues to remove patients no longer requiring appointments and is supporting elective recovery.

Cancer Performance

- 62-day cancer performance improved to 75.1%, achieving plan and reaching its highest level since December 2024. SPC identifies this as Special Cause Improvement.
- 62-day backlog reduced to 76 patients, the lowest level since April 2025.
- Cancer recovery appears increasingly embedded through pathway management and Cancer Improvement Group oversight.

Productivity

- Productivity improved from-11.6% to -11.2%, continuing a longer-term improving trend from the baseline position. SPC identifies this as Special Cause Improvement.

Workforce

- Staff Unavailability reduced from 22.8% to 21.2%, reaching the lowest position since November 2025. Although still materially off target, the direction of travel is positive.
- Staff turnover continues to improve and remains below target in several areas.
- Vacancy position remains favourable, with the Trust sustaining a positive net vacancy position.

Adverse variation:

Urgent and Emergency Care

- This is the most significant cluster of adverse variation.
- 4-hour ED performance reduced to 66.3% and is classed as Special Cause Concern.
- Ambulance handovers deteriorated to an average of 37 minutes, the worst level in more than two years and identified as Special Cause Concern.
- Ambulance handovers >45 minutes increased to 254, showing sustained deterioration.
- ED 12-hour breaches increased to 794.
- Use of Temporary Escalation Space / Corridor Care continues a sustained upward trend and is identified as Special Cause Concern.
- NCTR increased from 73 to 77 and remains significantly above target, although still classified as common cause variation rather than a new special cause event

Pressure Ulcers

- Pressure ulcers increased from 2.1 to 3.8 per 1,000 OBDs, significantly above the breakthrough objective target.
- Incidence doubled month-on-month (17 to 34 pressure ulcers).
- The narrative links this partly to heatwaves, longer ED stays and operational pressures.

Workforce Metrics

- While staff unavailability improved overall, several workforce measures remain concerning:

- Sickness absence increased to 4.23% against a target of 3%.
- Mandatory training compliance remains at approximately 82%, around eight percentage points below target and unchanged for a prolonged period.

  Non-medical appraisal compliance remains low at 70.6%, with almost 1,000 appraisals overdue.

Diagnostics

- DM01 fell to 86.2%, below plan, driven largely by Audiology, Cardiac CT and Urodynamics capacity constraints.

So what: The SPC view is increasingly bifurcated. The Trust continues to demonstrate sustained improvement in areas largely within its direct control, particularly elective recovery, cancer performance, outpatient access, productivity and improvement capability. In contrast, the strongest adverse SPC signals are concentrated around urgent and emergency care flow, including ED performance, ambulance handovers, NCTR, escalation capacity and pressure ulcer incidence. This reinforces that our greatest delivery challenge remains flow and discharge rather than elective recovery.

2.2 Assurance Committee Summary

People & Culture Committee - The People & Culture Committee concluded that overall assurance remains mixed. Positive assurance was received regarding leadership development, employee relations governance, Guardian of Safe Working arrangements, flu vaccination performance and the successful implementation of the new governance structure. However, the Committee highlighted continuing concerns regarding workforce availability (21.2% against a target of <16%), sickness absence (4.23%), mandatory training compliance (81.9%) and non-medical appraisal compliance (70.6%). Particular attention was drawn to the risk associated with HR and change management capacity during the Corporate Services Review and wider transformation programme, with the Committee emphasising the need for strengthened recovery trajectories, clearer accountability and continued oversight of workforce sustainability and organisational change capacity.

Finance & Performance Committee - The Finance & Performance Committee reported that the Trust remains broadly on plan at the end of Quarter 1, with RTT and cancer performance continuing to improve and CIP delivery slightly ahead of plan. However, the Committee identified significant risks relating to cash sustainability, delivery of the financial recovery programme, coding assumptions, workforce reductions and clinical transformation dependencies. Operationally, urgent care performance remains the most challenged area, with ED performance, ambulance handovers, NCTR and length of stay all contributing to pressure on flow. The Committee noted that actions are underway through the CIP Delivery Cell, turnaround arrangements, urgent care improvement programmes, UTC mobilisation and a new breakthrough objective focused on reducing length of stay. Key risks escalated included the financial position, cash balances, central booking instability, NCTR performance and estate infrastructure concerns.

Quality & Safety Committee - The Quality & Safety Committee reported a mixed assurance position, with positive assurance received regarding research governance, health inequalities work, patient experience, cancer performance improvement and maternity staffing indicators. Areas requiring further attention included oversight and assurance of actions arising from patient safety incidents, mortuary services governance, the outpatient follow-up backlog and maternity infrastructure risks. The Committee

highlighted continuing concerns regarding the lack of a dedicated second obstetric theatre, BAPM workforce compliance, operational pressures affecting quality and patient flow, and increasing assurance requirements arising from the NHS Maternity 10-Point Plan, Ockenden and Amos reviews. Actions are underway to strengthen patient safety action tracking, address follow-up backlog validation, improve mortuary service assurance and progress maternity workforce and infrastructure solutions, with the second obstetric theatre risk formally escalated through the governance process

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Section 3: Deep Dives

Group Transition and Transformation and Group Elective Delivery Transformation

The transition to BSW Group is progressing at pace and entering operational phase. The governance structure for the care organisation has been implemented. SFT have taken a 'broad church' approach to Committee membership which has been received well by the wider SLT, but will require some further development. Currently there is a risk that the work-plan of the People and Culture Committee overly focus' on the transactional nature of the People service rather than recognising the responsibility for driving cultural work across the care organisation.

The new risk approach is being embedded and has been well-received so far. There are capacity challenges within the risk and corporate governance teams limiting the ability to optimise the processes at this stage.

The Corporate Service Review will help with Group sustainability and must progress. The impact on colleagues' well-being and morale is increasing as a result of the delays and a number of people have left the Group as a result. Teams are being supported as best as possible locally. Tight and proactive management of the change process from design leads would mitigate this impact. Service delivery impacts are starting to surface, for example, in the SFT Employee Relations team and the SFT Organisational Development team.

The MD has taken on the SRO role for the Group to develop a business case considering the model for the corporate services hosting. The business case is due at the end of September for a Group governance review in October and November.

In addition to facilitating the release of the SFT CNO to the Group CSO role, the MD has recently supported the release of the SFT COO to lead the Group planning process for 26/27 building on the SFT planning approach.

There are a number of positive developments in the Group Elective programme workstream, for which the SFT MD is SRO.

A Group Elective Strategy has been developed, supported by funding from the SFT DASH project, and will be brought through Group governance in October and November.

The elective programme initiated and is delivering the dermatology transformation which is progressing well and is due to present a new model in October for ICB and Group approval. SFT is funding delivery resource for this programme. The transformation is a vanguard for the way an IHO style model could work and for delivering the 'three shifts'.

The programme is helping coordinate work across the three care organisations to establish the new Discuss and Refer model. SFT has financially underwritten additional work to the Cinapsis E-referral system to enable changes to be made across the Group in time for the October go-live.

Plans for the establishment of a Group Elective Referral Centre are well-advanced. The ERC would act as the hub for managing referrals across the Group facilitating the allocation of demand to meet capacity. Initially a small number of pathways will run through it, over time, the ambition is for the majority of elective referrals to come through the ERC and for the Group to manage the totality of the elective budget.

Maternity and Neonatal Services

Maternity and Neonatal Services continue to provide safe care and maintain a number of important quality indicators despite increasing operational, workforce and regulatory demands. Positive assurance was received through the Quality & Safety Committee regarding CNST compliance, labour ward staffing indicators, screening performance and neonatal outcomes. One-to-one care in labour and supernumerary labour ward coordinator cover continue to be consistently achieved, and the service has successfully avoided OPEL 3 and OPEL 4 escalation despite wider operational pressures across the organisation.

The service remains subject to significant external scrutiny and improvement requirements. Delivery of actions arising from the NHS Maternity 10-Point Plan, Ockenden and Amos reviews continues at pace, supported by strengthened governance arrangements and enhanced executive oversight. CNST training compliance was achieved at the first national reporting point, providing additional assurance regarding staff capability and mandatory training requirements. Regional recognition was also received for improvements in Retinopathy of Prematurity services.

The principal risks remain workforce sustainability and infrastructure capacity. Compliance with British Association of Perinatal Medicine (BAPM) neonatal workforce standards remains below expectation and a neonatal medical workforce review is underway to identify sustainable solutions. The absence of a dedicated second obstetric theatre remains one of the Trust's highest-rated quality risks and has been formally escalated through the governance framework (Risk SFT-6412; score 12). The risk reflects increasing obstetric demand, the potential impact on emergency theatre access and the consequential patient safety implications. Development of a business case for additional obstetric theatre capacity is progressing.

Looking forward, executive attention will remain focused on delivery of national maternity improvement requirements, neonatal workforce sustainability, climate resilience, EPR readiness and progression of the obstetric theatre solution. While significant challenges remain, the overall position is one of a service that continues to provide good assurance regarding quality and safety, whilst requiring sustained focus on infrastructure and workforce-related risks to support future resilience.

Section 4: Risk Escalation

4.1 Escalation Gateway

Risk ID & Title	5+5+5 Score	Controls Assessment	Reason for Escalation
SFT-8791 Financial Position 2026/27	13	Partially Effective	Material delivery risk within the financial recovery plan and dependency on savings, workforce and transformation dependencies particularly related to clinical transformation, corporate services and coding improvements.
SFT-8759 Unavailability of Cash Balances	13	Partially Effective	Cash forecasts indicate increasing pressure in H2 and remain dependent on delivery of CIP and key worker accommodation transactions.
SFT-8102 Central Booking Workforce and Process Instability	13	Partially Effective	Workforce shortages, operational backlog and risk to patient pathways, utilisation and income.
SFT-8800 Reduction in No Criteria to Reside	12	Partially Effective	Continued discharge delays impacting occupancy, emergency flow and use of escalation capacity.
SFT-6229 DSU Estate Infrastructure Failure	12	Partially Effective	End-of-life infrastructure creating operational, safety and patient experience risks.
SFT-8926 DASH Capital Shortfall	12	Partially Effective	Current cost estimates exceed identified funding by approximately £6m. This will be closed through Group capital in 27/28
SFT-8780 HR and Change Management Capacity	12	Partially Effective	Risk to delivery of CSR, organisational redesign and wider transformation programmes.
SFT-6412 Harm to Women and Babies Through Lack of Dedicated Second Obstetric Theatre	12	Partially Effective	Increasing obstetric demand and infrastructure limitations continue to present patient safety risk.

The People and Culture Committee proposed an escalation of a '10' risk related to 'Failure to deliver a sustainable workforce' because financial controls, recruitment constraints and operational pressures may affect workforce resilience and service delivery. The COMC did not agree this and identified that a strategic risk related to workforce sustainability was captured on the Group BAF.

Risk Narrative

The principal risks facing the organisation remain closely interconnected. Financial recovery, urgent care flow, workforce sustainability and transformation capacity each influence the others. Mitigations are in place across all areas; however, successful reduction in risk scores will depend on sustained progress in flow, workforce availability, financial delivery and organisational readiness for EPR and Group transformation programmes

The overriding strategic risk for the organisation is that the cumulative burden of operational pressure, financial recovery requirements, Group transition and EPR implementation begins to exceed organisational delivery capacity. While each programme is individually manageable and appropriate mitigations are in place, continued success will depend on disciplined prioritisation, effective sequencing of change and

timely support from both Group and system partners. The development of a Group Engine Room by the Group CSO is a timely and crucial intervention to mitigate this risk and the Group Board will be

Section 5: Care Organisation Summary

Salisbury NHS Foundation Trust continues to demonstrate resilience and organisational maturity despite operating within a highly challenging environment impacting staff morale and well-being. The organisation is delivering sustained improvement in elective recovery, cancer performance and outpatient access while simultaneously managing significant urgent care pressures, workforce constraints, financial recovery requirements and major transformation programmes. The transition to the BSW Hospitals Group operating model is progressing well, with new governance arrangements now established and SFT making a significant contribution to Group-wide priorities including elective transformation, Discuss and Refer, development of the Elective Referral Centre, and planning for future corporate service hosting arrangements. At the same time, the cumulative impact of EPR implementation, Corporate Services Review, financial turnaround programmes and system-wide transformation is increasing pressure on organisational capacity and staff wellbeing. The key focus over the coming months will be maintaining operational grip on flow and financial delivery, supporting colleagues through change, delivering EPR readiness, progressing major capital schemes including DASH and key worker accommodation, and ensuring that Salisbury continues to play a leading role in shaping and delivering the ambitions of the BSW Hospitals Group

Appendix A - Quality and Safety Committee Report to the Care Organisation Management Committee

Care Organisation	Salisbury
Committee	Quality and Safety Committee
Meeting date	28 July 2026
Author	Duncan Murray
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance /For Information
Linked to Strategic Priority (s)	
Linked BAF principal risk(s)	2; 9; 12
Reporting period	July 2026

1. Executive summary

The Committee scrutinised the inaugural cycle of quality and safety assurance under the new governance arrangements, including CMB escalation, corporate risks for Q&S oversight, IPR quality and care performance, maternity and neonatal assurance, mortuary services, follow-up appointment backlog, health inequalities, research, patient experience, and perinatal surveillance. The Committee reached a mixed assurance position: there was positive assurance on research governance, health inequalities work, patient experience, and key maternity staffing indicators, but only partial or limited assurance in relation to patient safety incident action oversight, mortuary services governance, and non-RTT follow-up backlog. Individual risks scoring 10 and above will be reviewed in detail next month.

2. Alert, Advise, Assure

2.1 Alert

- **Patient safety incident action oversight:** the Committee identified that it currently cannot be assured that actions arising from Patient Safety Incidents are being consistently completed or embedded, which is a significant area of interest for CQC inspections. Risk and Patient Safety teams are working with divisions to standardise the process. COMC is asked to support a clear deadline, accountable owner and reporting route back through CMB/Q&S.
- **Outpatient and non-RTT follow-up backlog:** the Committee noted an initial cohort of around 3,300 patients on non-RTT patients on inpatient pathways potentially overdue follow up and/or treatment, of whom around 1,400 still require validation, and this work is underway at specialty level. Further, early scoping suggests around 26,500 outpatients potentially overdue follow-up on non-RTT pathways, although significant data quality issues evident in both cohorts suggest actual number of overdue patients is considerably lower in each. Q&S will receive an update on this

work in November. COMC is asked to ensure the backlog is captured on the risk register, that clinical harm review is built into the validation framework, and that the issue has a clear executive owner across Quality and Safety and Finance and Performance. **BAF risk 12**

- **Mortuary services assurance statement:** the Committee was reassured but not assured after identifying gaps in the mortuary response and inconsistencies between locally tracked Fuller recommendations and NHSE expectations. COMC should note the incomplete assurance position and ensure the updated board assurance statement reflects the gaps, actions and timescales, including CCTV and bereavement access actions due by the end of August 2026. The board assurance statement submitted to NHSE will reflect the described assurance position.
- **Maternity and neonatal safety capacity:** the Committee noted ongoing patient safety risk from obstetric theatre capacity, BAPM medical compliance at 43%, estate temperature challenges, and significant assurance demands arising from the national 10-Point Plan, Amos and Ockenden reports. COMC should maintain oversight of the obstetric theatre options paper, paediatric workforce review and response to national actions in the Amos and Ockenden reports. The committee acknowledged the need for clarification of Board reporting arrangements for Maternity and Neonatal services within the new governance arrangements. **BAF risk 2; 6; 9**

2.2 Advise

- **Governance transition and committee purpose:** this was the first meeting under the revised governance arrangements. Members welcomed a more participative assurance discussion. The Committee identified that CMB approval authority and Q&S assurance responsibilities will need continuing clarification to prevent operational approval work drifting into the assurance forum. **BAF risk 6**
- **IPR data quality and narrative process:** concerns were raised about IPR data accuracy and timing, including incident and falls data and the available time window for IPR section owners to review data prior to IPR publication. Actions are in place for NP/LD to describe timelines and responsibilities, and for TL to follow up IPR accuracy with the Power BI team.
- **Risk allocation remains live:** the Committee agreed that risks should sit with the committee undertaking most of the mitigation work, while ensuring patient safety implications are not lost when risks are overseen elsewhere. Whilst agreement was achieved in the meeting amongst the chairs of Q&S, People and Culture, and Finance and Performance committees of the appropriate overseeing committee for the corporate risks (excluding strategy deployment and COMC), this allocation should be kept under review. A more comprehensive risk review will be undertaken next month when improved documentation on controls, metrics, targets and current status will be available. **BAF risk 6**
- **Operational pressures:** June data showed record ED attendances and average ambulance handover increasing from 30 to 37 minutes against a plan of 20. The high demand across the system was recognised as an important factor influencing quality and patient flow, with further review requested on corridor care, aseptic pharmacy impact on cancer performance, and progress on the stroke therapy business case. **BAF risk 8**
- **IPC antimicrobial stewardship:** the annual DIPC report was noted, including COVID outbreaks, periods of increased C. difficile incidence and the need for a plan to reduce antimicrobial usage in line with future requirements. AA will report back on the Trust approach.

2.3 Assure

- **Research governance and impact:** the Committee received positive assurance that research was delivered safely and in accordance with GCP, HRA requirements and Trust governance, with 115 active studies, 20 new studies, 3,099 participants and more than £1m of research funding during 2025/26.

- **Health inequalities:** the Committee commended progress from strategic intent to embedding Core20PLUS5, including cancer outreach activity, work on rurality and emerging examples of access support for patients with learning disabilities.
- **Patient experience:** the Committee noted over 15,600 FFT responses, with 94% of patients rating their experience as good or very good. Compassion, professionalism and staff attitude remain consistent strengths, with communication identified as the priority improvement theme.
- **Perinatal staffing indicators:** the Committee noted that 1:1 care in labour and supernumerary labour ward coordinator status were both achieved 100% of the time in June, while recognising wider safety, workforce and estates risks remain.
- **Cancer performance:** the 62-day cancer backlog reduced from 95 to 76 patients at month-end, the lowest point since April 2025. The Committee requested further assurance on the impact of aseptic pharmacy provision on 62-day performance.

3. Risk review

COMC should note that committee time was invested in ensuring correct overseeing executive assurance committee allocation. No risks were specifically discussed and reviewed, having undertaken review in previous month at final Clinical Governance committee. Q&S risks will be reviewed individually next month.

3.1 Risks formally escalated to the Managing Director

Risk ID & Title	5+5+5 score	Controls assessment	Reason for escalation
6412: risk of harm to women and babies due to lack of second obstetric theatre	5-4+3	Partially effective	Score of 12, deteriorating risk due to rising operative intervention rates in obstetric practice increasing frequency of concurrent urgent theatre demand

3.2 Narrative on escalated risks

6412: Risk of harm to women and babies through lack of dedicated second theatre – rising operative interventions rates in obstetrics is resulting in increased frequency of concurrent emergency demand for obstetric theatre space. The second available space is a poor environment for operating, especially in an emergency, and there is low confidence in obstetric teams being able to access main theatres reliably in an emergency. This results in delays to decision making whilst waiting for the main obstetric theatre to empty, and potential resultant harm to mothers and babies. An options paper for expanding obstetric theatre capacity is being developed by the Maternity team.

3.3 Risks reviewed for context (scoring 10–11)

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
7807: risk of patients with specialist MH needs in acute hospital (due to lack of comm/acute MH	Clinical quality/operational	4+3+3=10	Partially effective	To be reviewed next month

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
provision) receiving suboptimal care. Potential impact upon staff morale/retention				
8174: Risk of harm due to historic suboptimal paediatric audiology assessments	Clinical quality	3+4+3=10	Partially effective	Following national incident process for recall. Specific local issue in addition to national incident may increase consequence score. To be reviewed next month.
8264: Risk that incorrect management of patients with reduced mental capacity will occur	Clinical quality	4+3+3=10	Partially effective	To be reviewed next month

4. Good practice and innovation

- **Resilience, collaboration and ingenuity:** the Committee recognised the positive impact upon a patient of the commitment and collaboration between the research team and a clinical team to enable a trial patient's continued participation in a research trial despite aseptic pharmacy service disruption.
- **Health inequalities outreach:** high-impact cancer outreach, rurality as an additional line of enquiry and the embedding of Core20PLUS5 provide a useful model for translating strategic intent into pathway-level action.
- **Patient engagement infrastructure:** strengthened patient feedback routes, including FFT, patient panels and encouragement for executives to engage with real-time feedback, provide a strong basis for improvement focused on communication.

5. Committee approvals and recommendations

5.1 Approved by the Committee

- The Committee noted and received the reports presented during the meeting. No formal approvals were made.

5.2 Recommended to the Management Committee

- Confirm the ownership, timescale and reporting route for a standardised process to evidence completion and embedding of Patient Safety Incident actions. **Patient safety team to update Q&S in August**
- Request an update on the non-RTT follow-up backlog, including validated numbers, clinical risk stratification, harm review, data quality improvement and EPR transition implications. **LD to update Q&S in November**
- Note the limited assurance position on mortuary services and ensure the final board assurance statement is explicit about gaps, actions, owners and deadlines. **Board assurance statement submitted**. **GP to update Q&S on outstanding actions in August**

- Seek confirmation that IPR data quality and narrative responsibilities are documented, including opportunities for accuracy checking before wider committee submission. **Q&S action log**
- Receive the updated risk allocation and controls matrix for risks aligned to Q&S, including 5+5+5 scores, controls, metrics, target scores and current assurance ratings. **Q&S action log**
- Maintain oversight of maternity and neonatal actions arising from the Amos and Ockenden reports, the NHS 10-Point Plan, obstetric theatre capacity and workforce/BAPM compliance. **VM to update Q&S in August**

6. Looking ahead

- August meeting: deferred Annual Dementia Strategy Report; more comprehensive maternity/neonatal response to Amos, Ockenden and the national 10-Point Plan; specialist service deep dive into cleft lip and palate service
- Next risk cycle: review of updated corporate risk allocation, controls, metrics, targets and current status using the new spreadsheet template.
- Future cycle: update on follow-up appointment backlog in November, including validation progress, clinical risk stratification and any identified harm.

Appendices (optional)

Appendix B – Finance and Performance Report to the Care Organisation Management Committee

Care Organisation	Salisbury
Committee	*Care Organisation Management Committee*
Report Name	*Report from Finance and Performance Committee*
Meeting date	*5th August 2026*
Author	*Niall Prosser, Chief Operating Officer*
Reports to	*Care Organisation Management Committee*
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	*For Assurance*
Linked to Strategic Priority (s)	TBC
Linked BAF principal risk(s)	TBC
Reporting period	June Data

1. Executive summary

July's Finance and Performance Committee was the first time meeting in its new format and as such there was a large amount if building the new standard was of working. This also meant that there weren't some papers available and not complete attendance, with the agenda demonstrating a need to further refine attendees as for example there were no group improvement or digital colleagues in attendance. The committee also didn't undertake the deep dive that will be a part of the routine format. Also agreed that the IPR will now be presented by the clinical divisions in rotation.

Overall at the end of quarter 1 the Trust is broadly on plan but has some noticeable challenges and there is high risk in the remainder of the year. This in practical means:

- The Trust is on plan for finances, which includes delivery of CIP. The plan though anticipates a number of step changes in the coming months and delivery of these remains high risk and dependency laden. Further work is required to deliver the Coding changes described within the plan, a further 80 wte workforce reduction is required and group led clinical transformation is currently behind plan.

- On performance the trust has recovered its cancer performance to be back on plan, with RTT remaining ahead of plan, DM01 is slightly below. The 4 hour performance is significantly below plan and where the current area of greatest pressure is. There remains a half a day length of stay

opportunity and the Trust is still over agreed planning assumption for NC2R (with an average of 70 pts instead of the 40).

The committee reviewed three business cases for consideration, approving the UTC funding, procurement recommendation on

2. Alert, Advise, Assure

2.1 Alert

- **Cash** - Cash remains the single biggest organisational risk with current projections showing negative cash in November (assuming completion of Lease and Lease back in October).
- **Financial forecast** - The first 26/27 financial forecast has been produced. Giving three scenarios, bes case is a break even, Medium-case financial forecast shows a potential £22m deficit and worst case shows a £38m deficit. The committee discussed the actions required to help facilitate and ensure delivery of the best case scenario.
- **Coding** - The £10m coding and counting assumption remains unresolved. The Digital function within group is currently developing a business case to increase coding resource.
- **Performance** - ED performance (66.3%) and ambulance handovers (average 37 min) have deteriorated. This appears to be driven by growth in demand (although below plan level), specifically within the minors performance, higher NC2R than forecast, length of stay higher than the peer average. The Trust is launching its new breakthrough objective focusing on urgent care length of stay, continues to work on implementation of the new UTC, is undertaking more work on implementing the lessons from model ED and launching additional work to reduce NC2R.

2.2 Advise

- **NCTR -** NCTR remains well above trajectory and limits bed reductions and is averaging 77 against a plan of 40.
- **Lease and lease -** Key Worker Accommodation remains a critical dependency for financial delivery.
- **EPR** - readiness is progressing but significant implementation risks remain. On track to launch new breakthrough objective in October focusing on readiness. Key risks remain, Technology and device readiness, High-risk workflow sign-off, Training venue availability, Training backfill funding. Lack of a fully socialised programme plan.
- **Workforce -** availability is improving but remains off target and continues to drive temporary staffing pressures.
- **DASH -** DASH is currently forecasting to be £6m over current identified budget, further work is being undertaken to reduce cost of identify alternative funding sources. The current business case assumes funding comes from CDEL.

2.3 Assure

- **In month finance position** - Pay expenditure is £0.5m favourable to plan. Non-pay is £0.6m favourable to plan, helped by biosimilar/generic drug switches and one-off

maternity incentive income. Productivity continues to improve and CIP remains on trajectory.

- **Performance –** RTT (at 72.5%) and cancer performance (62 day at 75.1%) continue to improve despite operational pressures. This performance places us in line or above plan.
- **CIP -** delivery is on track (£85k ahead of plan) but Service Transformation and Workforce schemes remain high risk. Key dependencies for continued delivery include, key worker accommodation, bank partners staffing contract, maintaining the bed rationalisation and clinical service transformation programme.
- **Business case development -** Reviewed the feedback from TIG (still operating ahead of ORBIT) on the benefits realization of the investment in the physicians associated. This has recommended a disinvestment. Agreed that when this occurs the recommendation will go to the CIP cell for onward assessment utilizing that governance model.

3. Risk review

This was the first meeting of the committee and therefore the first opportunity for the group to help triangulate ownership of the risks (ie to the right committees) and triangulate the appropriate risk scores. As such most of the focus of the committee was confirming these different elements. The following risks were changed. The updated version of the risk register is available in the below format;

- Switchboard brought down to be in line with other risks.
- Central booking up and now above 12
- New risk on flow and performance. Risk use to be BAF but being converted into a Trust wide risk.
- Transformation resource being reviewed as currently above a 12.
- Fire risk reviewed up as not yet implemented solution

3.1 Risks formally escalated to the Managing Director

Risk Ref	Risk Title	Likelihood (L)	Impact (I)	Control Score (C)	Residual Score (L+I+C)
SFT-8791	Financial position 2026/27	5	5	3	13
SFT-8759	Unavailability of cash balances to support timely payments to staff and suppliers	5	4	4	13
SFT-8102	Central booking workforce and process instability resulting in risk of patient harm and reduced utilisation across all areas	5	4	4	13

SFT-6229	Risk of DSU - Estate Infrastructure failure	3	5	4	12
SFT-8800	Reduction of No Criteria to Reside (NCTR) to 9% as per plan	4	4	4	12
SFT-7917	Fire risk in Main Theatres corridors	5	3	4	12

3.2 Narrative on escalated risks

At the moment the risk scores are being calibrated. As highlighted above this is the first time the committee has met to review in this instance and the risk scores are needing to be tested against other risks. The scores marked in red are those that have evolved. The changes made in the meeting are:

- Central booking increased as a result of a better understanding of the impact on performance, income and turnover of staff in the service.
- Fire risk in main theatres – an understanding that the plan to manage the controls in coming but not yet in place.

3.3 Risks reviewed for context (scoring 10–11)

As this is the first reporting and to help triangulation across committees, below are all of the risks that are being managed by FPC. The scores highlighted red are the provision changes made within the meeting to reflect the committees views.

Risk Ref	Risk Title	Likelihood (L)	Impact (I)	Control Score (C)	Residual Score (L+I+C)
SFT-7946	Transformation programmes and projects are not delivered to time	5	3	3	11
SFT-8791	Financial position 2026/27	5	5	3	13
SFT-8759	Unavailability of cash balances to support timely payments to staff and suppliers	5	4	4	13
SFT-6229	Risk of DSU - Estate Infrastructure failure	3	5	4	12
SFT-8068	Increase in 2222 calls to Switchboard when lone working, Single operator cover	4	2	3	9
SFT-8800	Reduction of No Criteria to Reside (NCTR) to 9% as per plan	4	4	4	12
SFT-8820	EPR resourcing levels and readiness at SFT for implementation	3	4	4	11
SFT-5664	Risk inherent in the level of Trust Backlog Maintenance	3	4	4	11

SFT-7917	Fire risk in Main Theatres corridors	5	3	4	12
SFT-7573	Risk of sustained use of escalation areas impacts on patient safety, experience and operational effectiveness.	5	3	2	10
SFT-8789	Failure to meet the emergency access standards as outlined in the 26/27 planning guidance	4	3	3	10
SFT-7949	Inadequate function of emergency bleep system	2	3	4	9
SFT-7931	Lack of appropriate electrical power infrastructure in theatres (Main, DSU and Obstetrics)	4	2	3	9
SFT-8102	Central booking workforce and process instability resulting in risk of patient harm and reduced utilisation across all areas	5	4	4	13
SFT-8054	Policy Compliance	3	3	3	9
SFT-5955	Insufficiently robust management control procedures	3	3	3	9
SFT-7951	Failure to deliver new Standards of Cleanliness	4	2	2	8
SFT-6857	Financial loss due to fraud	3	3	2	8
SFT-8272	Failure to meet timely handover process for Ambulances (W45)	2	2	3	7
SFT-7139	Lack of dedicated Dietetic support for the Catering Department	3	2	2	7

5. Committee approvals and recommendations

5.1 Approved by the Committee

- UTC – approved following last meeting of old format and addressing some of the questions. The case increases spending in the emergency zone within 26/27 by £1m. This is in line with the Trusts business plan. The service is designed to support circa 80-90 patients a day being pulled out of the ED and caring for them in a better environment. It is anticipated to support delivery of the 4 hr performance in H2.
- Contract recommendation for the supply of end user devices. The procurement department have, across the group, agreed a new call off contract for the replacement of computers.
- After reviewing the Radiology Process Automation for Imaging Operations Business case, the committee agreed to seek further assurance from NHSE that the funding was revenue. NHSE have offered funding but at this stage stated it was capital and the requirement is for revenue. Further discussions are ongoing.

5.2 Recommended to the Management Committee

- The UTC funding business case needs COMC approval has its over £1m of revenue spend.

6. Looking ahead

Committee is in a cycle of quarterly reports. It has additionally agreed that its deep dive for August will be on central booking. The committee will also start to take ownership of the business plan and winter plan.

Appendix C – People and Culture Report to the Care Organisation Management Committee

Care Organisation	Salisbury NHS Foundation Trust Care Organisation
Committee	People & Culture Committee
Meeting date	29 July 2026
Author	Angie Ansell, Interim Chief Nursing Officer
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance, with specific Alert / Advise / Assure recommendations
Linked to Strategic Priority(s)	Developing an engaged workforce; Making our teams diverse and inclusive; Making our services safer; Improving health equity
Linked BAF principal risk(s)	Workforce sustainability; staff availability; workforce capability; leadership and culture; workforce transformation; mandatory training and appraisal compliance
Reporting period	July 2026 SFT People & Culture Committee and supporting leadership development appendices

1. Executive summary

The People and Culture Committee reviewed workforce performance, leadership development, employee relations, workforce risks, flu vaccination, Guardian of Safe Working arrangements and implementation of national workforce initiatives. The overall assurance position remains mixed. Positive assurance was received in relation to leadership development, employee relations governance, flu vaccination performance, Guardian of Safe Working reporting culture and the establishment of revised governance arrangements. However, continued oversight is required due to sustained workforce availability pressures, sickness absence above target, mandatory training and appraisal compliance below standard, and workforce transformation capacity risks.

2. Alert, Advise, Assure

2.1 Alert - matters requiring Management Committee attention or action

Staff unavailability remains significantly above target.

Staff unavailability remains 21.2% against the breakthrough objective target of less than 16%. Whilst this represents an improvement from 22.8% in Month 2, workforce availability continues to impact operational productivity and temporary staffing expenditure. The principal contributing factors remain sickness absence, vacancies and workforce turnover. The Committee should continue to monitor delivery of retention, recruitment and attendance management workstreams.

Sickness absence continues to exceed organisational target.

Sickness absence increased to 4.23% against a target of 3%, representing more than 5,200 working days lost within the month. Anxiety, stress and depression remain the largest cause of absence. Progress in attendance management is being constrained by limited HR advisory

capacity and low engagement by managers in attendance management training. Continued improvement is required if the organisation is to achieve sustainable workforce availability.

Mandatory training and appraisal compliance remain materially below standard.

Mandatory training compliance is 81.9% and remains approximately 8% below target. Non-medical appraisal compliance is 70.6%, leaving approximately 995 appraisals outstanding.

Neither indicator demonstrates sufficient improvement and both present governance, workforce capability and assurance concerns. The Committee should seek a strengthened recovery trajectory and clearer accountability arrangements.

Workforce and transformation risks require continued oversight.

The Committee reviewed risks within its remit and noted SFT-8780, the capacity of HR and change management resources to support transformation, as scoring 12 and requiring onward consideration through the corporate risk process. Other workforce-related risks discussed included SFT-8344 mandatory and statutory training reporting, SFT-7472 failure to deliver a sustainable workforce, SFT-8773 nursing workforce pipeline not matching projected demand, and SFT-8771 culture and leadership interventions. No amendments to current scores were agreed.

2.2 Advise - ongoing monitoring, partial assurance or emerging concern

Leadership development alignment remains a key Group priority. The Annual Leadership Review identified significant strengths across leadership development provision within SFT, RUH and GWH. However, variation remains in programme content, structure, evaluation and delivery models. Work is progressing toward a Group-wide design once, deliver locally approach aligned to the NHS Leadership and Management Framework. Continued oversight will be required throughout implementation.

Employee Relations governance is improving but maturity varies across the Group. The first Group Employee Relations Annual Report provides comparative workforce information across all three Care Organisations. Differences remain in case management systems, EDI reporting practices and workforce data maturity. A Group action plan has been developed and will continue to be monitored through People & Culture Committee reporting. A correction was noted: the resolution management figure should state 36 rather than 127.

Fairer Deal for Nurses programme carries delivery risks. The Committee reviewed progress against the Fairer Deal for Nurses programme. Strong governance arrangements have been established and baseline activity has commenced. However, programme delivery remains dependent upon job evaluation capacity, project management capability and clarification of future national funding arrangements. RAG-rated reporting will commence later in 2026.

Workforce transformation capacity remains under pressure. The Committee noted organisational change activity associated with Group shared service implementation and wider transformation programmes. There remains a risk that HR and organisational development capacity is insufficient to support transformational delivery while maintaining business-as-usual performance.

2.3 Assure - positive assurance achieved

Leadership development demonstrates strong evidence of impact.
The Committee received assurance that SFT has a comprehensive and mature leadership pathway across Bands 2-8+, with an alumni network and close alignment to the national leadership and management framework. Additional participation data by band and staff group will be circulated to support future oversight and the item will return in January 2027.

Employee Relations governance arrangements are in place.
The Annual Employee Relations Report demonstrates governance arrangements and identified positive areas for SFT, including sickness absence management arrangements, relationships at work policy, licence to manage training, job evaluation processes and alignment with staff side.

Flu vaccination programme delivered strong performance.
SFT achieved strong performance, with 61% of frontline staff vaccinated, SFT ranked third among South West acute trusts and fifteenth nationally. Further uptake data and a response plan for lower uptake areas will be circulated, and alternative vaccination data systems will be explored for future campaigns, potentially saving up to £60,000 across the Group.

Guardian of Safe Working Assurance.
The Annual Guardian of Safe Working Report provided assurance of a positive reporting culture, with 533 exception reports during 2025/26, eight missed educational opportunities and two immediate safety concerns which were not subsequently substantiated. The Committee noted the need to circulate the full report and reporting guidance and to align Guardian reporting dates and templates across the Group.

Governance arrangements have been established. The Committee received assurance that revised People & Culture governance structures are operating and the first meeting under the new structure was considered to have made a positive start in providing oversight of workforce priorities, organisational development activity and workforce risks. The revised arrangements support stronger assurance reporting and alignment across the Group. Members reflected on the need to move from contributing assurance to seeking assurance, strengthen constructive challenge, and ensure future papers draw out forward-looking plans, assurance requirements, risks and implications for staff and patients.

3. Risk review

The Committee reviews relevant risks on the Care Organisation Risk Register. Risks scoring 12 and above are without exception escalated to the Management Committee (and onward via the Managing Director's report to the Group Executive Committee, Group Risk and Assurance Committee, and Group Board). Risks scoring 10–11 should be included presented for context to support the Management Committee's assessment of scoring accuracy and emerging risk.

3.1 Risks formally escalated to the Managing Director

Risks scoring 12 or above. Use 5+5+5 methodology and the Group Risk Management Policy categories.

Risk ID & Title	5+5+5 score	Controls assessment	Reason for escalation
SFT-8780 – HR and change	12	Partially effective	Potential impact on successful delivery of corporate service

Risk ID & Title	5+5+5 score	Controls assessment	Reason for escalation
management capacity			redesign, workforce transformation and business-as-usual people activity.
SFT-7472 – Failure to deliver a sustainable workforce	10	Partially effective	Below formal escalation threshold but remains material due to workforce controls, vacancies, financial pressures and operational impact.

3.2 Narrative on escalated risks

SFT-8780: The HR and change management capacity risk reflects the scale of corporate service redesign and the concurrent pressure on OD&P resources. Controls include HRBP allocation, programme review structures and shared policy/templates, but the residual delivery risk remains material.

SFT-7472: The sustainable workforce risk is below the formal 12+ escalation threshold but remains important because financial controls, recruitment constraints and operational pressures may affect workforce resilience and service delivery.

3.3 Risks reviewed for context (scoring 10–11)

Risks just below the formal escalation threshold. The purpose of this section is to give the Management Committee , and onward readers , sight of the risks heading toward escalation and confidence that the Committee is exercising judgement, not simply applying a number. This can include lower scoring risks as well, at the Committee's discretion.

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
SFT-7472: Mandatory statutory training compliance in MLE	*Compliance*	*10*	*Partially effective*	*Scoring agreed. Ongoing monitoring to ensure accurate reporting.*

4. Good practice and innovation

• **SFT leadership development model:** Comprehensive pathway spanning Bands 2-8+, incorporating coaching, 360 feedback, action learning and evidence-based evaluation.

• **Data-driven organisational development:** Use of staff survey, workforce, employee relations, FTSU, patient feedback and turnover data to inform targeted interventions.

• **Flu campaign delivery:** Strong regional and national vaccination performance supported by roaming delivery, targeted communications and flexible access.

5. Committee approvals and recommendations

5.1 Approved by the Committee

• Received assurance from the Annual Leadership Review and noted the direction of travel toward an aligned Group leadership offer.

• Received assurance from the Group Employee Relations Annual Report and noted the Group action plan.

• Received assurance from the Annual Flu Report and noted SFT performance within the South West and nationally.

• Noted progress regarding delivery of the Fairer Deal for Nurses programme and the planned RAG-rated reporting route.

• Reviewed workforce performance, workforce risks and the Guardian of Safe Working Annual Report.

5.2 Recommended to the Management Committee

• Note the mixed assurance position and seek a strengthened trajectory for staff availability, sickness absence, mandatory training and non-medical appraisal compliance.

• Receive formal escalation of the 12+ risks and ask for clearer assessment of control effectiveness and expected score reduction milestones.

• Keep the HR/change capacity risk visible during corporate service redesign and Group People Services transition.

• Support continued development of the Group leadership offer, ensuring SFT good practice is retained and scaled appropriately.

• Monitor Fairer Deal for Nurses delivery risks, particularly job evaluation capacity, project management resource and funding dependencies.

6. Looking ahead

The next People & Culture Committee is scheduled for September 2026. Areas requiring follow-up include sickness absence performance, workforce availability, mandatory training compliance, appraisal recovery plans, workforce sustainability risks, leadership alignment work and Fairer Deal for Nurses programme delivery.

Royal United Hospitals Bath
Managing Director's Report:
RUH Care Organisation assurance, risk and delivery position

Report Title:	Managing Director's Report: RUH Care Organisation Assurance, Risk and Delivery Position
Date of meeting:	3 September 2026
MD / Lead:	John Palmer, Managing Director
Purpose:	☒ FOR ASSURANCE ☐ FOR DECISION ☒ FOR STRATEGIC STEER

At a glance

This report provides assurance on the first full cycle of the RUH Care Organisation governance structure (June (M3) data), supplemented by the latest Finance & Performance and Quality & Safety Committee evidence (July (M4) data). It highlights where Board attention is required to convert visibility into grip. The overall judgement is one of limited assurance at this stage of the financial and operational year. There is evidence of control in diagnostics, RTT, productivity and governance implementation, but a smaller group of high-impact risks remains across financial recovery, system demand, UEC flow, corridor care, winter capacity, quality, workforce and EPR delivery. Several cannot be resolved by RUH alone and require explicit Group, commissioner and wider system action.

- **Financial recovery and cash sustainability:** the £10.6m year-to-date deficit is £5.6m adverse to plan, with no evidenced route to break-even. **Active mitigations** are the working-capital application, refreshed divisional recovery plans, FIPB assurance points on 11 and 15 September, a Medicine deep dive, and tighter bank, agency and waiting-list initiative controls. **Remaining test:** recurrent cash-releasing savings and sustained monthly improvement sufficient to reduce the forecast deficit and cash exposure.
- **System demand, UEC flow and winter resilience:** attendances are approximately 9% higher over two years, ambulance conveyance and lower-acuity Type 1 activity are increasing, NCTR is materially off plan, 602 patients experienced more than 45 minutes of corridor care in July and modelling indicates a potential 72-bed peak deficit. **Active mitigations** are joint RUH and SWASFT analysis of the displacement hypothesis, review of alternative-pathway reliability, a strengthened clinically led Care Coordination model, the UEC 100-day programme, UTC reconfiguration, Hospital at Home (service consolidation and ICB escalation) and targeted NCTR reduction. **Remaining dependency:** commissioner funding, community-provider delivery and measurable system impact on demand, conveyance, discharge and bed use.
- **Quality and regulatory risk:** IPC outlier status, corridor-care exposure, End of Life Care capacity and maternity safety require continued oversight. **Active mitigations** are external IPC review and ICB support, a pre-winter stocktake of CQC UEC actions, maternity recruitment and escalation arrangements, diagnostic-results assurance and explicit inclusion of IPC in winter planning. The HTA inspection provides positive assurance on licensing, patient care and dignity; the identified procedural findings are being managed through the agreed improvement plan. **Remaining test:** sustained improvement in outcomes and closure of overdue actions.
- **EPR and transformation readiness:** outpatient templates, migration-critical data quality, CNIO and CSO capacity, training backfill and cutover resilience remain exposed within a digital portfolio of more than 700 programmes. **Active mitigations** are the RUH CCIO appointment, confirmed anaesthetic-monitor funding, identification

of 60% of training-facility requirements, specialty template work and post-cutover activity planning through the Business Planning Working Group. **Remaining dependency:** protected clinical-safety and operational capacity, quantified recovery trajectories and safe exception handling before Trial Load and cutover.

- **Workforce resilience and delivery capacity:** sickness absence, appraisal performance, temporary staffing and high-risk service gaps continue to affect quality, finance and operational resilience. **Active mitigations** are the Healthier Workforce Programme, bank-partner implementation, divisional recovery action, maternity and Medlock recruitment, and targeted skill-mix changes. **Remaining test:** measurable reductions in absence and temporary staffing, improved appraisal compliance and evidence that workforce actions are releasing capacity for recovery and transformation.
- **Overall assurance requirement:** the next cycle will aim to pair each material risk with a named owner, funded or agreed mitigation, quantified trajectory and explicit Group or system decision where RUH cannot deliver the control alone.

The risk visual in **Section 4** maps principal risks by residual exposure and strength of control, with the “Executive grip zone” highlighting issues where exposure is high and mitigations remain least secure.

Section 1: Executive Summary

1.1 Alert | Advise | Assure

ALERT: Draw attention to matters requiring the Board's awareness or action.

Financial recovery and cash require immediate Group oversight. The year-to-date deficit is £10.6m, £5.6m adverse to plan, and the medium forecast of £19.9m still requires approximately £1.5m monthly improvement with no evidenced route to break-even. Cash support is likely to be required. Active mitigations are the working-capital application, FIPB assurance points on 11 and 15 September, refreshed divisional plans, a Medicine deep dive and tighter temporary staffing and waiting-list expenditure controls. The Board test is whether these actions generate recurrent, cash-releasing improvement at the required pace.

System demand, flow and winter capacity now form one strategic risk. Attendances are approximately 9% higher over two years, ambulance conveyance and lower-acuity Type 1 activity are increasing, NCTR remains materially off plan and modelling indicates a potential peak-period adult bed deficit of approximately 72 beds. Improved handovers and same-day emergency care are positive, but unreliable alternatives and constrained discharge capacity risk shifting queueing and clinical exposure into Pitstop, corridors and waiting areas. RUH and SWASFT are jointly testing this displacement hypothesis, reviewing alternative pathways and strengthening clinically led Care Coordination, alongside the UEC 100-day programme, UTC changes, Hospital at Home work and targeted NCTR reduction. Delivery remains dependent on commissioner and community-provider action.

Quality, regulatory and workforce risks remain under active management. In July, 602 patients—6.5% of attendances—spent more than 45 minutes in an ED corridor. IPC outlier status, End of Life Care capacity, maternity workforce and safety, and cancer performance also require oversight. Mitigations include external IPC review, a pre-winter stocktake of CQC UEC actions, maternity recruitment and escalation arrangements, diagnostic-results assurance and targeted cancer recovery. The HTA inspection provides positive assurance on continued licensing, patient care and dignity, with procedural findings managed through an agreed improvement plan.

EPR readiness remains a major organisational delivery risk, with tangible progress but material dependencies. Anaesthetic-monitor funding, CCIO appointment, identification of 60% of training-facility requirements and structured post-cutover planning strengthen readiness. Executive grip is still required on outpatient schedules, migration-critical data quality, CNIO and CSO capacity, training backfill and safe exception handling ahead of Trial Load and cutover.

The immediate Board task is to convert these mitigations into accountable delivery. Each material risk now requires a named owner, funded or agreed action, quantified trajectory and time-bound assurance point, with explicit Group or system decisions where RUH cannot deliver the control alone. Detailed committee evidence and trajectories are set out later in the report.

ADVISE: Provide the context, analysis or recommendation the Board needs to understand the issue.

The first cycle of the Care Organisation assurance framework has demonstrated the value of triangulating quality, performance, finance and workforce intelligence. The key management insight is that several material risks are cross-cutting and cannot be fully understood through a single committee lens.

The Board is advised that some risks are currently more visible through assurance discussion than through the formal risk register, particularly EPR readiness, NCTR, maternity workforce, winter bed capacity, cancer performance and financial sustainability. The next cycle will therefore need to test whether there is sufficient capacity, capability, resource and executive ownership to deliver the proposed mitigations, particularly where delivery depends on staff release, clinical leadership, data quality remediation, programme backfill or system partner action.

The focus must now be on strengthening triangulation across quality, performance, workforce and finance, supported by rescoring the register using the Group 5+5+5 methodology and progressing risk housekeeping in line with agreed KPIs. This will be underpinned by risk education for staff and senior leaders, strengthened governance reporting and improved register quality, so that future escalation is based on clearer evidence, professional judgement and a more robust formal risk position.

ASSURE: Provide evidence (not assertions) that systems and controls are working as intended.

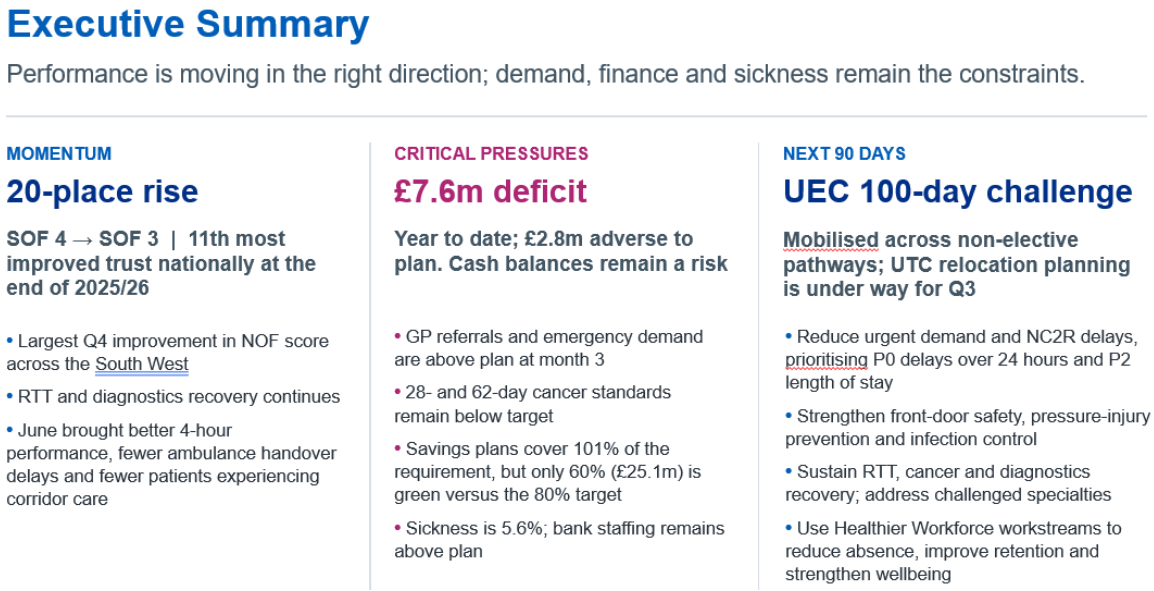
There is assurance that the new committee structure is operating as intended, with Quality & Safety, Finance & Performance and People & Culture Committees now feeding structured Alert, Advise and Assure reports into COMC. The first cycle has improved visibility of escalation matters and cross-domain risks, including Hospital at Home, IPC, EPR readiness, workforce resilience and financial recovery.

Specific evidence of controls operating includes diagnostic and RTT performance remaining above trajectory, with zero patients waiting over 65 weeks; productivity improving by 4.9% year on year, placing RUH in the top national quartile; establishment of a refreshed UEC leadership architecture; and active implementation of the 5+5+5 risk methodology. The unannounced HTA inspection confirmed that the mortuary remains suitable to be licensed, most standards were met and no significant patient care or dignity concerns were identified. The ten findings are procedural and are being managed through an agreed improvement plan: five actions are complete, four are due by October 2026 and the Estates flooring action has an agreed extension to August 2027. This supports placement of HTA assurance in the green assurance zone while retaining oversight of action completion. Across the wider risk portfolio, assurance remains developing and the next cycle must evidence impact and delivery trajectories.

1.2 Key Achievements and Good News

- Diagnostic performance remains ahead of trajectory, with 88.2% of patients receiving diagnostics within six weeks and continued reduction in breaches.
- Referral to Treatment (RTT) performance remains above trajectory and the organisation has sustained zero patients waiting over 65 weeks.
- The unannounced Human Tissue Authority inspection confirmed that the mortuary remains suitable for continued licensing and identified no significant patient care or dignity concerns. An improvement plan is in place for the ten inspection shortfalls, including five repeat findings.
- The annual staff flu campaign achieved 63.6% frontline vaccination uptake, ranking RUH second in the South West and sixth nationally.
- The revised assurance framework has been successfully implemented, establishing clearer governance, escalation and assurance arrangements across the Care Organisation.
- The RUH Intensive Care Unit (ICU) has received a highly positive external peer review from the South West Critical Care Network. The review described the unit as a high-performing service with clear evidence of progress since its previous assessment, recognising the team's work in addressing key risks and service pressures and highlighting strong plans for future development.
- The significant improvement in breast cancer performance at RUH has been recognised nationally, with the Trust cited as an exemplar on a recent national performance call. This reflects the breast team's work to implement a one-stop model and create sufficient capacity to support sustained improvement, with a positive impact on wider Trust cancer performance. This should be viewed in context: breast cancer performance has since dipped temporarily, largely due to sickness absence, and recovery may take time given the volumes involved.

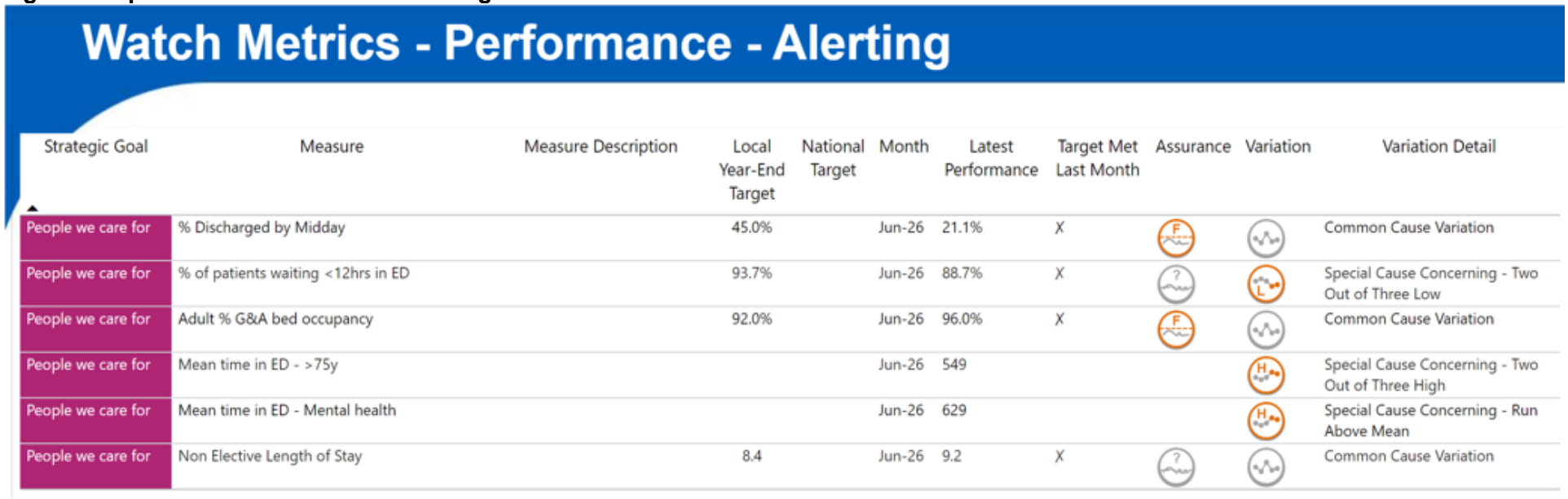
Figure 1: Integrated Performance Report (IPR) Executive Summary



Section 2: Performance Triangulation

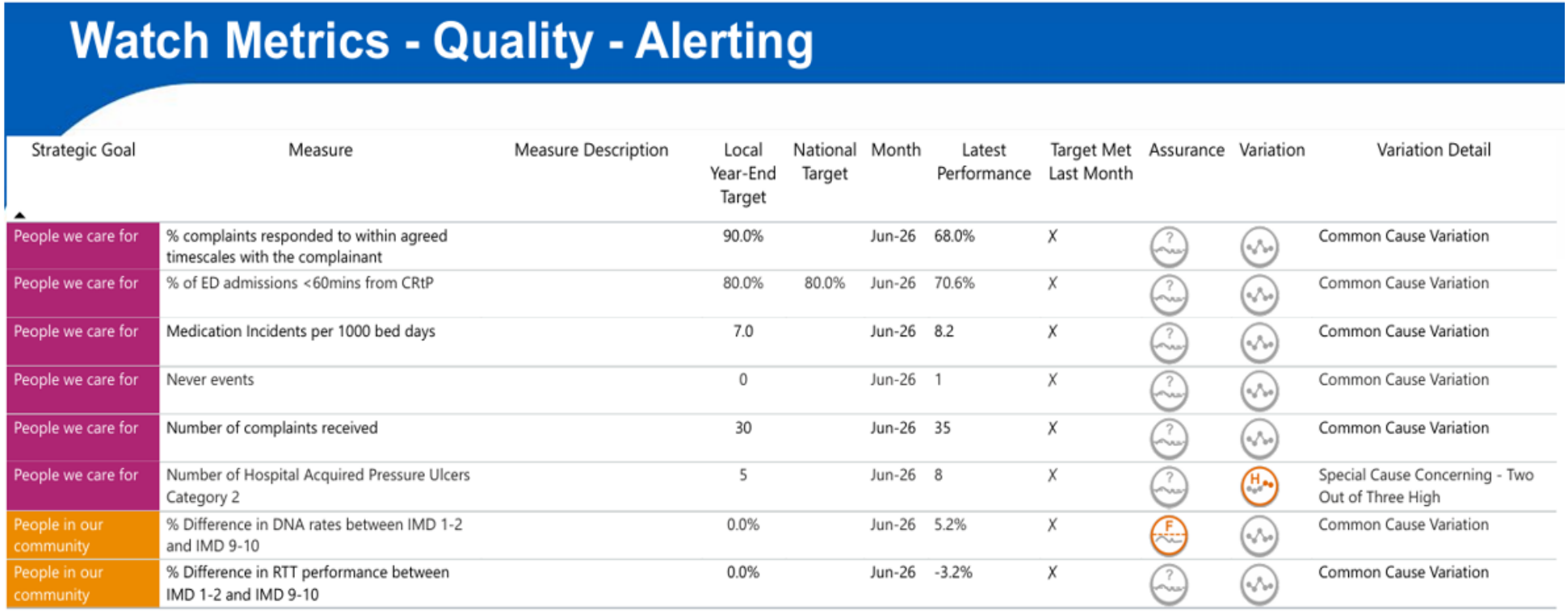
2.1 SPC Variation

Figure 2: Operational Performance Alerting Watch Metrics



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	% Discharged by Midday		45.0%		Jun-26	21.1%	X	F		Common Cause Variation
People we care for	% of patients waiting <12hrs in ED		93.7%		Jun-26	88.7%	X	?	L	Special Cause Concerning - Two Out of Three Low
People we care for	Adult % G&A bed occupancy		92.0%		Jun-26	96.0%	X	F		Common Cause Variation
People we care for	Mean time in ED - >75y				Jun-26	549			H	Special Cause Concerning - Two Out of Three High
People we care for	Mean time in ED - Mental health				Jun-26	629			H	Special Cause Concerning - Run Above Mean
People we care for	Non Elective Length of Stay		8.4		Jun-26	9.2	X	?		Common Cause Variation

Figure 3: Quality Alerting Watch Metrics



Watch Metrics - Quality - Alerting

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%		Jun-26	68.0%	X	?		Common Cause Variation
People we care for	% of ED admissions <60mins from CRtP		80.0%	80.0%	Jun-26	70.6%	X	?		Common Cause Variation
People we care for	Medication Incidents per 1000 bed days		7.0		Jun-26	8.2	X	?		Common Cause Variation
People we care for	Never events		0		Jun-26	1	X	?		Common Cause Variation
People we care for	Number of complaints received		30		Jun-26	35	X	?		Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Jun-26	8	X	?	H	Special Cause Concerning - Two Out of Three High
People in our community	% Difference in DNA rates between IMD 1-2 and IMD 9-10		0.0%		Jun-26	5.2%	X	F		Common Cause Variation
People in our community	% Difference in RTT performance between IMD 1-2 and IMD 9-10		0.0%		Jun-26	-3.2%	X	?		Common Cause Variation

Alerting Watch Metric Commentary: Medication Incidents per 1000 bed day

Total medication incidents per 1,000 bed days increased to 7.61, against a local year-end target of 7. This remains below the April 2026 high of 9.73.

Incident reporting should continue to be encouraged, with attention given to trends, themes and levels of harm, rather than overall numbers in isolation. Increased reporting is not, in itself, a cause for concern.

Most incidents were low or no harm, with one incident graded as severe harm and one as moderate harm. The ratio of harm to no-harm events has reduced from the April high. Where incidents meet the criteria for a learning response, they are managed through the Patient Safety Team. The Medicines Safety Group reviews initial Datix reports as a cohort to identify themes and trends, and receives updates on final reports when available.

Similar to previous months, administration and prescribing incidents were the most common incident types reported. High throughput areas including ED and pharmacy reported the highest number of incidents.

The Medicines Safety Group will continue to review this metric, alongside themes and trends, to identify areas for improvement.

Figure 4: Medication Incidents by Subcategory

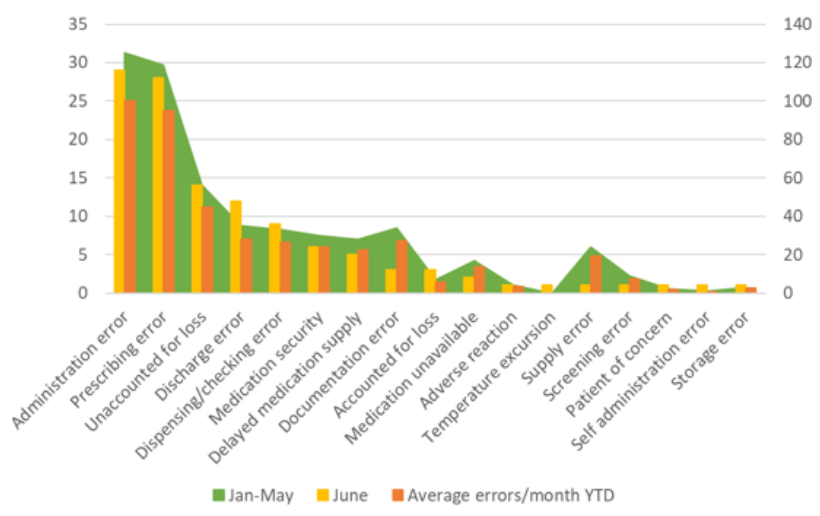
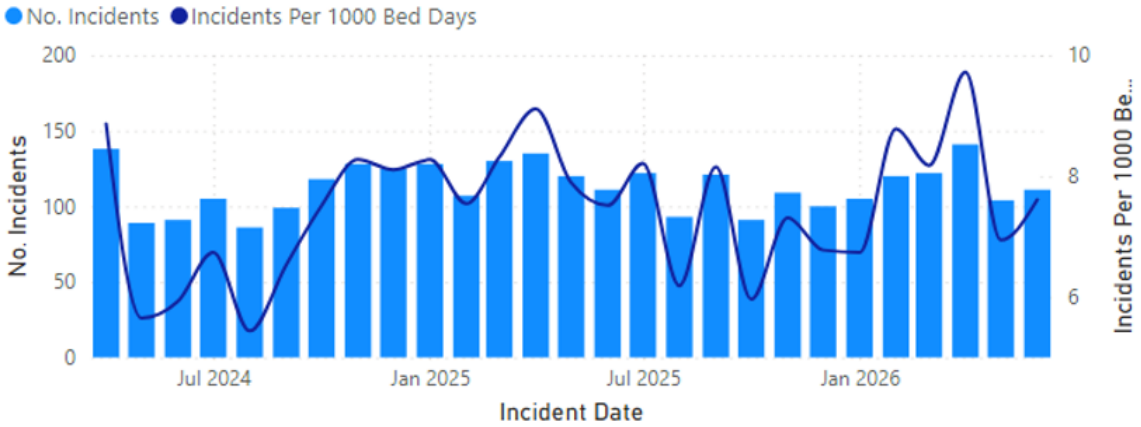


Figure 5: Total Incidents & Incidents Per 1000 Bed Days



2.2 Cross-Domain Analysis

Quality & Safety
Operational pressures continue to affect quality. The Trust is an IPC outlier for C. difficile and E. coli, with regional and ICB support reviewing drivers and strengthening improvement actions. Pressure-ulcer themes include acuity, prolonged ED stays, skin checks, repositioning and escalation. Further assurance work covers infection prevention, pressure-ulcer prevention, Hospital at Home and End of Life Care.

End of Life Care requires fuller context within the unmitigated quality and safety position. Although rated outstanding by CQC three years ago, this reflected a small team delivering high-quality care rather than a sustainable capacity model. Demand now exceeds capacity and performance is materially off benchmark. COMC concluded that a clear investment case is needed to demonstrate workforce resilience and service sustainability ahead of future CQC scrutiny.

Workforce & Finance
Workforce and financial performance remain closely linked. Sickness absence remains above trajectory and appraisal compliance is close to 80%, below the 90% organisational target. Temporary staffing remains elevated, and several high-scoring workforce risks continue to require oversight. Workforce resilience and financial sustainability should therefore be managed as a single strategic delivery risk.

Access & Operational Delivery
Performance remains mixed. Diagnostics and RTT are ahead of trajectory, while UEC and cancer remain challenged by demand and capacity. Cancer performance was 75.1% against the 80% 28-day Faster Diagnosis standard, driven principally by Breast and Skin; Skin received more than 300 additional referrals compared with June 2025 and experienced short-term locum disruption. The 31-day standard was achieved at 94.4%, but 62-day performance remained below target at 68.6%, with Urology and Upper GI contributing most to the deterioration. Recovery actions include weekend lists, insourcing, pathway redesign, diagnostic-capacity review and targeted consultant recruitment, although demand growth, workforce resilience and reliance on waiting-list initiatives, locums and outsourcing remain key risks.

Urgent and emergency care remains under significant pressure. Four-hour performance improved to 57.75% in June from 56.55% in May, with improvement across admitted and non-admitted pathways. It remains materially below the 72% trajectory because of exit block, ED crowding, constrained downstream flow, delayed senior decision-making and inconsistent UTC streaming. The UEC 100-day programme, ED/UTC reconfiguration and planned Q3 UTC relocation remain the principal mitigations.

Figure 6: IPR Executive Summary

Business Plan | Performance detail

	CURRENT POSITION	QUARTER 2 FOCUS
PERFORMANCE	Largest improvement in NOF scores across the South West in Q4, national ranking up by 20 places, moving from SOF 4 to SOF 3 and 11th most improved trust nationally at the end of 2025/26. Continue to operate in a highly pressurised environment with both GP referrals and emergency demand exceeding plan. Improved 4-hour and a reduction in ambulance handover delays and patients experiencing corridor care in month. Demonstrate good progress in our elective recovery plans for referral to treatment and diagnostics but cancer wait times for 28 day and 62 day remain below target.	Sustaining improvement in elective operational standards (RTT, Cancer, Diagnostics) and addressing delivery risks within challenged specialties; Improved partnership working to reduce urgent demand and non-criteria to reside (NC2R) discharge delays - discharged home (P0) & discharged to a community setting (P2). UEC 100-day challenge to support improvements across non-elective pathways and planning for relocation of the Urgent Treatment Centre by Q3.
FINANCE	Year-to-date financial performance is £7.6m deficit which is £2.8m adverse to plan, driven by £0.3m Industrial Action, £1.1m structural issues arsing from final contract settlement, SOC £1.1m adverse to plan and critical incident escalation £0.6m. Cash balances remain a risk. 101% of Savings plans identified, of which 60% (£25.1m) are assessed as Green in delivery or fully developed. £3.1m of savings have been delivered after 3 months, and £2.4m of income has been re-phased to achieve £5.5m overall delivery.15% CIP delivery in Q1 has been delivered.	Whilst strong progress on maturity of the savings plan has been made over quarter 1, the plan condition that 80% of savings were Green by end of June has not been met. Priority during quarte 2 is to shift opportunities and plans in progress into green schemes and achieve the 25% CIP target for quarter 2
QUALITY	Urgent and emergency care front-door environments; pressure-injury prevention; and infection control focused on E. coli and C. difficile remain the key quality and safety concerns. Priority clinical areas are receiving enhanced support in addition to Trust-wide quality improvement programmes.	Targeted improvement activity is focused on urgent and emergency care front-door clinical environments, alongside strengthening pressure injury prevention and infection prevention and control, with particular emphasis on reducing E. coli and *C. difficile* infections.
WORKFORCE	Workforce stability is evident through low turnover, manageable vacancies and mandatory training compliance. Bank staffing remains above plan, with agency spend on target but recent increased temporary staffing reliance due to hospital pressures. Sickness absence remains the key concern at 5.6%, above the trajectory required for the March 2027 target, with stress, anxiety and depression continuing to affect capacity and operational performance	The Healthier Workforce Programme is focused on reducing absence, improving retention and strengthening wellbeing through five targeted workstreams, with success measured through attendance, staff experience, leadership capability and culture. This will be further strengthened by the building of our People Plan that will enhance in year actions as well as ensure we have the right workforce for the future.

Figure 7: IPR Performance and Assurance Overview

Business Plan | Performance Metrics

July 2026 — *Performance against trajectory (in year)* — 3 Year Plan Profile

Domain	Metric	26/27 NHSE Instruction	Current Month Trajectory	Apr-26	May-26	Jun-26	Jul-26	Year End 26/27 RUH Plan	Year End 27/28 RUH Plan	Year End 28/29 RUH Plan
UEC	ED Attendance Growth YTD	*Versus 25/26 actual*	-0.5%	3.6%	3.0%	4.2%	3.9%	-0.5%		
	NEL Admission Growth YTD	*Versus 25/26 actual*	-4.6%	12.4%	5.5%	5.6%	5.6%	-4.6%		
	Eliminating Corridor Care	*0> 45mins by Nov '26*	0	556 (15%)	683 (15%)	587 (6.5%)	602 (6.5%)	0	0	0
	4-hour ED performance (type 1)	*66.9% by Mar '27*	59.9%	61.2%	56.6%	57.8%	56.2%	77.2%	72.9%	79.1%
	4-hour ED performance (all types)	*82% by Mar '27*	70.6%	71.1%	67.0%	68.9%	68.4%	82.9%	80.2%	85.0%*
	12-hour ED performance	*96.1%*	*92.2%*	92.0%	90.1%	88.7%	86.5%	93.7%	94.7%	95.0%
	Ambulance handover	*Reduce toward 15 mins*	27	33.1 mins	68.7 mins	53.2 mins	76.4 mins	30 mins	29 mins	28 mins
Elective & Diagnostic	GP Referral Growth YTD*	*Per planning assumption*	0.0%	10.9%	13.0%	13.2%	17.1%	0.0%		
	18w RTT Performance	*74.7% for RUH*	70.4%	70.3%	71.1%	70.4%	70.6%	74.7%	83.4%	92.0%
	52 Week Waiters	*Reduction towards zero*	310	183	155	133	156	198	62	0
	52 Week Waiters %	*Improvement on 1%*	0.9%	0.5%	0.4%	0.4%	0.4%	0.8%	0.4%	0%
	Diagnostics 6 week wait	*13.1% for RUH*	13.7%	14.7%	13.1%	11.8%	13.4%	12.50%	9.0%	1.0%
Cancer	28 day FDS *	*80% annual ave*	81.2%	79.8%	79.4%	78.8%	76.3%	80.0%	80.5%	80.7%
	31 day*	*94%*	92.8%	92.5%	95.0%	94.4%	95.4%	94.2%	96.0%	96.1%
	62 day RTT*	*80%*	74.2%	68.5%	70.0%	71.0%	68.9%	80.5%	82.7%	85.1%
Workforce	30% Reduction in agency use	*30% improvement from M06*	*tba*	13.3 WTE	21.2 WTE	11.6 WTE	14 WTE	5 WTE	3 WTE	0
	10% reduction in bank spend	*10% reduction from M06*	*tba*	283.7 WTE	289.2 WTE	302.9 WTE	296.2 WTE	237 WTE	-10%	-10%
	Sickness rate (rolling 12 month average)*	*Improvement*	*tba*	5.5%	5.5%	5.6%	5.6%	4.8%	4.6%	4.4%
Finance	2% productivity improvement	*(min 2% improvement)*	2.0%	6.5%	3.5%	1.9%	4.9%	5.0%	2.7%	1.5%
	Savings Plan	*37.6m (£56.6m over 3 yrs)*	8,779	1,400	2,170	3,089	4,861	37.6m	10.3m	8.7m
	Balanced or surplus financial position	*Balance or surplus*	(4,904)	(2,886)	(5,935)	(7,583)	(10,585)	0.0m	0.0m	0.0m
Discharge	Non Criteria to Reside (NC2R)	*Number of NC2R*	78	88	100	103	116			
	Pathway 0 - Home	*% within 24 hours*	97%	95.0%	94.4%	94.8%	93.1%			
	Pathway 1 - Home with support	*% within 48 hours*	100%	43.5%	44.1%	36.7%	38.9%			
	Pathway 2 - Community setting	*% within 48 hours*	100%	31.6%	26.8%	22.8%	19.2%			
	Pathway 3 - Residential care	*% within 7 days*	100%	42.9%	40.6%	38.2%	39.0%			

* one month lag

2.3 Assurance Committee Summary

Committee	Assurance Level	Key Focus Areas	Assurance Summary / Escalation
Quality & Safety	Limited Assurance	Hospital at Home, IPC performance, End of Life Care, CQC readiness, clinical audit governance, Medlock workforce risk and procedural HTA follow-up.	Limited assurance was reached because material risks remain in UEC flow, corridor care, infection prevention, End of Life Care capacity, maternity safety and wider regulatory follow-through. July recorded 602 patients spending more than 45 minutes in an ED corridor, representing 6.5% of attendances. CQC assurance must now test sustained improvement against the 53 UEC actions rather than completion alone. The HTA inspection provides positive assurance: the mortuary remains suitable for licensing, most standards were met and no significant patient care or dignity concerns were identified. Ten procedural findings are being managed through an agreed improvement plan, with five actions complete, four due by October 2026 and the Estates flooring action extended to August 2027. The Committee also highlighted the need to embed IPC explicitly in winter planning, strengthen assurance on diagnostic-results endorsement and maintain oversight of maternity digital interoperability and urgent-triage escalation.
Finance & Performance	Limited Assurance	Financial recovery, cash, UEC recovery, NCTR, cancer performance, EPR readiness, winter planning, diagnostics and RTT.	Limited assurance was reached because the financial, operational and delivery trajectories remain materially exposed. The year-to-date deficit is £10.6m, £5.6m adverse to plan; the medium forecast is £19.9m and requires approximately £1.5m monthly improvement, while cash support remains necessary. FIPB evidence shows £42.9m of savings identified against the £42.1m target, but only £28.5m, or 68%, is Green, leaving a £7.27m development gap to the end-September ambition. FIPB has commissioned refreshed divisional recovery plans by 11 September, team-level trajectory and deliverable visualisation for 15 September, a Medicine deep dive and options to reduce temporary staffing, agency and

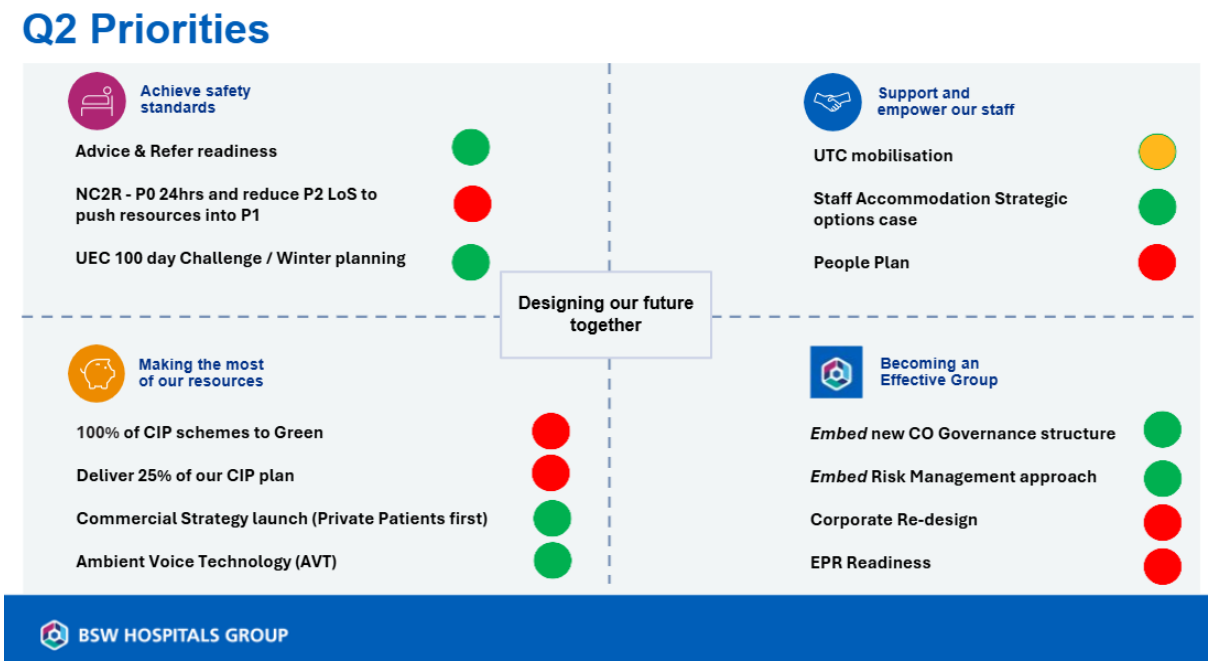
			waiting-list initiative exposure. FPC also escalated July UEC demand growth, NCTR of 116, the circa 72-bed winter deficit, digital capacity and clinical-safety constraints, dermatology recovery, and the need for a prepared commissioner negotiating position on demand, discharge, HCRG and block-contract exposure. Positive assurance remains in RTT, diagnostics and 4.9% year-on-year productivity improvement.
People & Culture	Limited Assurance	Sickness absence, workforce plan, temporary staffing, appraisal compliance, workforce risks, Healthier Workforce Programme and bank partner implementation.	Limited assurance was reached because sickness absence remains above trajectory, with over 17,500 WTE days lost, and workforce pressures continue to affect service delivery, financial performance and resilience. Oncology and haematology workforce risk remains under active mitigation following investment, while maternity and Hospital at Home workforce risks require reassessment to ensure scoring reflects the level of concern identified through triangulation. Positive assurance was received that the Healthier Workforce Programme is progressing and that bank partner implementation is being actively monitored, although operational, staff and reputational risks require continued oversight.

Across the first assurance cycle, COMC concluded that the committee reports are beginning to provide a stronger route for escalation. Continued focus is needed on improving triangulation across quality, performance, workforce and finance, supported by rescoring the register using the Group 5+5+5 methodology, progressing risk housekeeping and improving risk education for staff and senior leaders.

Please see **Appendices 1, 2, 2A and 3** for further detail.

Section 3: Deep Dive / Other Business

Figure 8: RUH Priorities for Quarter 2



The following deep-dive sections provide further detail on the highest-priority issues identified through the first assurance cycle, with a focus on areas requiring executive oversight, cross-committee escalation or further risk review.

EPR Readiness

Shared EPR implementation continues to progress, with tangible mitigations now in place or emerging in several enabling areas. However, the current cycle does not support de-escalation of EPR as an organisational delivery risk. The position is now best described as **progressing but constrained by key implementation dependencies**: capital funding, CCIO leadership and training facilities have strengthened readiness, but outpatient template configuration, CNIO and CSO capacity, migration-critical data quality and cutover activity planning remain material risks requiring executive grip.

Key progress in the previous period includes:

- Confirmation of capital funding for anaesthetic monitors which were a key enabler for introduction of the Shared EPR theatre and anaesthetics module.
- Appointment of RUH Chief Clinical Information Officer (CCIO).
- 60% of training facility requirements have been identified (from 0% in the previous period).
- Post-cutover activity planning will be reviewed through the RUH Business Planning Working Group. This will develop the approach to mitigating the estimated 25% reduction in activity during the five-to-eight-week period after cutover.

A key cutover risk is the volume of **clinics that do not follow a fixed schedule**. Fixed schedules are required so patient appointments can be migrated accurately. The programme requirement is for 75% of schedules to be fixed for Trial Load in October 2026 and 100% for cutover in October 2027. Approximately 32% of booked appointments at RUH are not linked to a fixed schedule, principally in Urology, Dermatology, Gastroenterology, General Surgery, Trauma and Orthopaedics. Work is under way with specialties to move to fixed schedules;

however, achieving 100% will not be possible without significant operational and performance impact. This creates a risk to workflow readiness, service capacity and safe implementation, particularly ahead of the October 2026 testing gateway. Key examples include:

- **Loss of capacity:** A fixed clinic schedule in dermatology will result in a loss of 480 cancer appointments per annum. Due to the volumes in skin cancer referrals, this would result in the Trust failing the 28-day Faster Diagnosis Standard.
- **Theatre/clinic room utilisation:** flexible schedules enable optimal use of theatres and clinic rooms, meaning a proportion of schedules are necessarily flexible.

A system approach will therefore be required to manage testing and migration for clinics that cannot be fixed because of operational constraints, for example by minimising the period for which the clinic schedule needs to be fixed.

COMC also noted that specialty-level briefing and escalation will be needed to ensure clinical teams understand the risks associated with non-standard clinic templates and the implications for testing, migration, and go-live readiness. Clear escalation into Finance and Performance Committee and Group Digital governance will be required so that progress, constraints and residual risks are visible and actively managed.

Figure 9: EPR readiness refresh — movement from previous overall readiness baseline

Readiness domain	Current assessment	Committee judgement
Governance and executive ownership	**Improving**	EPR is now visible through Finance and Performance Committee, COMC and Group Digital routes, but reporting still needs to move from awareness to accountable delivery.
Clinical leadership and safety capacity	**Partially mitigated**	RUH CCIO has been appointed, providing a confirmed mitigation for senior clinical leadership. CNIO and CSO capacity remain unresolved and are still critical to workflow sign-off, clinical safety assurance and legacy-system decommissioning.
Outpatient templates and migration readiness	**High risk**	Approximately 32% of booked appointments at RUH are not linked to fixed schedules. This is a separate outpatient migration indicator and should not be conflated with the previous overall EPR readiness judgement, which also stood at 32%. The 75% fixed-schedule requirement for Trial Load in October 2026 and 100% requirement for cutover in October 2027 will require specialty-level work, clear exception handling and a system approach for clinics that cannot safely be fixed without operational harm.
Training, backfill and operational capacity	**Partially defined**	Training facilities have moved from 0% to 60% identified. Activity planning post-cutover will be reviewed through the RUH Business Planning Working Group to mitigate the estimated 25% reduction in activity over the 5–8 week post-cutover period, but backfill, release capacity and operational impact remain unresolved.

Data quality and readiness evidence	**Insufficient assurance**	Migration-critical data quality issues, including unoutcomed appointments and patient index merges, remain insufficiently evidenced and require a quantified recovery trajectory before the next assurance cycle.
Theatre and anaesthetics readiness	**Mitigated enabler**	Capital funding for anaesthetic monitors has been confirmed, removing a key enabling constraint for introduction of the Shared EPR theatre and anaesthetics module.

The remaining programme risks now requiring focused executive follow-up are CNIO/CSO capacity, migration-critical data quality, specialty ownership of fixed-schedule exceptions, and operational backfill for training and cutover.

Overall, the refreshed assessment should be read against the previous overall EPR readiness judgement of 32%. There has been genuine movement in several enabling areas, including confirmed anaesthetic monitor capital funding, appointment of the RUH CCIO, identification of 60% of training facility requirements and routing of post-cutover activity planning through the RUH Business Planning Working Group. However, this does not yet support de-escalation because the least mature areas are those most likely to determine safe progression through Trial Load and cutover: outpatient template standardisation, operationally safe exception handling, data quality, CNIO and CSO capacity, training backfill and specialty-level ownership. Separately, 32% of booked appointments are not currently linked to fixed clinic schedules; this is a coincidental but important migration-risk indicator rather than a restatement of the overall readiness score. The Committee should therefore expect the next EPR update to provide a revised overall readiness score, a quantified trajectory to Trial Load, named owners for each dependency and explicit escalation of any issue that cannot be resolved within RUH.

Finance Overview

The financial position has deteriorated to a £10.6m year-to-date deficit, £5.6m adverse to plan. Key drivers include non-delivery of savings, continued Sulis operational pressures, critical-incident and industrial-action costs, structural commissioner-funding gaps and high temporary staffing expenditure. The medium forecast reduces the projected deficit from £30.5m to £19.9m but requires approximately £1.5m of monthly improvement, delivery of all Green and Amber savings assumptions and mitigation of current operational pressures. There is no evidenced route to break-even, and even the best-case scenario retains approximately £10m of unidentified risk. The Committee supported progression of the working-capital application, while noting that increased savings delivery alone does not remove the year-end cash risk.
FIPB provides the delivery evidence behind this judgement. At Week 20, £42.9m of savings had been identified against the £42.1m target, but Green-rated schemes remained at £28.5m, or 68%, leaving a £7.27m development gap to the ambition of £35.77m Green by the end of September. FIPB has therefore moved from opportunity identification to delivery control: refreshed divisional recovery plans are due through 11 September; the 15 September review will require visualisation of plan against trajectory and team-level deliverables; Medicine will receive a deep dive; and recommendations will be developed on bank, agency, waiting-list initiative and administrative controls. The programme must prioritise recurrent, cash-releasing delivery and protect named delivery capacity, including replacement of dedicated savings-programme coordination.

Cash is the most critical financial issue now facing the organisation. Current forecasts indicate that the Trust will run out of cash during September or October without further mitigation. Group-level mitigations are being explored, but the organisation is likely to need to apply to

NHS England for emergency cash support. This will require Board approval and will need to be supported by a credible recovery path, demonstrating how the Trust will reduce the deficit, strengthen savings delivery and stabilise its cash position.

Winter Plan

COMC reviewed the developing RUH winter plan, which is being prepared against a materially challenging operational baseline. Modelling indicates a potential peak-period adult bed deficit of approximately 72 beds if current demand, flow and NCTR assumptions remain unchanged. The plan is being developed using learning from winter 2025/26, staff feedback and system planning assumptions, with a focus on capacity, flow, NCTR reduction, demand management, front door streaming, vaccination, staff resilience and estates constraints.

The Committee recognised that the plan is more mature than at the equivalent point last year but remains dependent on key assumptions and external enablers. These include use of Medical Short Stay (MSS) capacity, agreement on surgical assessment and enhanced care models, progress on NCTR and high-intensity user demand reduction, activity-related funding discussions with commissioners, and clarity on whether any national or system funding will be available for Ward 4. The absence of confirmed Ward 4 funding remains a significant risk to winter resilience, particularly if activity and bed demand continue to exceed plan. COMC supported an out-of-committee route to meet the 30 August submission deadline, with further work required to quantify funding, workforce and governance implications before final sign-off.

Section 4: Risk Escalation

Figure 10: Risk portfolio view — concentration of exposure and control
A consolidated view of the major risks surfaced through COMC, showing where Board attention should focus to reduce residual exposure.

	LOWER CONTROL	HIGHER CONTROL
HIGHER EXPOSURE	**Executive grip zone** High impact; mitigations dependent or not yet secured ▲ Cash · ▲ EPR ▲ HaH / NCTR · ▲ Winter beds ▲ IPC · ▲ Maternity workforce **Executive task:** convert dependency into accountable delivery.	**Active management zone** High impact; controls visible but trajectory still exposed ▼ Cancer · ↔ UEC / ED flow ▲ End of Life Care · ↔ Medlock **Executive action:** test whether controls are changing trajectory.
LOWER EXPOSURE	**Watch zone** Lower current impact; potential to compound ↔ Appraisals · ▲ Sickness ▼ Risk maturity · ↔ HCID training **Executive action:** monitor for cumulative impact.	**Assurance zone** Controls operating; evidence of grip ▼ Diagnostics · ↔ RTT ▼ Flu uptake · ▼ Governance ↔ HTA assurance · Controls operating **Executive action:** replicate discipline in higher-risk areas.

Methodology: *the priority is to move risks out of the* ***Executive grip zone*** *by converting exposed dependencies into named owners, funded decisions, system escalations and time-bound milestones. Directional markers indicate month-on-month judgement:* ▲ ***worsening***, ↔ ***stable***, ▼ ***improving***.

4.1 Escalation Gateway

Category	Risk ID & Title	5+5+5 Score	Reason for Escalation
☒ Strategic (G-Line)	Financial recovery, system demand and EPR delivery	Formal 5+5+5 scoring to be confirmed	The £10.6m year-to-date deficit and likely cash-support requirement, system demand and winter-capacity exposure, and residual EPR clinical-safety and operational dependencies require Group visibility and decisions beyond RUH's delegated control.
☐ Operational (T-Line)	Discontinuation of RUH Hospital at Home Service (3314)	20 (5+5+5 scoring to be completed)	Risk 3314 has been escalated as a new major risk because the future sustainability of the Hospital at Home service is uncertain following the withdrawal of external funding and unresolved decisions about ongoing RUH funding. This creates a significant risk to patient flow, emergency care performance, winter resilience, capacity management, workforce stability, quality of care and system resilience. The risk remains high because funding arrangements are not yet agreed and planned mitigating controls have not been fully implemented.
	Workforce Challenges on Medlock (3324)	16 (5+5+5 scoring to be completed)	Risk 3324 has been escalated as a new major risk due to ongoing nursing workforce shortages within Medlock. Vacancies and long-term sickness are creating challenges in maintaining safe staffing levels, which could adversely affect patient care, patient experience and service sustainability. Although several controls and recruitment initiatives are in place, the service continues to rely on agency staff and temporary mitigations.

4.2 Risk Narrative

The principal risk theme emerging from COMC is that a number of operational pressures are now converging into strategic delivery risks for the Care Organisation and Group. Hospital at Home and virtual ward provision remain the most immediate escalation, with risk to patient flow, winter resilience and clinical safety if the future commissioning model does not provide sufficient capacity or fails to recognise the different acuity and clinical model requirements of step-up and step-down care. Although local mitigations are being pursued, including further correspondence with HCRG and the ICB, the current position remains insufficiently mitigated and requires Group visibility.

Infection prevention and control also requires escalation through a risk lens. Risk 2557 relates to the Trust's ability to maintain IPC-compliant isolation facilities, with the shortage of side rooms and en-suite accommodation creating a risk that infectious patients cannot be appropriately isolated. This increases the potential for hospital-acquired infections and impacts IPC performance. However, COMC recognised that the Trust's C. difficile and E. coli outlier position cannot be attributed solely to estate constraints. External IPC support is therefore being sought to provide an additional perspective on the drivers of performance, strengthen improvement actions and support a clearer improvement trajectory. As part of this work, Risk 2557 may need to be reviewed and broadened to ensure it reflects the full range of contributing factors, including estate constraints, clinical practice, operational flow, stewardship and wider IPC controls.

EPR readiness should be treated as an organisational risk rather than solely a programme-delivery issue. Concerns include data-cleansing capacity, unresolved Clinical Safety Officer capacity, gaps in senior clinical leadership for some workstreams, limited digital representation in assurance forums and the risk that non-standard clinic templates will prevent progression through the October testing gateway. This remains underrepresented in the formal risk register relative to the level of concern expressed through assurance committees.

COMC also identified risks that need to be more clearly scored and surfaced in the next cycle, including NCTR, maternity workforce and safety, winter bed capacity, cancer performance, workforce productivity and sickness absence. The Committee noted that no specific risks scoring 12 or above had been formally escalated through the first Risk Management Group report because the new process is still being embedded but expects the next cycle to provide clearer formal escalation using the Group 5+5+5 methodology.

Section 5: Care Organisation Context

The first full cycle of the Care Organisation governance structure has improved visibility of cross-cutting risks and strengthened triangulation between quality, workforce, performance and finance. The consistent themes emerging across the assurance committees are demand growth, workforce sustainability, financial recovery and readiness for major transformation programmes. These pressures remain significant and will require continued prioritisation, executive oversight and Group support over the coming months.

Delegated approvals and investment decisions

COMC considered the Respiratory Consultant business case under the Care Organisation's delegated authority arrangements and approved it in principle, supporting the case for investment in 2.0 WTE substantive Respiratory Consultants to address a structural capacity shortfall affecting RTT delivery, lung cancer pathways, workforce resilience and patient outcomes. The Committee was supportive of the case, noting that the rationale was clearly articulated and that substantive recruitment would replace temporary capacity, strip out reliance on short-term locum, WLI and insourcing costs, and provide a more sustainable workforce model. COMC requested further sharpening of the case, including clearer quantification of the financial implications and assurance around the proposed financial treatment. Final approval will be taken through Chair's action, in line with the relevant Standing Financial Instructions (SFIs) and delegated authority arrangements.

COMC considered the Perinatal Workforce Risk Mitigation and Birthrate Plus Phase 1 and 2 business case and supported the case in principle as a safety, workforce and regulatory compliance response to a materially changed risk environment. The Committee noted the changed national context following recent maternity reviews and the NHS England 10-point action plan, alongside the local Birthrate Plus reassessment. Although births have reduced by 5.5%, acuity and complexity have increased significantly, with 76% of births now in the two

highest complexity categories and an overall maternity workforce gap of 21.74 WTE identified. Phase 1 proposes cost-neutral redeployment and skill mix changes within the existing establishment, while Phase 2 seeks to address the minimum safe staffing gap through immediate recruitment of 15.12 WTE.
The Committee recognised the case as time-sensitive because of its links to safe staffing, Maternity Incentive Scheme requirements, clinical-negligence exposure and external confidence in maternity services, notwithstanding the service's previous CQC outstanding rating. With recruitment rounds due within 19 days, COMC agreed with the BSW ICB Place Director for Bath and North East Somerset that Band 5 and Band 6 recruitment should proceed at a £100k exposure to preserve the immediate opportunity. The remaining £840k exposure will be held and progressed through Group governance and the ICB Triple Lock before final approval. COMC also noted the need to close the loop on previous public and political commitments relating to alongside midwifery-unit provision through the developing estates strategy.
The Committee recognised the case as time-sensitive because of the link to safe staffing, Maternity Incentive Scheme requirements, clinical negligence exposure and the need to maintain external confidence in maternity services, notwithstanding the service's previous CQC outstanding rating. Given the time-sensitive nature of the case, and with recruitment rounds due to take place within the next 19 days, COMC agreed with the Place Director BANES BSW ICB that the Band 5 and Band 6 recruitment should be signed off at a £100k exposure to avoid losing the immediate recruitment opportunity. The remaining elements of the case, equating to £840k exposure, would be held and progressed through Group governance and ICB Triple Lock before final approval. COMC also noted the need to close the loop on previous public and political commitments relating to alongside midwifery unit provision as part of the developing estates strategy.

COMC approved the Rowlands Outpatient Pharmacy Contract Extension, supporting a £242,000 full-year effect uplift to the Pharmacy budget from Trust reserves to fund the time-limited extension of the Rowlands outpatient pharmacy contract. The extension is required to maintain safe and timely outpatient dispensing while the Trust mobilises the Wholly Owned Subsidiary outpatient pharmacy model, which has been approved by BSW Hospitals Group Board for planned go-live in 2026/27. The Committee noted that, although the extension creates an in-year cost pressure, the agreed annual rate of approximately £842,000 remains favourable against current market conditions and the rolling three-month notice period limits longer-term financial exposure. Approval mitigates the risk of outpatient pharmacy service instability, loss of contractual indemnity, disruption to the Wholly Owned Subsidiary mobilisation timeline and an unfunded Pharmacy pressure.

COMC supported the High Consequence Infectious Disease (HCID) preparedness paper and agreed that training should be put in place for key frontline areas. This will focus on FFP3 fit testing, HCID Personal Protective Equipment (PPE) donning and doffing competency, and development of a core training team to strengthen operational readiness and mitigate Risk 3264. The Committee noted a particular challenge in ensuring clinical medical staff across the organisation are able to attend the required training, given the need to release staff safely from operational duties while maintaining service cover. A further challenge was noted for nursing staff within Medical Assessment Unit (MAU) and MSS specifically, where the same requirement to release staff for training creates additional operational pressure.

Group programme responsibility: Commercial Programme

A refreshed outline Commercial Strategic Plan has now been received for this Group Board. It moves the programme from opportunity scoping towards a Group delivery framework, covering the financial imperative, commercial principles, leadership, PMO, benefits

management, engagement and a refined approach to reinvestment. The supporting appendices provide a streamlined programme scope and a brief update on current projects. As the strategy is on the Group Board agenda, this report simply notes the progress and does not duplicate the detailed proposals.

The programme continues to group opportunities across private care; pharmacy and research; estates and commercial estate; and other commercial activity. The immediate next step is Group Board consideration of the proposed ambition, governance and reinvestment approach, with a separate Board development session also being explored.

Summary and next steps

The latest assurance cycle confirms a position of limited assurance that is being actively managed. Financial, operational and quality risks are increasingly interdependent, but a clearer control framework and defined mitigations provide a credible route to stronger assurance. The organisation is responding to the £10.6m year-to-date deficit through the working-capital application, strengthened FIPB oversight, refreshed divisional recovery plans, a Medicine deep dive and tighter control of temporary staffing and waiting-list expenditure. System demand and winter pressures are being addressed through joint RUH and SWASFT data analysis, review of alternative pathways, strengthened Care Coordination, the UEC 100-day programme, UTC reconfiguration, Hospital at Home planning and targeted action on NCTR. Quality mitigations include external IPC review, a pre-winter CQC action stocktake, maternity workforce action and strengthened diagnostic-results assurance; procedural HTA findings continue to be managed through the agreed improvement plan. EPR readiness is progressing through confirmed capital funding, CCIO leadership, training-facility identification, specialty template work and structured post-cutover planning.

These actions do not yet remove the residual risks, particularly where delivery depends on commissioner decisions, community-provider capacity, Group prioritisation or protected clinical and digital resource. However, the next phase is a practical one: convert each mitigation into a named owner, funded or agreed action, quantified trajectory and time-bound assurance point. The Group Board is therefore asked to support the system and resource decisions that RUH cannot make alone, while holding the Care Organisation to account for demonstrable movement in savings, demand, conveyance, NCTR, corridor care, workforce resilience and EPR readiness. With this disciplined approach, the next assurance cycle should be able to show not only that controls are in place, but that they are beginning to change outcomes.

Appendices

Appendix 1: RUH Quality and Safety Committee Upward Report
Appendix 2: RUH Finance and Performance Committee Upward Report
Appendix 2A: RUH Finance Intervention Programme Board Upward Report and Week 20 Savings Position
Appendix 3: RUH People and Culture Committee Upward Report

BSW Hospitals Group Board

Agenda item	Item 6.1
Report title	Group Risk Register Report
Date of meeting	3 September 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 (August 2026) Risk and Assurance Committee (August 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

The Board's attention is drawn to four connected areas of risk. Financial sustainability and liquidity is the largest category, with 11 risks and two of the four risks scoring 14. Estates and infrastructure includes 10 risks, with further estate-related exposures recorded in other categories, including fire safety, Building Safety Act compliance, electrical capacity and constrained capital; a deep dive on Estates and Infrastructure has been commissioned by the Risk and Assurance Committee. Operational flow and access risks identify exposure to delayed care and patient harm, often with dependencies outside the

direct control of individual Care Organisations. Workforce and delivery capacity risks affect service resilience and the Group's ability to deliver financial recovery and transformation.

RECOMMENDATION

The Group Board is asked to:

1. Note the principal risk concentrations set out in this report.

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.

3. Note the commissioning of a deep dive on Estates and Infrastructure risk.

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.

Executive summary

The Group Risk Register contains 44 risks scoring 12 or above. Four risks score 14, ten score 13 and thirty score 12. The four highest-scoring risks are delivery of the Group financial plan, the Corporate Services Transformation finance tracker and savings forecasting, RUH delivery of the annual financial plan, and RUH outdated policies and limited governance resource.

The risk profile is dominated by financial sustainability, estates and infrastructure, operational flow and access, and workforce and delivery capacity. These themes interact. Financial recovery depends on sufficient operational and transformation capacity, while financial and capital constraints limit the pace at which estate, workforce and service risks can be addressed.

Risks requiring Board attention

1. Financial sustainability and liquidity

Finance is the largest risk category with 11 entries. The register includes delivery of the Group and Care Organisation financial plans, cash availability, savings delivery and the capacity to track and forecast Corporate Services Transformation savings. The Group financial plan risk scores 14 and identifies potential escalation within the NHS Oversight Framework, loss of financial autonomy and reduced capacity to invest in safe, high-quality care.

The Risk and Assurance Committee identified the financial position at Great Western, within the wider Group financial risk, as the dominant current risk. The Board should focus on the evidence that delivery is improving, the realism of the recovery trajectory, the sustainability of savings and the independent assurance available.

2. Estates, infrastructure and capital sufficiency

Ten risks are categorised as Estates and Infrastructure, with other estate-related risks recorded under Quality and Safety and Finance. The register identifies Building Safety Act compliance, fire safety, electrical infrastructure capacity, unsuitable clinical environments, backlog pressures and insufficient capital for improvement and PFI handback readiness.

The central Board question is whether available capital and organisational capacity are sufficient to address the safety and compliance requirements identified, and what exposure will remain where they are not. The Risk and Assurance Committee has commissioned an estates and fire safety deep dive and referred capital sufficiency to the Finance and Sustainability programme.

3. Operational flow, access and patient safety

The register includes high hospital occupancy and impaired flow, stroke performance, Surgical Assessment Unit capacity, central booking instability, patients with no criteria to reside and reduced

Hospital at Home capacity. The stated consequences include delayed assessment and treatment, missed or incorrect appointments, poorer patient outcomes and harm associated with overcrowding.

The Board should seek assurance that the Group has distinguished matters it can control directly from those requiring system intervention, and that external dependencies are being escalated where they prevent improvement.

4. Workforce and delivery capacity

Workforce risks include specialist clinical shortages, temporary staffing, leadership capacity, central booking vacancies and constrained capacity in digital, clinical informatics, governance and change management. These risks affect immediate service resilience and the ability to deliver financial recovery, transformation and control improvements.

The Risk and Assurance Committee highlighted the tension between workforce affordability and safe staffing. The Board should consider the cumulative effect of vacancy and expenditure controls on elective recovery, safe services and transformation capacity.

Overall assurance

The register provides a clear view of the Group's principal exposures and the actions being taken. The concentration of financial, capital, operational and workforce risks means that progress in one area may be constrained by decisions in another. Board oversight should focus on the credibility of recovery trajectories, evidence that controls are changing outcomes, and whether the Group has sufficient capacity and capital to deliver the mitigations on which the risk scores depend.

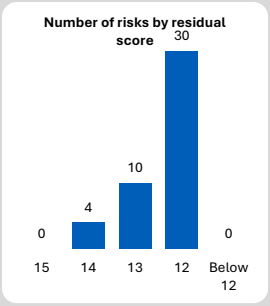
BSW Hospitals Group August 2026 Group risk register dashboard

August 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
44	10	5	1	14

Risk concentration by category and organisation

Category	GWH	RUH	SFT	Corporate	Programme	Group	Total
Quality and Safety	2	4	2	0	0	0	8
Workforce	2	0	1	2	0	0	5
Finance	2	2	4	3	0	0	11
Performance and Access	1	1	1	0	0	0	3
Estates and Infrastructure	3	5	2	0	0	0	10
Digital and Cyber	0	1	0	4	0	0	5
Regulatory and Compliance	0	1	0	0	0	0	1
Strategic	0	0	1	0	0	0	1
Total	10	14	11	9	0	0	44





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	New to register	Group Chief Financial Officer
–	Corporate	CST programme: finance tracker and savings forecasting	5	5	4	14	New to register	0
RUH-3165	RUH	Delivery of Annual Financial Plan	5	4	5	14	No change	Managing Director
RUH-3235	RUH	Outdated Policies and Limited Governance Resource	5	4	5	14	No change	Head of Corporate Governance

Risks with an increased score this period

Ref	Org	Risk title	L	I	C	Score	Status this period	Risk owner
SFT-7946	SFT	Transformation programmes and projects are not delivered to time	5	4	4	13	Score increased	Director of Transformation
SFT-8102	SFT	Central booking workforce and process instability resulting in risk of patient harm and reduced utilis	5	4	4	13	Score increased	Chief Operating Officer
GWH-1560	GWH	The footprint of the Maternity Care Centre and Day Assessment Unit is not adequate to fulfil the dem	4	4	4	12	Score increased	Luisa Goddard - Chief Nursing Officer
SFT-7734	SFT	Limited Capital Funding to support safety, building and equipment	5	4	3	12	Score increased	Director of Finance
SFT-7917	SFT	Fire risk in Main Theatres corridors	5	3	4	12	Score increased	Chief Operating Officer

Risks de-escalated from the register this period

Ref	Org	Risk title	Prev	New	Now managed on

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, August 2026 (for Risk and Assurance Committee, 19 August)

Residual Score = Likelihood (L) + Impact (I) + Control Score (C). Likelihood measures the chance of the consequence happening, not the cause. Risks scoring 12 and above are reported to Group Board.

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.

IDENTIFICATION						THE RISK				SCORING AND CONTROLS								
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 (LxIxC)	Previous Residual Score	Direction of Travel	Status this Period
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 the c.7% required. 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 3 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 Recovery Board, with a documented action 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 advisor support accelerating the Medium Term		4	14			New to register
	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. There is variation in how CST CIP 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			New to register
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	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	5	4	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 (3) 4. Enhanced Pay Controls eg. VCARP(2) 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	9	Deteriorating	No change
RUH-3235	RUH	12/22/2025	Outdated Policies and Limited Governance Resource	Regulatory and Compliance	R8 Reducing Avoidable Harm	There is a risk of non-compliance with statutory and regulatory requirements, including Care Quality Commission (CQC) Fundamental Standards and NHS England governance frameworks as a result of out of date policies and guidelines.	1. The Trust has a significant number of corporate policies and guidelines that are out of date 2. There is a no resource within the Corporate Governance team to administer the policy process. 3. The inherited process is inefficient. 4. One Drive the access is limited 5. Creating or reviewing a policy is a bureaucratic process.	1. Failure to comply with CQC regulations and NHS governance standards. 2. Increased likelihood of adverse findings during inspections or audits. 3. Reputational damage and potential enforcement action. 4. Operational inefficiencies and lack of clarity for staff, leading to inconsistent practice.	Yes	5	4	1. Policy register maintained by Corporate Governance team. (2) 2. Limited prioritisation of high-risk policies for review. (5)	There is no evidence of control effectivenes	5	14	9	Deteriorating	No change
	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 infrastructure 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 infrastructure 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			New to register
	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 2025 to capture a baseline of the digital ask for services.		3	13			New to register
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.Workforce shortages affecting delivery of key elements of the stroke pathway. 2.Delays in assessment, investigation and treatment of stroke patients. 3.Limited capacity within specialist stroke services. 4.Challenges achieving national performance standards and SSNAP measures.	1.Delays in assessment, treatment and rehabilitation for stroke patients. 2.Poorer patient outcomes, recovery and quality of life. 3.Increased morbidity, mortality and long-term disability. 4.Failure to achieve national stroke performance standards and SSNAP indicators. 5.Reputational impact resulting from poor service performance.	Yes	4	5	1.Performance and op manager overseeing data input (causes 2, 4). 2.Amendment of Stroke Unit SOP to ensure two Falcon beds are ringfenced (cause 3). 3.Oversight of cross divisional SSNAP performance recovery plan (causes 1, 2, 4). 4.Continue efforts to safeguard dedicated stroke beds, ensuring timely admissions and reducing delays on specialist care. promotion of ring fenced beds in Acute Stroke Unit. Launch of new stroke SOP (cause 3). 5.Monthly dashboard avaialble which is sent to domain leads for real time data reviews (causes 2, 4). 6.Meet monthly with Cheif Medical Officer for escalation and oversight (causes 1, 4).	SSNAP provides independent, nationally benchmarked quarterly reporting of stroke performance across key domains, enabling objective assessment of service quality and outcomes. 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	12	Deteriorating	No change

BSW Hospitals Group - Group Risk Register, A

Residual Score = Likelihood (L) + Impact (I) + Control Score (C). Likelihood

Control Score: 1 = Fully Effective 2 = Largely Effective 3 = Partially Effectiv

IDENTIFICATION					TRAJECTORY									
Risk Ref	Care Org	Date Opened	Risk Title	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
GRP-FIN-01	Corporate Service		Delivery of the Group financial plan								Group Chief Financial Officer		5/28/2026	6/28/2026
	Corporate Service		CST programme: finance tracker and savings forecasting	No finance tracker or forecasting tool is yet in place, so there is no operating control 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		
RUH-3165	RUH	9/16/2025	Delivery of Annual Financial Plan	Sufficiently granular Delivery Plans underpinning Savings Plans Actions outside Trust direct control to reduce demand to annual planned levels eg. UEC, NCTR, High Cost Drugs Lack of short term mitigations such as no contingency funding, further controls impact already incorporated, delaying activity due to access and performance risks	All actions complete	Site FD	N/A	Amber	10	N/A	Managing Director	Finance and Performance	8/14/2026	9/14/2026
RUH-3235	RUH	12/22/2025	Outdated Policies and Limited Governance Resource	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.	All actions complete	Head of Corporate Governance	N/A	Green	10	3/31/2026	Head of Corporate Governance	Non-Clinical Governance Committee	3/31/2026	4/30/2026
	Corporate Service		Insufficient digital, data and technology resource to meet increasing Group demand	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
	Corporate Service		CST programme: digital enablement investment		1. Digital Enablement paper to Group Board, September 2026. 2. PA Consulting to review designs. [Date not stated in source]							CST Steering Group		
GWH-1267	GWH	11/6/2024	Stroke service performance and timely access to care	1.4 hour performance impacted by overcrowding in ED and times where inpatient flow is compromised 2.Operational pressures and high bed capacity impacts on ability to keep these beds ringfenced 3.Potential that the data is not being input in a timely manner 4.Risk of Bournemouth stopping supporting this 5.BSNAP 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 state and impact on stroke care. 2026-03-31 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. 2026-03-31	Divisional Director - DOM	3/1/2026	Red	7	11/30/2026	Kathryn Bateman - Chief Medical Officer	Unscheduled Care Divisional Board Meeting	7/29/2026	8/29/2026

IDENTIFICATION						THE RISK				SCORING AND CONTROLS								
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
GWH-1576	GWH	4/10/2026	Failure to deliver planned improvement programme	Finance	R5 Increasing Financial Sustainability	There is a risk GWH does not have the capacity or capability to achieve the scale of the financial improvements to achieve the plan.	1.Insufficient internal capacity and capability to identify and implement recurring savings. 2.Scale of financial improvement requirements exceeds available resources. 3.Operational pressures limiting the delivery of transformational change. 4.Dependence on a small number of programmes to achieve planned savings targets.	1.Failure to achieve planned financial targets and control totals. 2.Reduced financial sustainability of the Trust. 3.Increased reliance on non-recurrent savings measures. 4.Reduced ability to invest in service improvements and strategic priorities. 5.Increased scrutiny from regulators and system partners.	Yes	5	4	1.Financial governance oversight in place with clearly defined savings targets, timelines and accountable owners (causes 1, 2). 2.Financial performance information and reporting mechanisms are used to track progress, forecast variances and support decision making (causes 2, 4). 3.External expertise is engaged where internal capacity is insufficient e.g. Hunter Healthcare (causes 1, 2). 4.Corporate Project oversight identifies overlap/resource constraints and aids prioritisation of effort and resources (causes 2, 3). 5.Performance management frameworks executed through monthly ERMs - linked to breakthrough objectives (causes 2, 3, 4).	As at month 3, £3.54m has been delivered of savings against a year to date plan of £7m. Whilst below plan, delivery has improved through the quarter and remains ahead of the same point last year. As at Month 3, £46.9m of opportunities have been identified against the £47.2m target, representing 99% identification and significant progress from Month 2. Fully developed schemes now account for the majority of the programme, reflecting continued work with divisions to improve scheme maturity, ownership and deliverability. Oversight remains through monthly Financial Improvement Board (FIPB), actions were reviewed 21st July for progress updates.	4	13	13	Static	No change
RUH-3273	RUH	2/25/2026	Future RUH site development lack of electrical infrastructure	Estates and Infrastructure		There is a risk that the RUH has insufficient electrical capacity to support any future significant development on the RUH site	1. There is a lack of available electricity coming onto the Combe Park site.	1. Any service and estate developments require assessment against available existing capacity to determine ability to support and monitor increased demand on the existing capacity.	No	4	5	1. All new capital projects are approved at CPMG. (1) 2. Electrical SEO Electrical demand monitored (1)	External contractor report about state of electrical infrastructure. Commissioned a second review. In discussion with National Grid. Ability to record percentageof ielectrical capity used.	4	13	9	Deteriorating	No change
RUH-3314	RUH	5/7/2026	Discontinuation of RUH Hospital at Home Service	Performance and Access	R8 Reducing Avoidable Harm	The Hospital at Home Service may be significantly reduced due a change in the contract which will increase the risk of daily inpatient bed pressures.	1. HCRG withdrawing funding for 42 HH@H beds 2. RUH provides insufficient funding to maintain a service above 20 beds	1. Increased inpatient bed pressure and escalation. 2. An increase in ED pressure and flow failure 3. A reduction in quality and safety. 4. Regulatory action and reputational damage. 5. A deterioration in staff wel being and morale.	Yes	4	5	1. To make increased use of HCRG provided hospital at home beds. (1) 2. To manage more patients on discharge without hospital at home. (2) 3. Frailty and Surgical SDEC in combination could absorb up to 20% of the hospital at home workload. (2)	HCRG does not have ease of access, the rolling audit of access times to the single point of access line shows frequent delays and abandonment. The patient pathway is limited to low acuity patients with reduced clinical and investigation.	4	13	9	Deteriorating	No change
SFT-7946	SFT	1/2/2024	Transformation programmes and projects are not delivered to time	Strategic	R4 Transforming Models of Care	There is a risk that transformation programmes and projects are not delivered to time, leading to the Trust not realising the benefits of the work and being unable to deliver its full savings programme for the year.	1. Competing priorities across the organisation. 2. Shifting resource plans. 3. Sub-optimal scoping of projects. 4. Following the decision announced on 22/05/2025, all non clinical vacancies across the organisation pass through the workforce control process (WCP). 5. The Transformation team is holding vacancies and has reduced capacity as a result.	1. The Trust does not realise the benefits of the work. 2. The start of new work is delayed. 3. More corporate resource time is spent than budgeted. 4. The Trust is unable to deliver its full savings programme for the year.	Yes	5	4	Note re score: Consideration of controls in place, draws us to conclude the effectiveness of current controls is lower than desired. All controls listed are running and have minutes and agendas to evidence their work in decision making. Transformation programme Boards, including Digital Steering Group (DSG) Resource scheduling bi-weekly meeting Urgent and Emergency Care and Planned Care Boards Small projects Board Corporate Projects Prioritisation Group feeding into the Engine Room Project documentation to support delivery	Good knowledge of transformation programmes and projects underway as overseen in the Corporate Projects Prioritisation Group which meets monthly. Monthly review of on/off-track to project/programme plan at Transformation team Performance Review Meeting.	4	13	12	Deteriorating	Score increased
SFT-8102	SFT	6/18/2026	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, 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 with	1. Delays to patient care. 2. Missed or incorrect appointments. 3. Patients being lost 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	5	4	Recruitment into vacant posts and ongoing recruitment activity Updated processes, including using RPA (Robotic Processing Automation) for some eRS tasks Specialty admin teams providing additional support to process booking and outcome forms Closer working between Central Booking and the wider Specialty Teams - Ops and Clinical Continuing Transformation programme within Central Booking focussing on processes and ways of working	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	4	13	9	Deteriorating	Score increased
SFT-8759	SFT	7/8/2026	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 £32.5m efficiency programme must be delivered in full to maintain 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. SOP 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 in	12 month rolling cash forecast included on monthly Finance report. BSW Hospital group cash committee has been stood up. SFT financial recovery group and internal turnaround team to ensure savings delivery.	4	13	13	Static	No change
SFT-8791	SFT	4/2/2026	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	5	- Cash flow forecasting - monitoring reports to F&P - SFTs 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.	3	13	13	Static	No change
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 deferred 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			New to register

IDENTIFICATION				TRAJECTORY										
Risk Ref	Care Org	Date Opened	Risk Title	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
GWH-1576	GWH	4/10/2026	Failure to deliver planned improvement programme	1.Financial governance and reporting arrangements identify savings risk, but do not in themselves provide the operational capacity required to deliver recurrent transformation at the scale required. 2. Delivery remains dependent on a limited number of high-value schemes and external support, creating a gap in resilience if planned schemes under-deliver, slip or prove non-recurrent. 3. There is not yet a fully evidenced recurrent savings pipeline sufficient to mitigate the full scale of the financial improvement requirement.	1.Map, review and link risks across Trust which fall under the broader theme of financial capacity/capability. 2026-08-30	Risk, Legal and Governance Facilitator	8/31/2026	Amber	7	10/17/2029	Johanna Bogle – Site Finance Director	Finance and Performance Committee	7/29/2026	8/29/2026
RUH-3273	RUH	2/25/2026	Future RUH site development lack of electrical infrastructure	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.	All actions complete	Head of Infrastructure	N/A	Amber	10	N/A	Associate Director of Estates	Non-Clinical Governance Committee	7/31/2026	8/31/2026
RUH-3314	RUH	5/7/2026	Discontinuation of RUH Hospital at Home Service	Access to the HCRG is limited to one slow point of access. Frailty SDEC is not open as yet. Ambulatory is at capacity Patients discharge will be delayed with a reduced hospital at home bed base.	All actions complete	Clinical Lead for Hospital@Home	N/A	Amber	10	8/14/2026	Divisional Director of Operations - Medicine	Finance and Performance Committee	7/14/2026	8/14/2026
SFT-7946	SFT	1/2/2024	Transformation programmes and projects are not delivered to time	Capacity and capability to deliver to time Capacity to demand mismatch for resource allocation to top contributing projects for achieving the organisation's plan. There is a risk that Corporate Projects may be prioritised and started outside of a multi-portfolio review. This gap in control can lead to too much change going on at once. There is a gap in our controls where we	1) Completion of the Corporate Services re-design for Transformation.	Alex Talbott - Deputy COO	9/30/2026	Green	8		Director of Transformation	Strategy Deployment Committee	7/28/2026	8/28/2026
SFT-8102	SFT	6/18/2026	Central booking workforce and process instability resulting in risk of patient harm and reduced utilisation across all areas	Continued staffing vacancies and reliance on ongoing recruitment and training (approx 6mths 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. Implement robust and routine reporting and dashboard oversight for OP utilisation 2. Develop robust booking guides/SOPs for use within Central Booking 3. Implement a stabilisation plan for Central Booking workforce, including accelerated recruitment, deployment of bank/agency staff, and implementation of the revised staffing	Nikki Hislop - Outpatient Divisional Manager Surgery	31/08/2026 30/09/2026 30/09/2026	Green	6		Chief Operating Officer	Finance and Performance Committee	7/28/2026	8/28/2026
SFT-8759	SFT	7/8/2026	Unavailability of cash balances to support timely payments to staff and suppliers	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. Submission of PDC revenue support application in line with National Process. 2. Aim to transact key worker accommodation in Q2 which will provide cash coverage for circa 3 months.	Lynne Abbott - Financial Recovery Lead Niall Prosser - COO	31/08/26 30/09/26		9	3/31/2027	Chief Finance Officer	Finance and Performance Committee	7/28/2026	8/28/2026
SFT-8791	SFT	4/2/2026	Financial position 2026/27	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. Reporting by run-rate identifying the gaps that will result in not achieving the financial plan if they are not resolved. 2. Full standing up of turnaround team and financial governance in place and functioning.	Jennie Wyatt - FD	30/09/26 30/09/26	Green	9	3/31/2027	Director of Finance	Finance and Performance Committee	7/28/2026	8/28/2026
GRP-FIN-02	Corporate Service		Cash availability and liquidity								Group Chief Financial Officer		5/28/2026	6/28/2026

IDENTIFICATION						THE RISK				SCORING AND CONTROLS								
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	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 in part 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			New to register
	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			New to register
	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			New to register
	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 AfC 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 AfC 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			New to register
GWH-1085	GWH	11/27/2023	High hospital occupancy and impaired patient flow	Performance and Access	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 levels of bed occupancy reducing flexibility across inpatient services. 2.Delays in patient discharge and transfers of care. 3.Rising emergency demand and admissions. 4.Limited capacity within community and social care services to support patient flow.	1.Delays in admission, transfer and discharge of patients. 2.Increased risk of patient harm associated with overcrowding. 3.Reduced elective activity and increased cancellation of procedures. 4.Deterioration in operational and emergency care performance. 5.Increased pressure on staff wellbeing and productivity.	Yes	5	4	1.Introduction of additional cohort areas (causes 1, 3). 2.Seasonal plan actions (cause 3). 3.Increased safety and welfare checks (causes 1, 2). 4.Immediate escalation of safety concerns (causes 1, 2, 3). 5.Use of nerve centre for live information on patient placement to support quality reviews (causes 1, 2). 6.Information to patients when placed in bed spaces (cause 1). 7.Support for teams who are supporting cohort areas, extra bed spaces on wards (causes 1, 3). 8.Emergency zone operational group (set up to support communication between all partners) (causes	Control effectiveness is evidenced through routine monitoring of bed occupancy, NCTR performance and length of stay against the agreed breakthrough objective trajectory. 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. These measures are reported and reviewed regularly to identify deteriorating flow, assess the impact of improvement actions, and support timely escalation and intervention.	3	12	12	Static	No change
GWH-1382	GWH	4/14/2025	Interventional radiology workforce shortage	Workforce	R2 Taking Our People With Us	There is a risk to service provision & patient safety due to Interventional Radiologist shortage.	1.Insufficient number of substantive interventional radiologists within the service. 2.Limited resilience and consultant cover during periods of leave, sickness or vacancies. 3.National shortage of interventional radiologists affecting recruitment. 4.Increasing demand for interventional radiology procedures and support to clinical pathways.	1.Delays in access to interventional radiology procedures. 2.Increased clinical risk and poorer patient outcomes. 3.Increased reliance on alternative treatments or patient transfers. 4.Reduced resilience and sustainability of the service. 5.Potential loss of local service provision.	Yes	4	4	1.Cases are triaged and decisions are made regaring waiting v transfer (causes 2, 4). 2.Patients able to be transferred for IR procedures (causes 1, 2). 3.Referral of urgent cases to tertiary centre (causes 1, 2, 4). 4.There is one Interventional Radiologist who is on the bank 0.4 WTE a week when available (causes 1, 2). 5.SLA with third party provider provision for IR radiologists (causes 1, 2, 3). 6.Agency staff to provider additional cover (causes 1, 3). 7.Support from NHSE confirmed for hub and spoke model. (causes 1, 2, 3).	Control effectiveness is evidenced through monitoring of interventional radiology activity, including the number of cases undertaken on site, transferred to partner organisations and delayed. 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
GWH-1401	GWH	5/22/2025	Building Safety Act compliance and liability risks	Estates and Infrastructure	R8 Reducing Avoidable Harm	Building Safety Act: There is a risk that the recently introduced Building Safety Act 2022 introduces complexities, uncertainties & liabilities on building upgrade works	1.New legislative requirements introduced through the Building Safety Act 2022. 2.Uncertainty regarding interpretation and application of regulatory requirements. 3.Increased governance, assurance and reporting obligations for building works. 4.Potential for additional liabilities, delays and costs associated with compliance.	1.Delays to building upgrade and estate improvement projects. 2.Increased capital and revenue costs associated with compliance. 3.Exposure to regulatory enforcement action or legal challenge. 4.Increased organisational liability and governance risk. 5.Reduced ability to deliver planned estate transformation programmes.	Yes	5	3	1.Oversight & awareness, including reporting through to TMC & FIDC (causes 2, 3, 4). 2.Review risk on a monthly basis (causes 2, 3). 3.Legal Advice procured from Bevan Brittan to better understand Trust's position and our approach to defining the Higher-Risk Building (HRB) boundary (causes 1, 2, 4). 4.Testing advised position with the Building Safety Regulator (BSR) to provide clarity and, subject to agreement, enable significant areas of the site to be reclassified as no longer high risk (causes 1, 2). 5.Building Control to act as the determining body and arbiters to testing approach (causes 2, 3). 6.Submissions to the Building Safety Regulator via SERCO and THC covering the IFD, UTC, BTC and	Control effectiveness is evidenced through ongoing regulatory and governance oversight, including documented legal advice from Bevan Brittan, submissions to the Building Safety Regulator and routine review through established governance forums. 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
GWH-1493	GWH	11/11/2025	Insufficient clinical leadership capacity and development	Workforce	R2 Taking Our People With Us	Insufficient Clinical (Medical) leadership capacity and training.	1.Limited availability of clinicians to undertake leadership roles alongside clinical commitments. 2.Insufficient succession planning for key clinical leadership positions. 3.Inconsistent access to leadership development and training programmes. 4.Increasing organisational and service demands placed on clinical leaders.	1.Reduced clinical engagement in strategic and operational decision-making. 2.Delays in delivery of service improvement and transformation programmes. 3.Increased burden on existing clinical leaders. 4.Reduced organisational resilience and succession planning capability. 5.Difficulty sustaining improvements in quality, safety and performance.	Yes	4	4	1.New CMO appointment (causes 1, 2, 4). 2.Support from current AMD and Exec leadership team (causes 1, 2, 4). 3.New training commencing: Triumvirate Clinical Leadership ; three initial cohorts then evaluate (causes 2, 3). 4.Essential Management skills for Clinical Leads program being rolled out (causes 1, 3).	Effectiveness demonstrated through delivery of the Triumvirate Clinical Leadership Programme and Essential Management Skills training, with cohort numbers, uptake and completion rates monitored. Leadership workforce indicators, including vacancies and long-term sickness, are reviewed routinely. Formal programme evaluation is scheduled following completion of the current cohorts.	4	12	12	Static	No change

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	Corporate Service		LAN refresh and network infrastructure resilience	The risk based technology refresh programme is in development and is not yet an operating control. There is currently one control in place against two causes, and none that addresses the end of life infrastructure itself.	1. Development of a risk based technology refresh programme with defined milestones and delivery oversight, to ensure timely replacement of high risk 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
	Corporate Service		Insufficient clinical informatics capacity and capability across the Group	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
	Corporate Service		Workforce plan delivery									Group Executive Committee		
	Corporate Service		Temporary staffing	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		
GWH-1085	GWH	11/27/2023	High hospital occupancy and impaired patient flow	1.Sustained high occupancy continues to reduce flexibility across inpatient bed capacity, meaning the organisation remains reliant on escalation areas and additional cohort capacity rather than 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 actions has not yet been fully	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 reduce - this should be monitored and escalated to partners as required. Data on referrals to be requested. 2026-09-30 2.Onboarding and implementation of GIRFT Recommendations 2026-08-28 3.Review of OPEL action cards 2026-08-28	Chief Operating Officer - GWH	9/1/2026	Red	4	9/30/2026	Benny Goodman - Chief Operating Officer	Finance and Performance Committee	7/29/2026	8/29/2026
GWH-1382	GWH	4/14/2025	Interventional radiology workforce shortage	1.Not always available when needed 2.Potential patient not stable enough to be transferred 3.There is a lack of interventional radiologist provision in the southwest and within WoEIN 4.Transfer relies on informal arrangements between colleagues at other Trusts 5.Not always available when needed 6.Potential patient not stable enough to be transferred 7.There is a lack of interventional radiologist provision in the southwest and within WoEIN	1.Confirm future model for regional (GWH+GRH/NBT/OUH) IR service 2026-09-18 2.Contracted external provider with 2 days per week interventional radiologist cover throughout 26/27 unless successful recruitment 2027-03-31 3.Ongoing meetings to agree emergency and out of hours SLA with NBT/GRH 2026-06-30 4.Ongoing meetings with Gloucestor Royal Infirmary Executives and Radiology regarding emergency cover and future model 2026-06-30 5.Paper to be sent to CMO and COO requesting executive support to facilitate formalised meeting either via the WoE Imaging	General Manager - Imaging Services	9/1/2026	Red	8	10/22/2026	Kathryn Bateman - Chief Medical Officer	Trust Management Committee	7/29/2026	8/29/2026
GWH-1401	GWH	5/22/2025	Building Safety Act compliance and liability risks	1.Transfer relies on informal arrangements between colleagues at other Trusts 2.Given recent issues experienced in Bristol, there is understandable caution to using Building Control as arbiters during testing 3.If the hospital site could notionally be split up into smaller sections, only parts of the hospital will fall under the BSA not all. 4.BERCO's project management on Building Safety Act-related works is currently costed at approximately 30%, significantly higher than the typical 10%	1.Obtain lessons learnt from other Trusts 2026-07-25	Site Director of Estates and Facilities		Amber	8	4/1/2027	Rupert Turk – Site Director of Estates & Facilities	EFM / THC Joint Management Board	7/29/2026	8/29/2026
GWH-1493	GWH	11/11/2025	Insufficient clinical leadership capacity and development	1.Insufficient places available for requirements. - effectiveness unknown untested programme (will be evaluated) - no sustainable funding plan confirmed 2.No Medical Leadership development training 3.Partial control for this is GWH Leadership training, which is open to all staff (usually B6-8) 4.Vacancies, long term sick leave and part filled posts in Deputy and AMD posts	1.For DCMO Clinical transformation 2026-10-22 2.Re-design of Medical Leadership roles and structure, based on results from Action 13237 2026-06-30 3.Review consultant training offer with BSW and provide options appraisal 2026-03-26 4.Review Med L/ship need Agree priority areas Review current offer Gap analysis Review options - internal/external offer Review funding options 2026-09-25	Chief Medical Officer - GWH	9/30/2026	Amber	7	4/1/2027	Kathryn Bateman - Chief Medical Officer	People and Culture Committee	7/29/2026	8/29/2026

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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	R8 Reducing Avoidable Harm	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 front-door services, combined with increasing demand, case complexity and attendance levels that exceed available capacity, may result in delays to assessment, emergency response, ongoing care and medical review, leading to compromised patient safety and adverse maternal and neonatal outcomes.	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.Inadequate 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 intensive 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.Inefficient patient flow, resulting in longer waiting	Yes	4	4	1.Environmental Risk Assessment for the department has been completed (Causes 1, 2, 5, 7, 10) 2.Emergency Buzzer in place (Causes 6, 7, 8, 9) 3.Midwives attend yearly PROMPT training on obstetric emergencies (Causes 4, 6, 7, 8, 9) 4.Structured Maternity Early Warning Score (MEWS) system used to identify and escalate maternal deterioration (Causes 4, 6, 8, 9)	The department maintains a completed and signed Environmental Risk Assessment, with identified risks and associated improvement actions monitored and escalated through relevant governance structures. Evidence of implementation and progress against actions is regularly reviewed. Emergency buzzers are in place to enable staff to rapidly summon assistance during maternal and neonatal emergencies. Evidence of control effectiveness includes records of routine emergency drills demonstrating buzzer activation and response times, as well as incident reviews and Datix investigations confirming appropriate functionality during real events.	4	12	11	Deteriorating	Score increased
GWH-1577	GWH	4/10/2026	Suboptimal clinical environment affecting care quality and patient experience	Estates and Infrastructure	R8 Reducing Avoidable Harm	There is a risk that suboptimal clinical environment is impacting patient experience and effectiveness of clinical care.	1.Ageing estate and infrastructure impacting functionality and patient experience. 2.Clinical areas that are not designed to meet current models of care. 3.Maintenance and backlog estate issues affecting the quality of the environment. 4.Limited capital investment available to modernise facilities.	1.Reduced quality and effectiveness of patient care. 2.Deterioration in patient experience and satisfaction. 3.Increased operational inefficiencies and service constraints. 4.Difficulty meeting modern healthcare standards and expectations. 5.Challenges recruiting and retaining staff within outdated facilities.	Yes	4	4	1.GWH Trust Executive Oversight (causes 1, 2, 3, 4). 2.Infection prevention and control measures including audit to minimise risk (causes 1, 3). 3.Duty of candor to patients and feedback mechanisms (causes 1, 2). 4.Compliance with health and safety risk assessments. Routine risk assessments and monitoring (causes 1, 3). 5.Regular reviews of environmental risks through divisional governance committees (causes 1, 2, 3). 6.Capital bids submitted for areas identified as a risk e.g. maternity triage (causes 2, 4). 7.Capital masterplan for Way Forward Programme in place - limited planning at GWH (causes 1, 2, 4).	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. Complaints have increased in month rising to 90 in month, however the main reported concern relates to waiting times rather than environmental or inpatient experience. 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
GWH-1608	GWH	5/12/2026	Insufficient capital funding for estate betterment and PFI handback readiness	Finance	R5 Increasing Financial Sustainability	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.Limited capital funding available beyond THC-funded lifecycle works. 2.Competing organisational priorities for available capital resources. 3.Requirement to address legacy estate issues not covered within PFI contractual obligations. 4.Need to improve estate condition and functionality ahead of PFI contract handback.	1.Inability to address legacy estate issues prior to PFI handback. 2.Deterioration in estate condition and fitness for purpose. 3.Increased future maintenance and capital expenditure requirements. 4.Missed opportunities to improve infrastructure and support service transformation. 5.Increased operational and financial risks following contract expiry.	Yes	4	4	1.Development and maintenance of a Trust approved PFI Expiry Capital & Betterment Plan, aligned to lifecycle delivery and informed by condition survey outputs, with prioritisation through the EFM Board and active engagement with System, IPA and DHSC to identify and secure available central or alternative funding sources (causes 1, 2, 3, 4). 2.A Trust approved, resourced PFI Expiry Programme Plan is in place which identifies expiry critical activities, sets out required clinical and corporate capacity, prioritises expiry delivery over business as usual where necessary, and is supported by targeted use of external specialist support. Progress, capacity constraints and funding assumptions are reported regularly through EFM	Effectiveness demonstrated through approved Capital and Betterment Plan, funding secured against identified need, and regular oversight through EFM Board and FIDC. Condition survey findings inform investment priorities and support delivery of the capital programme.	4	12	12	Static	No change
GWH-570	GWH	8/18/2020	Surgical Assessment Unit capacity and patient flow pressures	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 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.Increasing demand and attendance levels within the Surgical Assessment Unit. 2.Insufficient physical capacity to accommodate peak patient activity. 3.Workforce pressures affecting timely triage and medical assessment. 4.Patients being assessed or treated in non-designated clinical areas during periods of escalation.	1.Delays in patient triage, assessment and treatment. 2.Increased risk of patient deterioration whilst awaiting review. 3.Delivery of care in inappropriate clinical environments. 4.Reduced patient experience and satisfaction. 5.Failure to achieve urgent care performance standards.	Yes	5	4	1.Daily Divisional Huddle, monitors demand and challenges faced by SAU which takes place 3 times a day in the week (causes 1, 2). 2.Daily Divisional safety & Quality Meeting. Meeting takes place at 9am each day to discuss any immediate safety concerns, review of acuity across the division and staffing allocation (causes 1, 3). 3.Matron of Day role - has oversight of staffing position and is an escalation point for safety concerns (causes 3, 4). 4.Escalation Protocols: Clear criteria to receive surgical patients (causes 1, 2). 5.Rapid Triage Systems: Streamlined triage to identify and prioritise the sickest patients quickly (cause 3).	Effectiveness evidenced through real-time dashboard monitoring of occupancy, acuity, flow and time to first assessment. Additional assurance provided by tracking triage room availability, escalation compliance, non-surgical admissions and Matron of Day escalation records. Dashboard data is reviewed routinely to identify and address delays in patient assessment.	3	12	12	Static	No change
RUH-1882	RUH	9/18/2017	Non-compliance with fire compartmentation	Estates and Infrastructure		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 evacuation and increased danger to life. 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 60-minute compartmentation for inpatient areas, prioritised on a risk-assessed basis, but is dependent on capital being available. (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 accomodation.	3	12	9	Deteriorating	No change
RUH-2110	RUH	1/21/2021	Business interruption as a result of backlog maintenance, or critical infrastructure risks	Estates and Infrastructure		There is an escalating risk that the Trust is unable to maintain the estate to the required standard as set by Health & Safety Executive (HSE), SFG20 and HTM. Clinical services may experience interruption and possible closure due to the backlog of maintenance.	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	5	4	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 schemes implemented by the onsite maintenance team to prolong the life of Estate assets and to react quickly to breakdowns to minimise operational impact.	Previous 6-Facet survey - this is being repeated this year.Backlog maintenance prioritised by subject matter experts. Insufficient funding .	3	12	9	Deteriorating	No change
RUH-2124	RUH	2/24/2021	Oncology/Haematology Workforce and Service Delivery	Quality and Safety	R8 Reducing Avoidable Harm	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	5	4	1. Agency Locum Consultants cover in place due to being unable to recruit substantively at Consultant level.(2) 2. Use of cancer pharmacists for designated outpatient clinic work (1) 3. Frequent overview of rosters to optimise patient safety and staff wellbeing (1)	Partially effective use of agency locum: 2.6WTE 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 6.9WTE reducing to 4.9WTE with business case funding in Jan 2027. Partially effecitve 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	9	Deteriorating	No change
RUH-2218	RUH	11/9/2021	Electrical Infrastructure Capacity	Estates and Infrastructure		Once the Cancer Centre has been built, the RUH site will be at its maximum electrical capacity meaning that further development is not possible without upgrading the electrical distribution network or decommissioning other parts of the site.	1. The capacity of the electrical infrastructure on the site is nearing full load. 2. There is a lack of available electricity coming onto the Combe Park site.	1. No further development can be considered due to this limitation, or if they are, there is a risk that there will not be enough electrical capacity to power the Cancer Centre	No	5	3	1. All Capital Projects should be approved at CPMG, and CPMG has representation from the Head of Capital Projects and the Head of Estates who understand this risk and can advise of implications. (1) 2. Any commissioning of new projects must involve Trust AP(Elec) who understands this risk. (1)	This risk will be closed at E&F Board on Monday 17 August 2026	4	12	7	Deteriorating	No change

IDENTIFICATION				TRAJECTORY										
Risk Ref	Care Org	Date Opened	Risk Title	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
GWH-1560	GWH	2/3/2026	The footprint of the Maternity Care Centre and Day Assessment Unit is not adequate to fulfil the demand.	1.On going risks identifies with no further opportunities to improve the area. 2.Emergency buzzer does not sound in delivery suite. 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 participation 4.There is inconsistency in the application and escalation of MEWS in	1.A documented Standard Operating Procedure setting out the pathway for responding to obstetric emergencies in Maternity Care Centre 2026-08-21 2.Develop detailed plans for construction, service relocation, operational impact. 2026-08-21 3.Development of capital plan to carry out reconfiguration plans case for presentation at capital group to secure commitment to fund. 2026-08-04 4.Implement a Flow Midwife to facilitate the	Head of Midwifery and Neonatal Services	8/31/2026	Red	8	8/21/2026	Luisa Goddard - Chief Nursing Officer	Quality and Safety Committee	8/4/2026	9/4/2026
GWH-1577	GWH	4/10/2026	Suboptimal clinical environment affecting care quality and patient experience	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. Capital bids and masterplanning are in progress, but approved funding, prioritisation and delivery timescales are not yet confirmed for all areas of concern.	1.Map, review and link risks across Trust which fall under the broader theme of clinical environment 2026-08-30	Risk, Legal and Governance Facilitator	8/31/2026	Amber	6	10/17/2029	Benny Goodman - Chief Operating Officer	Quality and Safety Committee	7/29/2026	8/29/2026
GWH-1608	GWH	5/12/2026	Insufficient capital funding for estate betterment and PFI handback readiness	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: External support mitigates pressure but increases cost and is dependent on funding approval. 4.PFI Expiry Programme Plan: Funding assumptions remain uncertain and are subject to wider Trust and system financial constraints. 5.PFI Expiry Programme: The	1.Define what elements will be supported through internal resource, external specialist support, and anticipated capital or revenue funding, and review these assumptions regularly. 2026-08-31 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. 2026-08-31 3.Identify expiry critical activities, required skillsets, internal capacity gaps, and points where business as usual activity must be deprioritised to protect the expiry timeline. 2026-	Estates Planning Manager, GWH	8/1/2026	Amber	7	10/17/2029	Johanna Bogle – Site Finance Director	EFM Key Issues	7/29/2026	8/29/2026
GWH-570	GWH	8/18/2020	Surgical Assessment Unit capacity and patient flow pressures	1.Divisional huddles do not take place at weekends 2.Rapid triaging not always possible most of the time due to triage rooms being bedded. 3.SAU has no control over type of patients admitted to department. In times of escalation, criteria not always followed resulting in Medical and Orthopaedic patients in the department. This causes flow standstill. 4.SPC have one Surgical ward which often holds medical outliers and T&O patients, this limits how much Melton ward can pull from SAU.	1.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. 2026-12-02 2.To review the full impact of having the 2nd register and ensure there is monthly monitor of the KPI's in terms of first assessment and senior reviews 2026-11-05	Head of Service – General Surgery, Urology and SAU - GWH	12/1/2026	Amber	7	12/21/2026	Luisa Goddard - Chief Nursing Officer	Surgery and Planned Care Divisional Board Meeting	7/29/2026	8/29/2026
RUH-1882	RUH	9/18/2017	Non-compliance with fire compartmentation	There is insufficient capital funding to fully address all known breaches in fire compartmentation. Cases for investment continue to be made via CPMG, which reports to TME and Trust Board. Due to capital constraints, there is currently no on-going financial resource identified to address Trust-wide breeches in fire compartmentation and fire doors.	1. Complete CID for fire door inspection to high risk and residential areas 2. Prioritise list for fire door replacement 3. Completion of compliant Urology out patient fire compartmentation. 4. Completion of compilation fire compartmentation in Mary Ward.	Fire Safety Manager Fire Safety Manager Head of Infrastructure Head of Infrastructure	31/08/2026 31/08/2026 23/11/2027 23/11/2027	Amber	10	8/31/2026	Fire Safety Manager	Non-Clinical Governance Committee	7/31/2026	8/31/2026
RUH-2110	RUH	1/21/2021	Business interruption as a result of backlog maintenance, or critical infrastructure risks	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 Hospitals' (RUH) average annual investment of £1-2m into backlog maintenance.	1. Review External Backlog maintenance policies to establish best practice	Senior Estates Officer (Systems)	9/4/2026	Amber	10	9/23/2026	Associate Director of Estates	Non-Clinical Governance Committee	7/31/2026	8/31/2026
RUH-2124	RUH	2/24/2021	Oncology/Haematology Workforce and Service Delivery	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 total job plan minutes to cover OP clinics, in 25/26, there is a requirement for an additional 4.73 WTE for substantive consultants working a 10 PA job plan.	1. Seek approval for medical and nursing posts within the Haematology & Oncology Investment Case 2. Recruit 2nd Clin Onc for Prostate cover 3. Recruit 2nd Clin Onc for Skin Cancer	Specialty Manager, Haematology & Oncology	31/07/2026 30/10/2026 30/10/2026	Amber	10	7/31/2026	Divisional Director of Operations, FASS	People Committee	7/31/2026	8/31/2026
RUH-2218	RUH	11/9/2021	Electrical Infrastructure Capacity	Minimal conversations about external power supply increase in the short term	1. Act as Estates Lead to support the project team complete a stage 3 detailed design, engage with DNO and identify costing options for electrical upgrades	Senior Estates Officer (Systems)	9/30/2026	Amber	10	9/30/2026	Associate Director of Estates	Non-Clinical Governance Committee	7/31/2026	8/31/2026

IDENTIFICATION						THE RISK				SCORING AND CONTROLS								
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
RUH-2683	RUH	11/1/2024	ED overcrowding and delayed emergency treatment	Quality and Safety	R8 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 four 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 W45 policy.	1. Increased mortality and morbidity associated with overcrowding. 2. Patient deterioration before first assessment. 3. Compromised privacy 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 assessments (cause 1). 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 (performance dashboard). NCTR occupancy 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
RUH-2973	RUH	11/14/2024	Insufficient medical palliative care provision	Quality and Safety	R8 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 EofL 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 7-day service. (1)	April 25-April 26 49.05% of deaths at the RUH were reviewed by SPCT (Palliative and EofL Steering Group, August 2026). MUO in place with DHH. Partially effective as currently only able to offer a 6 day nurse led service due to vacancies. NACEL shows RUH is in a good position in relation to peers in SW and Nationally (2025).	4	12	8	Deteriorating	No change
RUH-3230	RUH	12/18/2025	Insufficient Patient Safety, Risk, Audit and Quality Improvement Resource	Quality and Safety	R8 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, funds 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
RUH-3243	RUH	1/13/2026	IT equipment age replacement (laptop/desktops)	Digital and Cyber	R3 Delivering Digital Maturity	There is a risk that IT assets across the three Trusts may not be replaced at the end of their standard lifecycle. All laptop and desktop devices are procured with a three-year manufacturer warranty, and delays to replacement could result in equipment being operated beyond its supported warranty period.	1. This risk is driven by a lack of capital funding availability resulting from the Shared EPR programme. Consequently, IT assets across the three Trusts may not be replaced at the end of their three-year warranty period, increasing the risk of hardware failure, reduced performance and higher support costs.	1, Clinical and non-clinical staff, particularly new starters, may be unable to receive appropriate devices in a timely manner, impacting productivity, user experience and service delivery. 2. Laptops and desktop PCs that remain in service beyond their intended lifecycle may experience degraded performance, reduced reliability and an inability to support current and future operating system requirements. In addition, older hardware may not meet the technical requirements needed to utilise emerging technologies and AI-enabled capabilities, limiting the organisation's ability to realise the benefits of digital transformation initiatives. 3. The continued use of ageing IT equipment increases cyber security risks, as older devices may	Yes	5	4	1. Device age-replacement activity has been prioritised and restricted to critical clinical areas and devices assessed as no longer fit for purpose. This ensures that the most significant clinical and operational risks are addressed within the limited capital funding available. (1) 2. The July 2026 IT Capital Finance Report identifies an annual allocation of £547,000 for the IT Rolling Replacement Programme / PC Growth. At the reporting date, £258,584 had been spent or committed, leaving £288,416, or 53% of the allocation, not yet committed. This funding provides partial mitigation but is insufficient to address the full age-replacement requirement across the three Trusts. (1)	Over 1,000 end-user devices have been replaced at RUH during 2025, resulting in a significant reduction in IT support demand and improved reliability in the areas that received refreshed equipment. This demonstrates the positive impact of the replacement programme on user experience, productivity and service resilience. However, whilst this has reduced the immediate operational impact, the underlying risk remains. The control score cannot be reduced further until sustainable recurring capital funding is identified and secured to support the ongoing replacement of ageing devices across the three Trusts.	3	12	9	Deteriorating	No change
RUH-3280	RUH	3/6/2026	Absence of Retrospective Building Fire Strategies (RBFS) for Existing Healthcare and Other Buildings	Estates and Infrastructure		There is a risk that current fire precautions, compartmentation arrangements, evacuation methodologies, and fire safety systems do not meet required regulatory standards.	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 regulatory action. 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, increasing the likelihood of enforcement action by the Fire & Rescue boundaries.	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 life 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	9	Deteriorating	No change
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 ty to pay suppliers in a timely fashion, 2. Deferred capital expenditure and process demands on finance, procurement teams and budget holders.	Yes	4	5	1. Internal - Budget delivery 2. Internal - Under development 3. External - apply for Revenue support PDC 4. External - ICB working capital cash support 5. External - Group working capital cash support 6. External - contract renegotiation 26/27 and 27/28 onwards	Rolling daily cash flow forecast based on current run rate. Before applying control of national revenue PDC support.	3	12	8	Deteriorating	No change
SFT-6229	SFT	1/13/2023	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
SFT-6412	SFT	4/16/2026	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	4	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 PSRs are not showing recurrent moderate, major or catastrophic harm.	3	12	12	Static	Score reduced

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RUH-2683	RUH	11/1/2024	ED overcrowding and delayed emergency treatment	No effective control over ambulance handover delays. Escalation framework unevidenced at surge. RN vacancy rate static.	1. Business case for ED majors expansion to Group Investment Group (Sep 2026). 2. Commission external review of escalation framework effectiveness (Jul 2026). 3. Joint review of W45 handover protocol with SWAST (Aug 2026).	Deputy COO, RUH	9/30/2026	Amber	10	3/31/2027	Chief Operating Officer, RUH	Group Quality Committee	6/30/2026	7/30/2026
RUH-2973	RUH	11/14/2024	Insufficient medical palliative care provision	There is no provision to back fill the 10 weeks when there is no medical cover for patients within the RUH. Current medical provision falls below professional standards (minimum 1 wte for 250 beds). The RHU is a negative outlier when compared with services across the region (1 wte for 893 patients). Dorothy house helpline out of hours (OOH) is designed to offer support to patients within the community rather than supporting health care professionals within an acute setting.	1.Robust data collection to provide insights to service provision and need. 2. Develop a working group with Dorothy house to meet monthly to discuss opportunities around the development of a more collaborative service across the organisation 3. Review current followup patients/ referrals.	Lead nurse palliative and end of life care	31/08/2026 31/08/2026	Amber	10	7/31/2026	Divisional Director of Operations, FASS	Quality Assurance Committee	7/21/2026	8/21/2026
RUH-3230	RUH	12/18/2025	Insufficient Patient Safety, Risk, Audit and Quality Improvement Resource	National corporate services benchmarking (2023/24) shows RUH governance and risk investment is significantly below national and BSW region, confirming a resourcing gap. Operational pressures and workforce shortages continue to compete with improvement commitments. Critical reliance on single individuals without cross cover/succession plans. Capacity constraints reduce progress towards quality improvement maturity, accreditation, and delivery of mandatory audit requirements.	All actions complete	Associate Director of Patient Safety & Quality	N/A	Green	10	7/31/2026	Chief Nurse Officer	Quality Assurance Committee	5/30/2026	6/30/2026
RUH-3243	RUH	1/13/2026	IT equipment age replacement (laptop/desktops)	Current age-replacement modelling across the BSW Group identifies a backlog requirement of approximately £2.64m from 2025/26, a further £5.63m required to maintain the estate in 2026/27, and £3.02m required in 2027/28. This represents a total forecast replacement requirement of approximately £11.29m across RUH, SFT and GWH. Without sufficient capital investment, devices will remain in service beyond their intended lifecycle, increasing the risk of hardware failure, reduced	1. This risk has been escalated to the Group Director, Jonathan Hinchliffe, to support capital prioritisation and highlight the impact of underinvestment in the end-user device replacement programme.	Senior IT Operations Manager	1/28/2026	Amber	10	5/17/2026	Group Director of Technology	Non-Clinical Governance Committee	7/31/2026	8/31/2026
RUH-3280	RUH	3/6/2026	Absence of Retrospective Building Fire Strategies (RBFS) for Existing Healthcare and Other Buildings	No RBFS documents exist for several buildings. No definitive confirmation of original design intent or current compliance baseline .Incomplete visibility of compartmentation, evacuation strategy, and systems integration	All actions complete	Fire Safety Manager	N/A	Amber	10	N/A	Associate Director of Estates	Non-Clinical Governance Committee	7/31/2026	8/31/2026
RUH-3289	RUH	3/12/2026	Working Capital cash shortfall	Pace of savings delivery and commissioner funding uplift	Grop and ICB working capaital cash policy	Site FD	9/3/2026	Amber	10	5/14/2026	Site FD	Finance and Performance	8/14/2026	9/14/2026
SFT-6229	SFT	1/13/2023	Risk of DSU - Estate Infrastructure failure	[07/07/2023 12:00:42 Laurence Arnold] 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. seed funding allocated to SFT - requires development of the business case 2. DASH monies approved pending short business case sign off - anticipated Sep 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	Laurence Arnold - Programme Lead	6/30/2026	Red			Chief Operating Officer	Finance and Performance Committee	7/28/2026	8/28/2026
SFT-6412	SFT	4/16/2026	Harm to women and babies through lack of dedicated 2nd obstetric theatre	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. Broad cost information to be added to options appraisal and then re-presented at COLT. 2. 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	Vicki Marston - Director of Midwifery	31/08/2026 31/08/2026	Amber	3	3/31/2028	Chief Medical Officer	Quality and Safety Committee	7/28/2026	8/28/2026

IDENTIFICATION						THE RISK				SCORING AND CONTROLS								
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 por 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
SFT-7734	SFT	9/21/2023	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	5	4	- capital control group prioritises capital programme - monitor Datix incident reporting related to infrastructure and equipment - rolling 15 month cashflow forecast - maintain a risk assessed 5 year plan - Additional funding received through the estates safety fund.	Incident reporting highlighting areas of concern to ensure appropriate priortisaiton 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	3	12	12	Static	Score increased
SFT-7917	SFT	4/8/2026	Fire risk in Main Theatres corridors	Estates and Infrastructure	R8 Reducing Avoidable Harm	There is a risk of fire and obstructed evacuation in the Main Theatres corridors, leading to harm to staff, patients and visitors.	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	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. Fire Team conducting weekly walk rounds. Theatre staff reminded regularly as to their responsibilites to keep corridors clear as possible	4	12	11	Deteriorating	Score increased
SFT-8780	SFT	3/20/2026	Capacity of HR and change management resources 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	To be updated... 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.	HRBP team is in place until Jun 26 - planning to replace members leaving is ongoing	4	12			No change
SFT-8800	SFT	4/9/2026	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	4	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. Expert panel which reviews all patients with LoS over 7 days with CTR. 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 SFT's 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. The number of discharges going out on Pathway 0 and 1 supported by ESD has increased to 64% within 48 hours. 89% within 0-5 days.	4	12	12	Static	No change
SFT-8926	SFT		Capital Shortfall for the DASH Project	Finance	R4 Transforming Models of Care	There is a risk that the £6m 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 £77.8m. 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	4	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)	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.	4	12			New to register

IDENTIFICATION				TRAJECTORY										
Risk Ref	Care Org	Date Opened	Risk Title	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
SFT-7734	SFT	9/21/2023	Limited Capital Funding to support safety, building and equipment	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 2027/28	1. Ongoing review of cashflow forecast to ensure maximisation of capital expenditure within affordability	Jennie Wyatt - FD	3/31/2027	Green	9	3/31/2027	Director of Finance	Finance and Performance Committee	7/28/2026	8/28/2026
SFT-7917	SFT	4/8/2026	Fire risk in Main Theatres corridors	Despite the above still unable to remove all trays and equipment out of the corridors due to as lack of available alternative space.	No open actions	NA	NA	Green			Chief Operating Officer	Finance and Performance Committee	7/28/2026	8/28/2026
SFT-8780	SFT	3/20/2026	Capacity of HR and change management resources to support transformation	to be updated ….One to ones with HR and OD&P staff who are affected by the CSR Consultation with the affected teams	no actions	NA	NA	Green			Director of Organisational Development and People, Director of Transformation, Managing Director	People and Culture Committee	7/29/2026	8/29/2026
SFT-8800	SFT	4/9/2026	Reduction of No Criteria to Reside (NCTR) to 9% as per plan	Reporting of timelines in patients journeys challenging with current IT systems. Complexity in pathway management is leading to delays in discharge. We no 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. A3 on Pathway 3 and counter measures continue to be delivered and reported through UEC board. 2. A3 on Pathway 1 and counter measures continue to be delivered and reported through UEC board.	Emma Cavill - Head of Site and Patient Flow Alison Peebles - Head of Therapies	30/06/2026 30/06/2026	Red			Chief Operating Officer	Finance and Performance Committee	7/28/2026	8/28/2026
SFT-8926	SFT		Capital Shortfall for the DASH Project	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. Plan for an allocation of £6m capital to be made available for 2028/29 to fund the balance of the construction cost 2. Maintain strong cost control on DASH project throughout the remainder of design stages, through to construction and completion 3. Try to identify other sources of funding to supplement existing allocations for DASH	Laurence Arnold - Programme Lead	31/01/2028 29/12/2028 29/12/2028	Green	6	11/16/2026	Managing Director	Finance and Performance Committee	7/28/2026	8/28/2026

BSW Hospitals Group

Risk and Assurance Committee Chair's Report to the Group Board

Report from	Risk and Assurance Committee
Report to	Group Board
RAC meeting date	19 August 2026
Board meeting date	3 September 2026
Author	Faried Chopdat, Chair of the Risk and Assurance Committee
Status	Assurance
Reporting period	The Committee's meeting of 19 August 2026
Supporting material	The full Group Risk Register is available in the Board Reading Room as an Excel file.
Linked BAF principal risks	All

1. Executive summary

The Committee's principal business was the Group Risk Register and the Board Assurance Framework. On the Board Assurance Framework it took **limited assurance**, which reflects the framework's maturity rather than the risks it describes. On the Group Risk Register it recognised marked progress since June, while concluding that the register requires further development before it can be relied upon as a consistent source of Group-level assurance.

Six matters are set out for the Board's attention at section 5. Four require particular emphasis: the financial position at Great Western within the Group's wider financial risk; priority development areas in the assurance framework; estates and capital compliance; and the visibility of cyber risk. The Committee also commissioned its first deep dive, on estates and fire safety, and has itself agreed its scope and assurance questions. Separately, the Board is asked to approve the Committee's own Terms of Reference and to consider whether executive members should attend the Committee rather than vote on it.

2. The Group Risk Register at a glance

The dashboard below is generated from the register and remains in development. **The full register is in the Reading Room as an Excel file** (a thirty-column register does not reproduce legibly in a meeting pack).

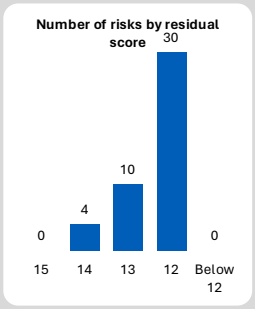
BSW Hospitals Group August 2026 Group risk register dashboard

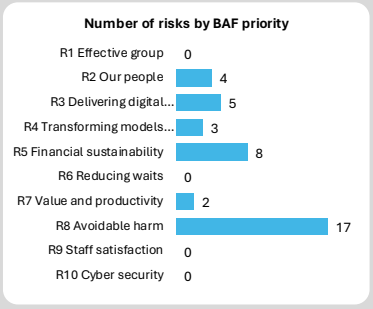
August 2026 · Generated automatically from the Risk Register sheet · Escalation threshold: residual score 12 and above (L+I+C, 5+5+5 model)

Risks on register	New this period	Score increased	Score reduced	Highest score
44	10	5	1	14

Risk concentration by category and organisation

Category	GWH	RUH	SFT	Corporate	Programme	Group	Total
Quality and Safety	2	4	2	0	0	0	8
Workforce	2	0	1	2	0	0	5
Finance	2	2	4	3	0	0	11
Performance and Access	1	1	1	0	0	0	3
Estates and Infrastructure	3	5	2	0	0	0	10
Digital and Cyber	0	1	0	4	0	0	5
Regulatory and Compliance	0	1	0	0	0	0	1
Strategic	0	0	1	0	0	0	1
Total	10	14	11	9	0	0	44





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	New to register	Group Chief Financial Officer
–	Corporate	CST programme: finance tracker and savings forecasting	5	5	4	14	New to register	0
RUH-3165	RUH	Delivery of Annual Financial Plan	5	4	5	14	No change	Managing Director
RUH-3235	RUH	Outdated Policies and Limited Governance Resource	5	4	5	14	No change	Head of Corporate Governance

Risks with an increased score this period

Ref	Org	Risk title	L	I	C	Score	Status this period	Risk owner
SFT-7946	SFT	Transformation programmes and projects are not delivered to time	5	4	4	13	Score increased	Director of Transformation
SFT-8102	SFT	Central booking workforce and process instability resulting in risk of patient harm and reduc	5	4	4	13	Score increased	Chief Operating Officer
GWH-1560	GWH	The footprint of the Maternity Care Centre and Day Assessment Unit is not adequate to fulfil t	4	4	4	12	Score increased	Luisa Goddard - Chief Nursing Offic
SFT-7734	SFT	Limited Capital Funding to support safety, building and equipment	5	4	3	12	Score increased	Director of Finance
SFT-7917	SFT	Fire risk in Main Theatres corridors	5	3	4	12	Score increased	Chief Operating Officer

Risks de-escalated from the register this period

Ref	Org	Risk title	Prev	New	Now managed on

44 risks scoring 12 or above are now recorded across all three Care Organisations and Group corporate services. Estates and capital is the largest theme at 14 entries, followed by finance at 11 and the two are connected by capital sufficiency. Four entries score 14. Scores are largely static and the Committee has been advised to expect them to fall once likelihood is rescored.

3. Alert, Advise, Assure

3.1 Alert

- **Financial position at Great Western, within the Group's financial risk.** The Committee identified this as the Group's dominant current risk: a likely Great Western deficit of £25m, the NHS England correspondence of 26 June 2026, the associated cash pressure and the linked elective waiting time position. The material reviewed did not yet provide the Committee with sufficient evidence to conclude on the credibility of the recovery trajectory of the group as a whole to return to plan by year end, or the independent assurance supporting it. The Committee asked what independent assurance is intended. **The Board is asked to consider what independent assurance it requires on the recovery trajectory and by when.** The recovery plan itself and the Group's response to NHS England are before the Board separately.
- **Foundational gaps in the Board Assurance Framework.** Risk appetite is not agreed, so no residual score can yet be judged acceptable. Assurance levels remain to be populated across the framework. Two principal risks, R6 Reducing Waits and R8 Reducing Avoidable Harm, have no senior responsible owner. The 2026/27 internal audit programme is in its early delivery phase and has not yet produced completed reviews that can

be mapped as third-line assurance against the Group BAF (see appendix 1 for internal audit plan). However, it is accepted that this remains an interim BAF until the Group agrees its overall strategy. **These are matters for the Board rather than for the Committee alone.**

- **Estates, fire safety and capital sufficiency.** 14 risk entries concern estates and capital, including Building Safety Act compliance and fire compartmentation and two maternity units repurposed rather than designed for their present use, both carrying high-consequence risk descriptions. **The Committee's question is whether the capital exists to address the compliance exposure and what will remain unmitigated if it does not.** That question is referred to the Finance and Sustainability Committee. However, in the meantime the Committee has requested a deep dive into this risk (see later in the report).
- **Visibility of cyber risk.** Cyber security scores 13 on the Board Assurance Framework and does not appear on the Group Risk Register at all. It is one of four principal risks not yet reflected in the register (see section 4.1) and is highlighted separately here because of the potential consequence of the risk and because assurance on it currently reaches the Board outside this Committee. The Committee notes that cyber assurance has reached the Board by other routes, with the Data Security and Protection Toolkit findings reported in July showing standards met at all three sites and improved on last year and the annual cyber report due at this meeting. The gap is therefore one of governance completeness rather than absence of assurance. **The Committee asks that cyber risk is visible on the register and flows through this Committee.**

3.2 Advise

- The register currently brings together local returns but does not yet present a fully consolidated Group view. The same exposure appears several times, for example financial sustainability, transformation capacity and estate condition. The Committee's concern is that expressing a shared problem three times invites three local solutions rather than one Group answer, which is the purpose of being a Group. The Committee agreed it needs both the site-level detail and an aggregated Group position in a consolidated view, with a clear distinction between risks generic to all three organisations and those specific to local circumstances. The Group Executive Committee will bring an escalation report to the Committee in September covering Group-wide risks to address this.
- **Scores are likely overstated and the register should be expected to reduce.** Likelihood has not been rescored since the risk descriptions were rewritten, so some scores still measure how often a situation occurs rather than how likely the resulting harm is. Work is underway to rescore through that lens. The Committee expects both the number of risks and the scores to reduce as a result, and will test the rescoring to satisfy itself that any reduction reflects the method working rather than a softening of judgement.
- The methodology is intentionally sensitive to control gaps, which shapes the profile presented to the Board. The Committee noted that no entry in the escalated cohort is currently rated fully or largely effective and that two entries at Royal United Hospitals, both scoring 14, record controls as absent. It also noted the counterpoint: the methodology is designed to surface weak controls, so control scores of 3, 4 or 5 are a feature of the arithmetic rather than a finding in themselves. The consequence is a potential blind spot in both directions. A serious risk that is well controlled may never escalate, while a lesser one that is poorly controlled will. Risks scoring 8 to 11 are seen by Care Organisation management committees and the Committee was advised that some of those are serious but well managed, elective caesarean capacity being the example given. **The Committee agreed that it will wish to take periodic sight of that band of risks.**
- **Workforce affordability against safe staffing.** Great Western reports 249 whole time equivalent vacancies described as unaffordable against savings targets, while Royal United Hospitals is over-recruited by approximately 92 whole time equivalents against a deliberately different three-year plan. The Committee regards this as a collision point between financial recovery and safe staffing and asks how the two are being reconciled across the Group. It also noted the read-across that tightening recruitment controls carries an inherent risk to elective recovery capacity.
- **Corporate Services Review financial delivery.** The risk to delivery of the Corporate Services Review is scored 14. While its financial value is small relative to the Group's overall financial exposure, the score reflects delivery uncertainty and the maturity of the supporting controls rather than its comparative scale.

The risk should therefore remain visible and be monitored through the relevant programme governance, without being presented as equivalent to the wider financial recovery risk.

- **Committee composition.** The Committee's Terms of Reference are before the Board for approval. The Chair's recommendation is that executive directors attend the Committee as attendees rather than as voting members, so that the Committee's assurance opinions are formed by non-executive members independently of the executives whose management of risk the Committee is reviewing. This would align the Committee with the Group's Audit Committee and with usual practice for a committee whose function is independent assurance. The Board is asked to determine the position when approving the Terms of Reference.

3.3 Assure

- The Group Risk Register has improved markedly since June and now provides a substantially stronger foundation for further development. 44 risks are now identified across all three Care Organisations (Great Western, RUH Bath, and Salisbury) and corporate services on a common template and scoring method and every entry carries actions, owners, dates and control evidence. These features were not present in the June iteration. The template has been refined to focus attention on controls and on gaps in controls.
- **Improvement is evident in the performance position.** The Committee took partial assurance from the Integrated Performance Report, noting improvement in handover, MRSA and diagnostics at Great Western.
- **Cyber assurance has been provided to the Board.** Data Security and Protection Toolkit findings reported to the Board in July showed standards met at all three sites and an improvement on the previous year.
- **A deep dive process has been established and the first commissioned.** The Committee agreed that the assurance questions must be defined before a deep dive is commissioned, so that each links back to a specific gap in assurance. It shortlisted estates and fire safety, urgent and emergency care, transformation capacity and financial sustainability. For the latter it was agreed that the Finance and Sustainability Committee would undertake the detailed work.

  Estates and fire safety was commissioned as the first deep dive.

4. Independent view of the BAF and Group Risk Register

4.1 Board Assurance Framework

The Committee took limited assurance from the framework at this stage of its development. This judgement relates to the extent to which the current framework enables the Committee to assess the management of the principal risks consistently; it is not, in itself, a judgement on the severity of those risks or the effectiveness of all the work under way to manage them. Assurance levels are unpopulated, risk appetite is unagreed (the Board development session on 1 October), and no principal risk carries third-line assurance.

The Committee identified a number of priorities for the next stage of development. Four principal risks, cyber security, becoming an effective Group, reducing waits and improving staff satisfaction, are not yet reflected in the Group Risk Register. The Committee also observed that the current BAF does not yet fully reflect the range of mitigating work already under way and that the timing of some recorded actions should be reviewed to ensure it is sufficiently responsive to the gaps identified. Reducing waits was discussed as an example. Addressing these points will provide a more complete and balanced account of both the Group’s exposure and its response, including for external readers.

The Committee noted that the current iteration provides a foundation from which the BAF can develop as the Group strategy is finalised. It has agreed that, once the strategic BAF has been approved, it will establish a standing cycle of reviewing one or two principal risks at each meeting. A baseline risk appetite proposal has been requested in September to support the Board development session on 1 October. These steps are intended progressively to strengthen the evidence beneath each risk, clarify the relationship between controls and assurance, and enable the Committee to provide a more mature and differentiated assurance judgement in subsequent cycles.

4.2 Group Risk Register

The register is a credible working document and is progressing towards a fully consolidated Group document. All three Care Organisations and corporate services are represented, but the structure remains local returns aggregated rather than a Group position. Completion is uneven: one Care Organisation submitted its full corporate register while the other two submitted only entries above the reporting threshold, so the current submission does not provide a consistent view of risks below the reporting threshold across all three Care Organisations.

On themes, estates and capital dominates at 14 entries and finance follows at 11. The Committee is not yet able to reach a reliable conclusion on direction of travel, because the likelihood rescoring is outstanding. It supported the development of a visualisation of exposure against control strength, adopted as a consistent house style, so that risks moving into the area of greatest concern can be surfaced and the Committee's attention focused there. Taking the register as a whole, the Committee took limited assurance from it at this stage of its development, on the same basis as its judgement on the Board Assurance Framework: the register is a credible and improving working document, but it is not yet capable of being relied upon as a consistent source of Group-level assurance. The Committee applies a four point scale of substantial, moderate, limited and no assurance, and reports separately on the effectiveness of controls, which is rated on the Group's five point control effectiveness scale.

5. Items for Board attention

Matter	Score	RAC view of controls	Assurance	Recommendation to Board
Financial position at Great Western within Group financial risk	14 on the register, R5 and R7 at 14 on the BAF	Effectiveness not yet sufficiently evidenced	Independent assurance not yet identified	Audit CIC to commission a review of recovery trajectory (Sep 26) to report to RAC Nov 26.
BAF R6 Reducing Waits and R8 Reducing Avoidable Harm	12 each	Not yet assessable pending confirmation of senior responsible owners	None	Immediate appointment of senior responsible owners based on the recommendation in the covering report for the BAF
Risk appetite and BAF assurance levels	n/a	n/a	Limited	Agree risk appetite at the development session on 1 October and set a date from which the Committee takes assurance from the BAF
Estates, fire safety and capital sufficiency	14 entries, highest 13	Evidence reviewed supports no more than partial effectiveness at this stage	Limited	Refer capital sufficiency to the Finance and Sustainability Committee alongside the commissioned deep dive
BAF R10 Cyber Security	13 on BAF, absent from register	Not yet assessed through this route	Partial, via DSPT	Require cyber risk to be visible on the register and to flow through the Committee

Matter	Score	RAC view of controls	Assurance	Recommendation to Board
Workforce affordability against safe staffing	Not separately scored; read across R5, R7 and R8	Not yet assessed as a Group position	None at Group level	Require a reconciliation of financial recovery assumptions with safe staffing requirements across the Group, for report to the Committee in September and to the Board thereafter
Committee Terms of Reference	n/a	n/a	n/a	Approve and consider whether executive members should be attendees rather than voting members

6. Forward look

- **Estates and fire safety deep dive.** Scope and assurance questions agreed and circulated, with the deep dive reporting to the Committee and its findings to the Board.
- **The September register.** Rescored, carrying Group level risks agreed by the Group Executive Committee, with the register anomalies closed and the Group Executive escalation report alongside it.
- **Risk appetite and BAF maturity.** A baseline appetite proposal in September ahead of the Board development session on 1 October and the start of the standing cycle of principal risk reviews.
- **Independent assurance on financial recovery.** To be pursued with internal and external audit, noting that the internal audit plan does not currently include a specific review of the recovery trajectory.

Appendix 1 – Internal Audit plan 2026/27

	Review	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Included in....		
In common reviews																
02/26	Clinical Governance													✓	✓	✓
03/26	Finance: Budget Management													✓	✓	✓
04/26	Absence Management													✓	✓	✓
05/26	Business Continuity													✓	✓	✓
06/26	DSP Toolkit													✓	✓	✓
Joint reviews																
07/26	Fit and Proper Person Test													✓	✓	✓
08/26	Risk Management													✓	✓	✓
09/26	Corporate Services													✓	✓	✓

GROUP BOARD RISK AND ASSURANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution

The Group Risk and Assurance Committee (the Committee) is established as a standing committee of the BSW Group Board. Its Terms of Reference are set out below and are subject to amendment at future Group Board meetings.

The Committee will operate within the Group's governance framework and report to the Group Board.

2. Purpose

The Committee is responsible for overseeing the identification, assessment, monitoring and mitigation of strategic and major operational risks across all areas of the Group, ensuring alignment with the NHS Code of Governance and the Trusts' constitutions. The Committee monitors the Group Risk Register and Board Assurance Framework content, ensuring effective risk management and appropriate assurance against the Group's principal risks.

The Committee reviews the effectiveness of first line (operational management and service delivery) and second line (oversight functions such as risk management, compliance, health & safety, information governance) assurance through management reports, performance data, and oversight function reporting.

The Committee works in partnership with the Trust Audit Committees (which meet in common), which have complementary responsibility for reviewing the design and effectiveness of governance and assurance frameworks and receiving third line assurances (internal audit, external audit, and counter-fraud). Together, both committees provide comprehensive oversight on behalf of the Group Board and Trust Boards

3. Authority

The Committee is authorised by the Group Board to:

- instruct professional advisors and request the attendance of individuals and authorities from outside the Group with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
- to obtain such internal information as is necessary and beneficial to the fulfilment of its functions.
- investigate any activity within its terms of reference.
- seek any information it requires from any employee across the Group.
- commission reviews, deep dives or expert advice where necessary to fulfil its functions.
- require attendance at meetings from any Group or Care Organisation staff member.

- establish time-limited task and finish groups to address specific issues.

4. Duties

The Committee will oversee and seek assurance on all matters and will make recommendations to the Board where appropriate and in line each Trusts' Scheme of Delegation. Specifically, this will include the following:

a) To review escalated performance exceptions and risks across the four domains (quality, finance, people, performance) as identified and escalated by the Group Executive Committee. The Committee will scrutinise the adequacy of executive response and mitigation plans for performance issues outside agreed tolerances, significant control failures, or emerging strategic risks.

b) To review the operational effectiveness of internal controls and risk mitigation strategies through management reporting and second-line oversight functions, including those related to clinical, operational, financial, and reputational risks. The Committee monitors whether controls are working as intended in practice based on performance data, incident reports, and oversight function assessments

c) To agree and monitor action plans where remedial steps are indicated to improve performance.

d) To receive and evaluate first line assurances (from operational management, service delivery teams, and executive directors) and second line assurances (from oversight functions including risk management, compliance, health and safety, information governance, and quality assurance), monitoring their effectiveness in managing risks and achieving objectives

e) To have overarching responsibility for risk and review and challenge the Group's Board Assurance Framework content (principal risks, risk ratings, controls, assurances, gaps, and risk mitigation actions), as developed by the Group Executive Committee and risk management arrangements, ensuring alignment with the NHS Risk Management Standard and NHS England's guidance on Board Assurance Frameworks. The Trust Audit Committees review the Board Assurance Framework methodology and overall framework effectiveness through independent third-line assurance

f) To promote the 'risk management' culture and the 'risk appetite' of the Group.

g) To ensure significant risks to the Group's principal objectives are identified and managed effectively and efficiently.

h) To review the adequacy of risk-related disclosures contained within the Annual Reports for statutory organisations within the Group.

i) To provide assurance to the Trust Audit Committees (meeting in common) on the risk management and performance delivery content that underpins the Annual Governance Statement for each Trust, based on the Committee's review of first and second-line assurance effectiveness. The Trust Audit Committees have responsibility for reviewing and recommending the Annual Governance Statement to their respective Trust Boards.

j) To ensure adequate first and second line assurance mechanisms exist and are appropriately monitored to enable self-certifications and declarations of compliance

with national standards and guidance to be confidently given, noting that the Trust Audit Committees review third line assurance (independent audit) and the overall assurance architecture.

k) To provide assurance to the Board that ensures ongoing compliance with each Trust's authorisation and statutory duties, within the Group.

l) To review any new NHS guidance or mandated requirements and ensure that appropriate action is put in place to ensure effective delivery.

m) To provide assurance that the necessary mechanisms exist and are in place to enable the review and where required, remedial action in relation to regulatory issues or compliance reports.

n) To establish and maintain an effective relationship with the Trust Audit Committees (which meet in common), with clear distinction of responsibilities and coordinated working.

5. Principles of operation

The Committee will operate according to the following principles:

1. Risk-Based: Prioritises attention based on level of risk and assurance required.
2. Forward-Looking: Focuses on emerging risks and future performance, not just historical review.
3. Evidence-Based: Decisions informed by data, intelligence and robust analysis.
4. Constructive Challenge: Supportive but critical scrutiny of performance and assurance.
5. Proportionate: Level of scrutiny matches level of risk and concern.

6. Membership

Members:

Six Non-Executive Directors
Group Chief Executive
Group Chief Finance Officer
Managing Director, Great Western Hospital Care Organisation
Managing Director, Royal United Hospital, Bath Care Organisation
Managing Director, Salisbury Hospital Care Organisation

In attendance:

Group Chief Risk Officer
Group Chief People Officer
Group Chief Digital and Information Officer

It is anticipated that others executive directors will attend as required to support the agenda.
The Group Company Secretary is required to attend meetings of the Committee in a non-voting capacity.
Representatives from Care Organisations and corporate services presenting specific items.

Quorum: At least six members including the Chair (or Vice Chair), with at least half being Non-Executive Directors, and at least one Care Organisation Managing Director.

Requirements of membership

Members of the Committee must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance at the Committee will be recorded and monitored

Equality Diversity & Inclusion

In conducting its business, members must demonstrably consider the equality and diversity implications of decisions they make and consider whether in the management of risk control, the Group achieves positive change around inclusion, equality and diversity.

Conflicts of Interest

If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the Group Conflicts of Interests Policy. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.

The Committee should provide assurance through an annual declaration of interests review and ensure a standing agenda item to review any new or updated declarations.

7. Meetings

Frequency:

- Monthly meetings scheduled in advance for the financial year
- Meetings are scheduled in sequence to enable timely escalation: Group Executive Committee → Group Board Risk and Assurance Committee → Group Board
- Additional extraordinary meetings convened as required
- Scheduled to enable timely escalation to the Group Board

Meeting Management:

The Group Company Secretary will plan to ensure that the Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

Agendas and papers will be circulated 5 working days in advance of the meeting.
Minutes will be circulated to Committee members as soon as is reasonably practicable. An Action Log will be maintained and monitored.

8. Reporting arrangements

The minutes of all meetings of the Committee shall be formally recorded and submitted to the following meeting for approval.

The Committee is accountable to the Group Board. The Committee will report to the Board following each meeting via an assurance report which will provide key assurances and any identified exceptions/risks in relation to the delivery of the priorities set out in the Group's Strategy and annual business planning objectives. In reporting to the Board, details should include any associated action plans to mitigate the level of risk to the Group.

The Committee will receive escalation reports from the Group Executive Committee for all new or escalated risks (as defined by risk thresholds in the Group Risk Management Strategy) that require Board-level attention. The Group Executive Committee provides executive-level oversight of Group-wide risks, coordinates risk management across the Group, and escalates matters requiring Board RAC scrutiny based on defined criteria.

Care Organisation performance and risk management is overseen by the Group Executive Committee. Care Organisation Managing Directors report directly to the Group Board at each meeting, including summaries of the work undertaken by their Care Organisation Management Committees and assurance committees.

The Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its effectiveness and performance according to a standardised framework and process.

Terms of Reference:

Will be reviewed annually and updated as required to reflect changes in governance arrangements. The Terms of Reference will be approved by Group Board along with any future material changes.

Approved by: Joint Committee
Date of Approval: 9th June 2026

Review Date: [Date - annually]
Version: Final 1.0

BSW Hospitals Group Board

Agenda item	Item 7.1
Report title	Corporate Services Transformation Programme Update
Date of meeting	3rd September 2026
Sponsor	Jude Gray – Chief People Officer
Prepared by	Claire Warner – Site HR Director John Ridler - Associate Director of Finance – FP&A
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
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGE

1. Corporate Service Transformation (Financial Delivery)

This month's Board assurance focuses on the financial position of the Corporate Services Transformation Programme against the agreed 11% efficiency target. The report provides an assessment of financial delivery to date, including RAG ratings for each corporate function based on savings achieved, confidence in delivery of Year 1 targets, and the plans in place to deliver the full savings requirement across Years 1 and 2. Overall, £3.41m of savings has been achieved to date against a Year 1 target of £8.12m, (overall £15m over 2 years), with several functions reporting confidence in delivery through organisational redesign, vacancy management, non-pay efficiencies and future operating model changes. (Appendix A)

The Board is asked to note that while good progress has been made in several areas, delivery remains dependent on the pace of implementation of redesigned structures, completion of consultation activity, and the finalisation of governance and service level arrangements in several functions. Concerns remain regarding the pace and deliverability of the Estates programme, where operating model, governance and SLA development remain in the design phase.

2. Temporary Staffing Operating Model

The paper including information on the new Operating Model for temporary staffing which successfully went live on the 1st August 2026 with no negative impact on clinical service. It should also be noted that the ownership of Pulse Healthcare Ltd (trading as Bank Partners) is expected to change later in August 2026. Procurement colleagues have reviewed the proposed ownership change and associated advice, and no concerns or further actions have been identified at this time. Governance arrangements will be in place to monitor contract performance and delivery through the established performance management framework.

3. Corporate Service Employer Model

The paper also summarises on the work is underway to develop the Corporate Services Employer Model business case, with Nick Johnson (SRO). As part of this work, the Group Chief Executive has requested that a single budget management approach for Corporate Services be implemented across the Group by 31 March 2027 (led by Simon Wade). This is intended to support clearer accountability, improved financial management and the continued development of a more integrated Group operating model

4. Digital Enablement

The paper also includes an update on Digital Enablement, recognising that digital convergence is a critical enabler of the wider transformation programme. Significant work is already underway to align contracts, strengthen Group-wide digital infrastructure and support future shared service arrangements. Current priorities include implementation of a single Digital Front Door through Halo, alignment of cyber security and endpoint management through Tanium, development of common identity and access arrangements, and support for consolidated Finance reporting requirements. The Board is asked to recognise that major application convergence activity will largely follow Single EPR implementation in 2027, with current efforts focused on enabling foundations and maximising opportunities for future efficiencies and service improvement.

RECOMMENDATION

The Group Board is asked to:

[State clearly what is being asked, using Receive / Note / Approve / Endorse.]

1. Note the current financial position of the Corporate Services
2. Review areas of delivery risk, in Corporate Service RAG rated Red and Amber
3. Note the Digital Enablement update
4. Note the change in ownership of Bank Partners.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
Appendix A	Corporate Services Transformation Programme Update Presentation
Appendix B	Digital Enablement of Corporate Services Update
Appendix C	Acacium Group Change of Ownership Notice (Bank Partners)

BSW HOSPITALS GROUP

NHS

Corporate Services Transformation Programme Update



NHS
Great Western Hospitals
NHS Foundation Trust

NHS
Royal United Hospitals Bath
NHS Foundation Trust

NHS
Salisbury
NHS Foundation Trust

Month 3 Finances

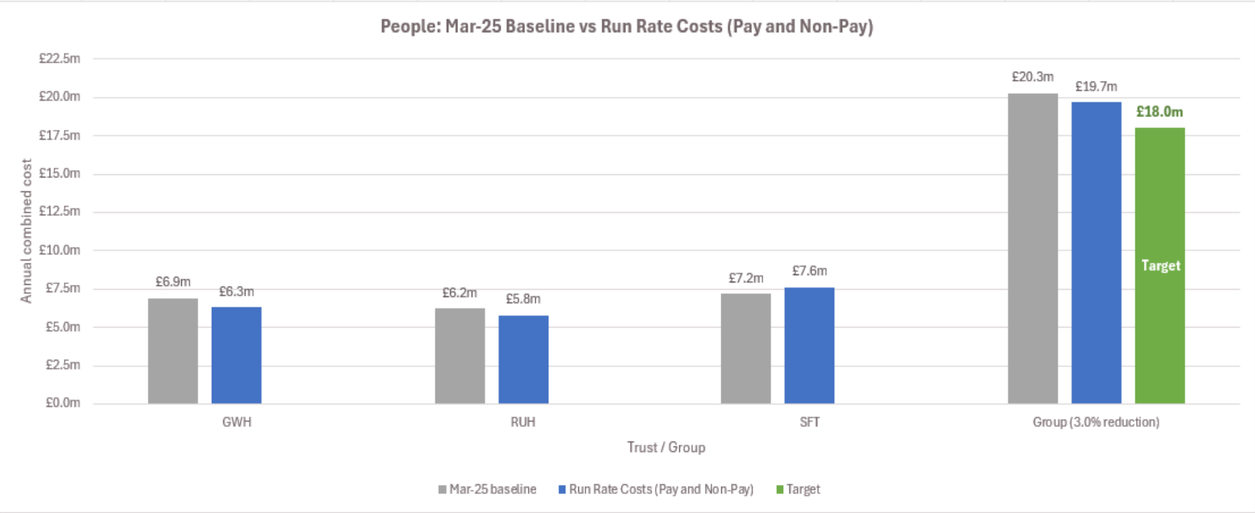
Function	Baseline cost - Mar-25 benchmarking £m	TO-BE cost £m after 11%	11% Target £m	Agreed Target £m	Year 1 Target	Achieved to date - June 2026	Year 1 variance +adverse	Tracker vs 11% to date	Year 2 Target
People	£20.27	£18.11	£2.16	£2.16	£1.08	£0.60	£0.48	3%	£1.08
Finance	£9.52	£8.43	£1.09	£0.90	£0.90	£0.07	£0.83	1%	£0.00
Procurement	£5.42	£4.86	£0.56	£0.56	£0.28	£0.17	£0.12	3%	£0.28
Corp Gov	£1.68	£1.50	£0.18	£0.18	£0.18	£0.23	-£0.05	14%	£0.00
Digital	£35.34	£31.24	£4.10	£4.10	£1.50	-£0.28	£1.78	-1%	£2.60
Communications	£1.37	£1.23	£0.14	£0.14	£0.14	£0.07	£0.07	5%	£0.00
TIPS	£5.91	£5.32	£0.59	£0.59	£0.59	£0.50	£0.09	10%	£0.00
Estates	£50.94	£45.34	£5.60	£5.93	£2.97	£2.04	£0.93	4%	£2.97
Group leadership	£4.38	£3.90	£0.48	£0.48	£0.48	£0.01	£0.47	0%	£0.00
Total	134.83	£119.93	£14.90	£15.04	£8.12	£3.41	£4.70	3%	£6.93

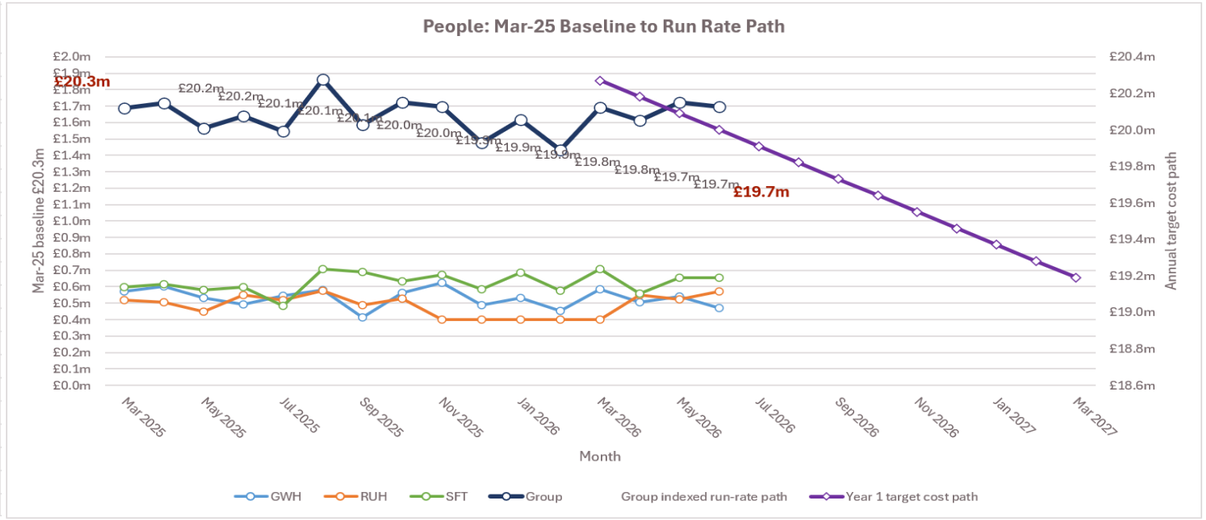
Baselines have been set on actual benchmarking cost levels – not budget
*Achieved to date is predicated on the recurrent vacancies still being met as part of the 11% where they apply
(if they are subsequently invested in new designs then the level of saving won't actually be achieved)

Finance Update – People

Financial Delivery RAG Rating

SRO – Jude Gray (Chief People Officer)



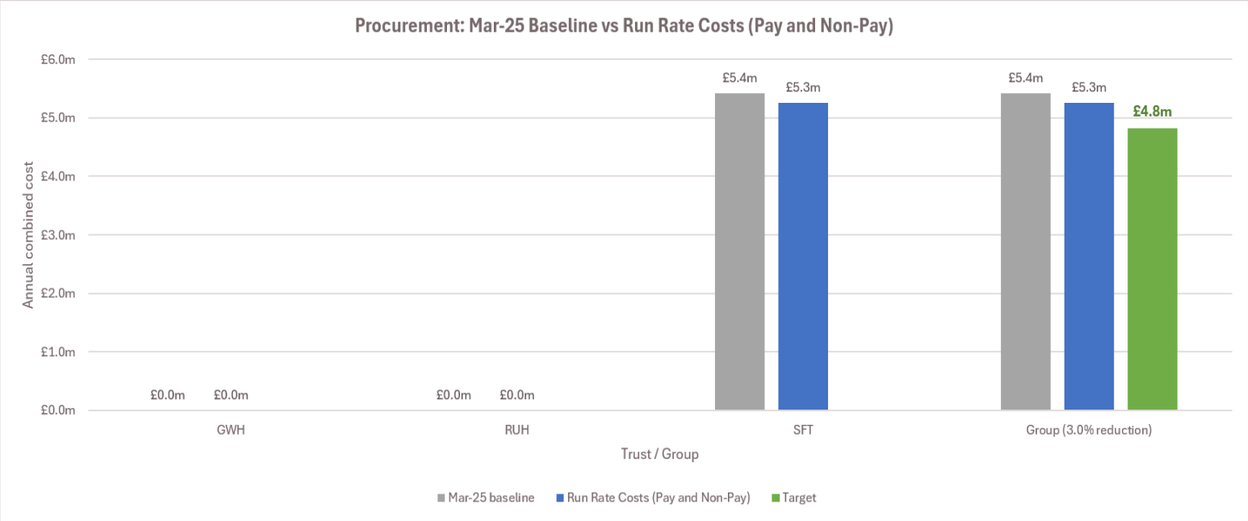


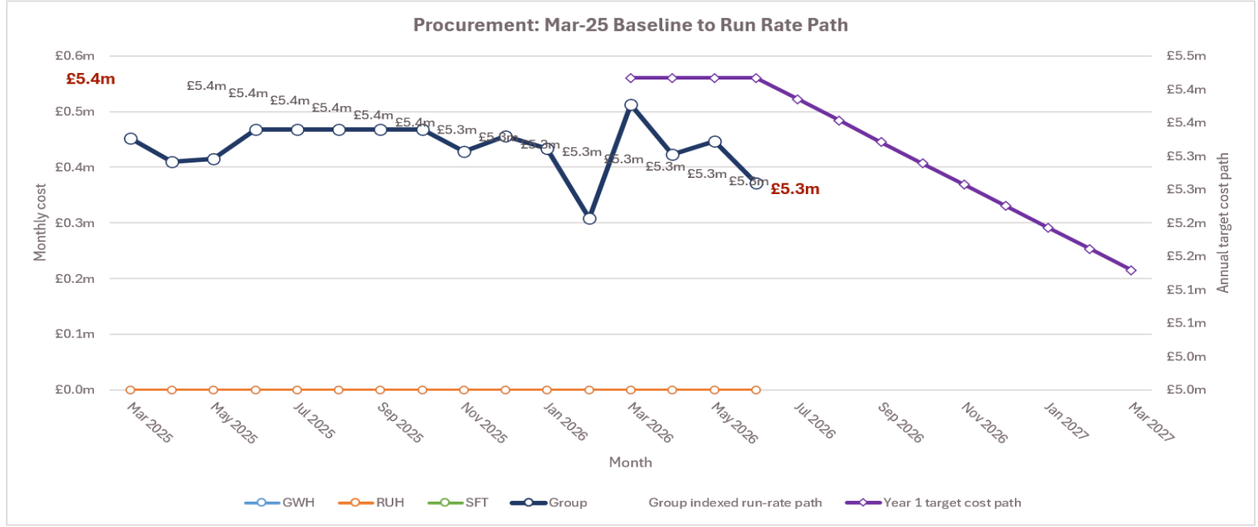
- Year 1 savings to be delivered by holding current vacancies.
- Year 2 savings to be delivered through restructure.
- Level 4 consultation to be completed by end-August.
- Potential Level 4 redundancy remains subject to confirmation.
- Remaining consultation activity to be completed by end-March 27 (B7 and below).
- Overall confidence remains high that the **£2.16m** savings target will be delivered by March 2028.
- Commercial opportunities explored in 2027/28 for delivery in 2028/29 (Occ Health, Education & Training)

Finance Update – Procurement

Financial Delivery RAG Rating

SRO – Rob Webb – (Director of Procurement)





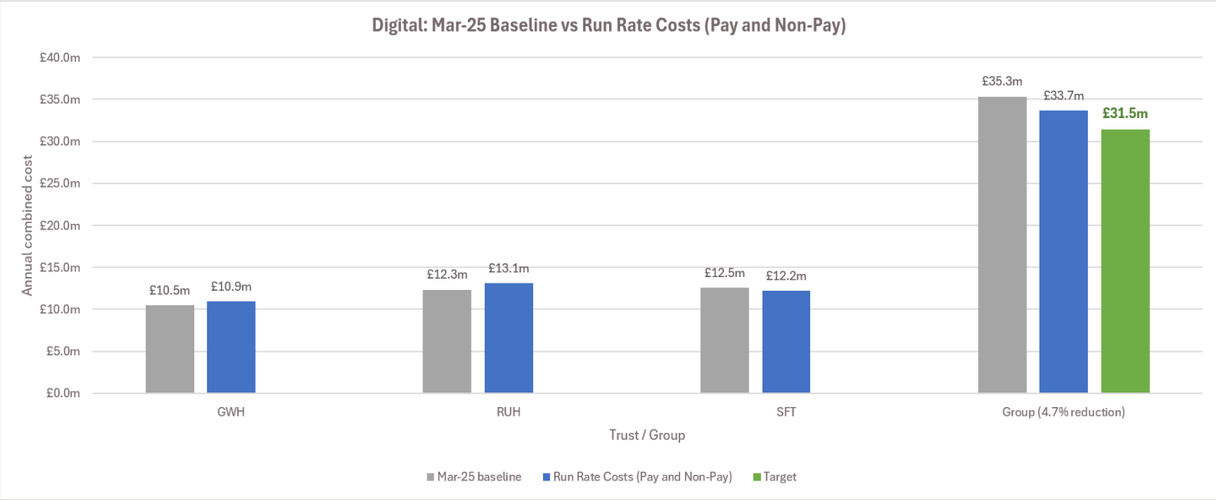
- £170k of savings has been delivered to date, achieving 60% of the Year 1 target and representing 3% of the overall 5.5% savings requirement for 2026/27.
- Procurement remains on track to achieve the full 2026/27 savings target of £280k, supported by a defined delivery plan for the remaining opportunities.
- Key risks and dependencies have been identified and are being actively managed through established mitigation plans.
- The potential TUPE risk associated with the expiry of the Lifecycle contract has been successfully mitigated, with the related CIP benefit scheduled for recognition in Month 6.
- Recruitment and agency reduction initiatives are supporting sustainable cost reduction; however, delivery remains dependent on successfully recruiting to substantive vacant posts.

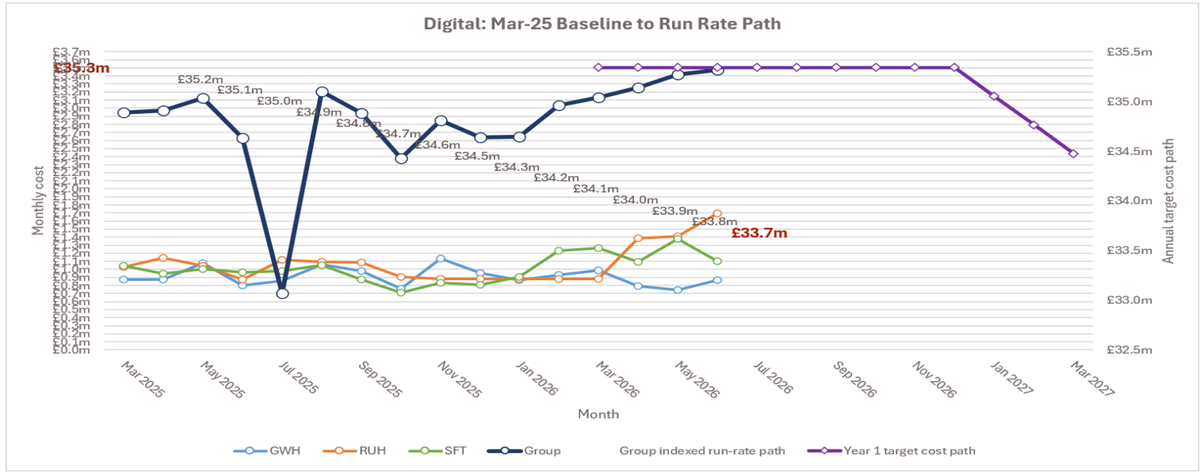
Procurement remains on track to deliver the agreed savings trajectory through to 2028

Finance Update – Digital

Financial Delivery RAG Rating

SRO – Jonathan Hinchliffe – (Group Chief Digital and Information Officer)



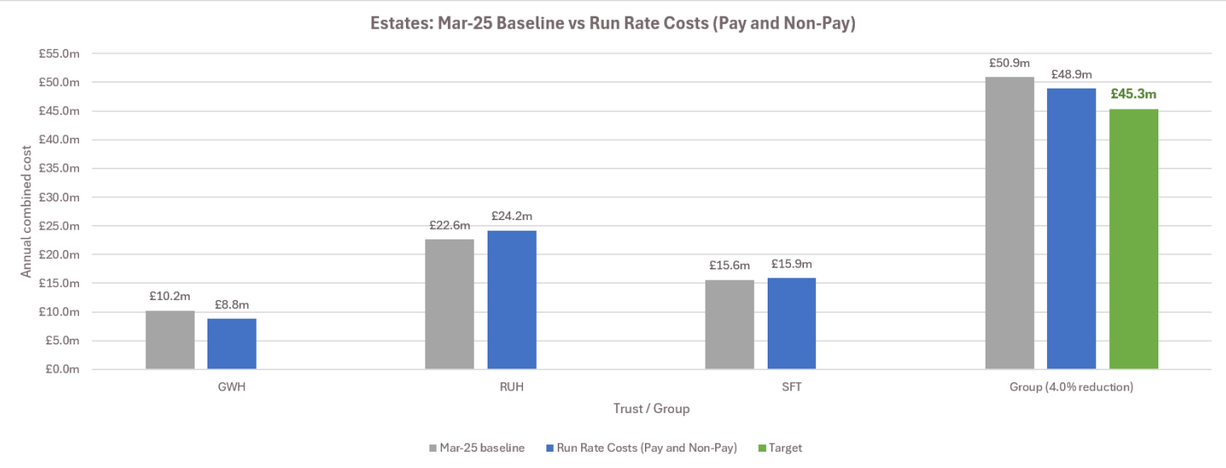


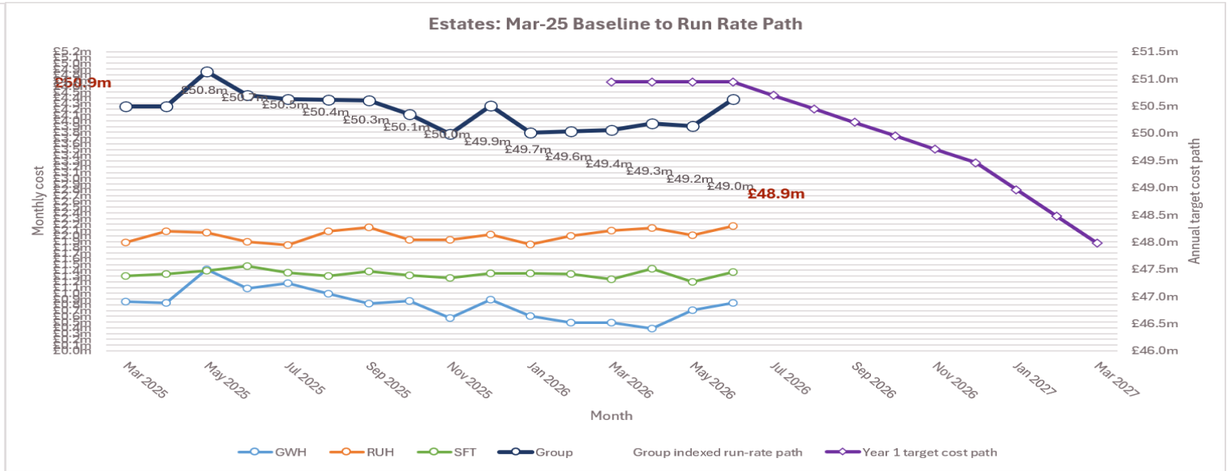
- FY25/26 and FY26/27 savings delivered through vacancies and identified non pay savings
- FY27/28 delivered through contract consolidation and digital convergence
- Phase One consultation concluded July 2026
- Phase Two consultation planned for Autumn 2026
- Full restructure should be operational by March 2027
- Need to identify potential impact of MARS launched July 2026
- There is continued increasing DDAT demand and dependency on digital enablement to achieve CST targets for all corporate services
- Overall confidence remains high that the £4.1m savings target will be delivered by March 2028

Finance Update – Capital, Estates and Facilities

RAG Rating

SRO – Simon Wade – (Chief Finance Officer)



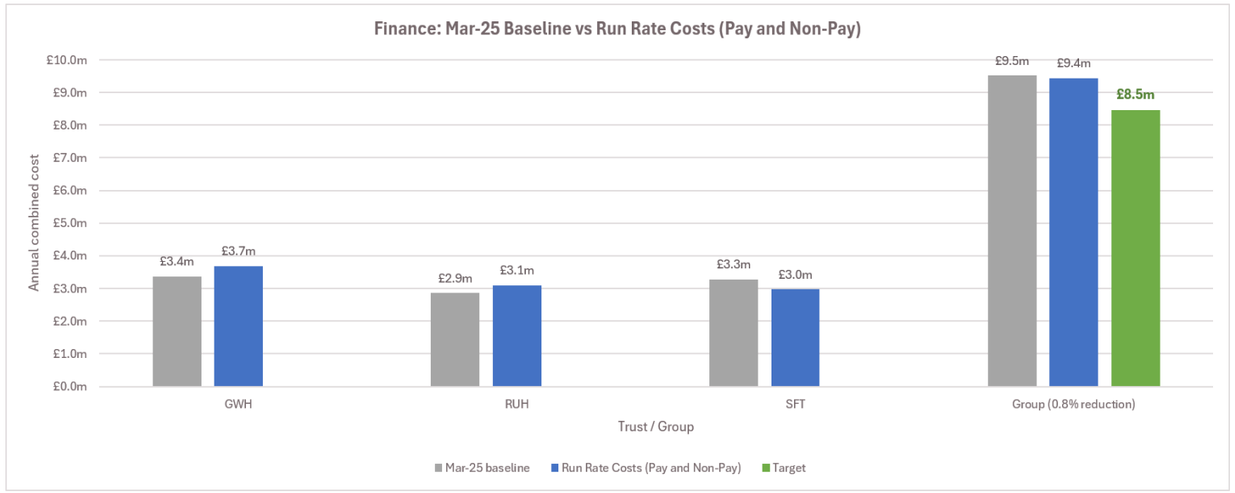


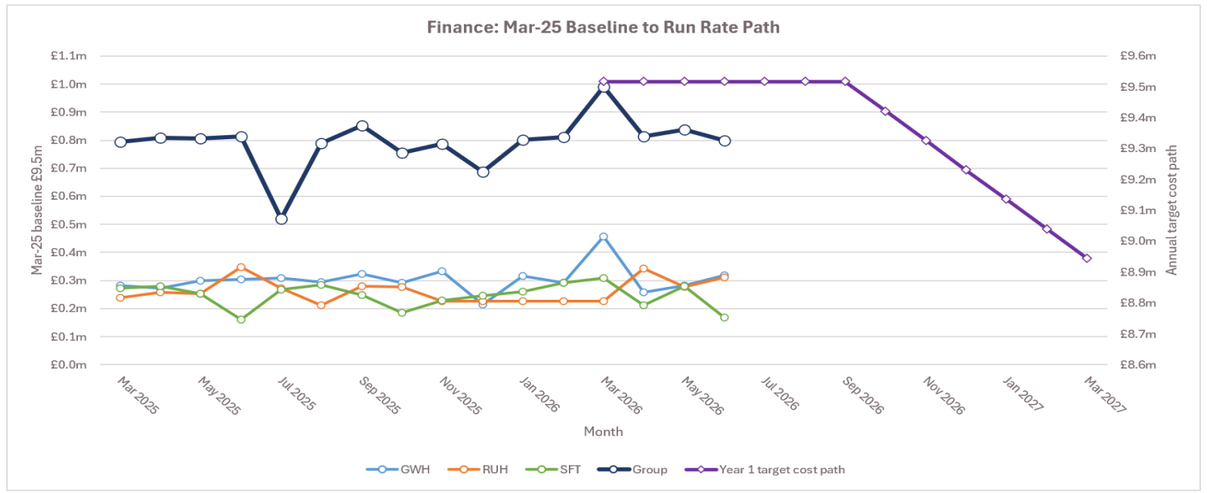
- FY25/26 and FY26/27 savings have been delivered through vacancy management and identified non-pay efficiencies.
- The Estates operating model, governance arrangements and SLA remain in the design phase.
- There are two CIP programmes contributing to Estates savings targets. For the purposes of Corporate Transformation reporting, only Corporate Transformation CIPs are included in this tracker.
- The Programme Team remains concerned about the pace of progress and the deliverability of the Estates programme, given the dependencies on the future operating model, governance arrangements and implementation timescales.

Finance Update – Finance

Financial Delivery RAG Rating

SRO – Simon Wade – (Chief Finance Officer)



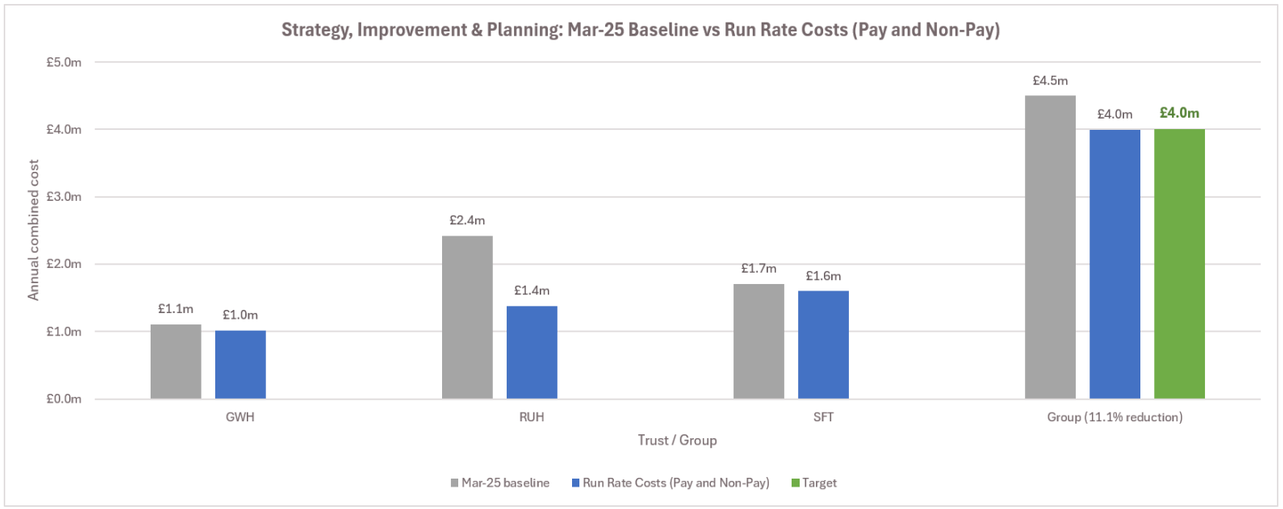


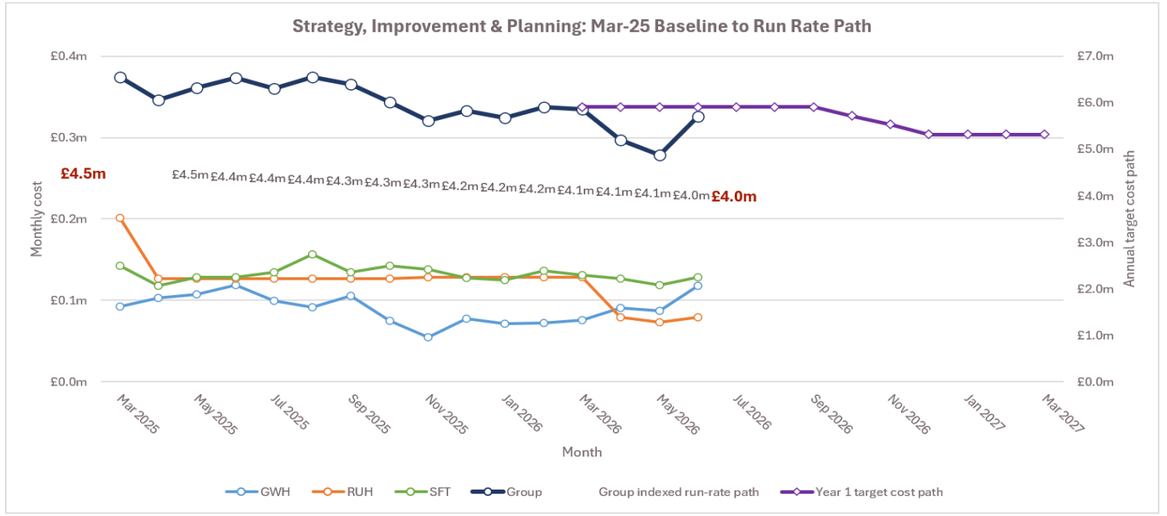
- Some Year 1 savings target to be delivered by holding current vacancies into the remaining levels of redesign phases
- Further savings to be delivered through restructure of all levels below level 3
- Remaining consultation activity to be completed by end November
- Current gap of c.£0.2m to be found by further non-pay or identifying further opportunity from single ledger solution
- Commercial opportunities to be explored for delivery in Year 3 – could include the managed outsourcing of some finance areas of work i.e. costing solutions
- Continue to explore further shared service solutions as part of corporate group and recovery

Finance Update – Transformation, Strategy, Improvement and Planning

Financial Delivery RAG Rating

SRO – Judy Dyos – (Chief Strategy Officer)



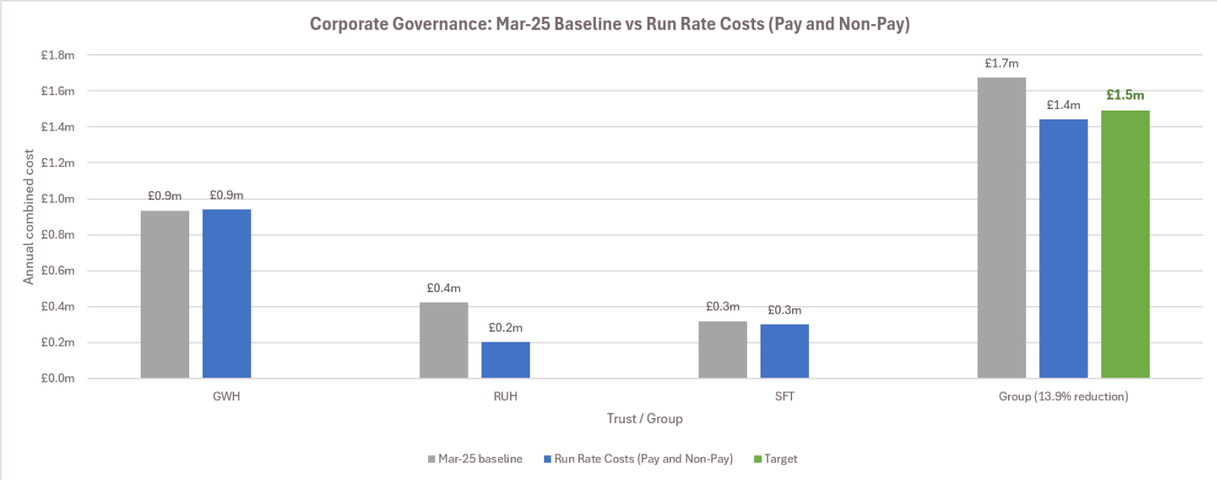


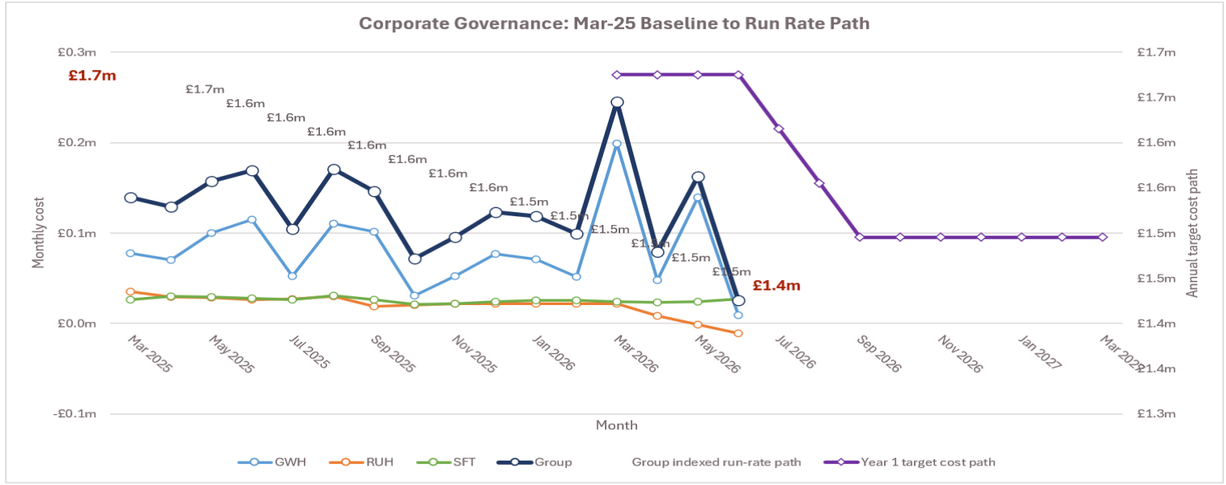
- On track for delivery. Benefits realisation should be reviewed once the final structure has been implemented and embedded.
- There is a risk that additional resource may be required to support local transformation programmes and financial recovery initiatives in 2026/27, increasing the ongoing cost base.
- There is a risk that additional planning capacity will be required, which is not currently reflected within the established run rate budget.

Finance Update – Corporate Governance

Financial Delivery RAG Rating

SRO – Mark Ellis – (Chief Risk Officer)



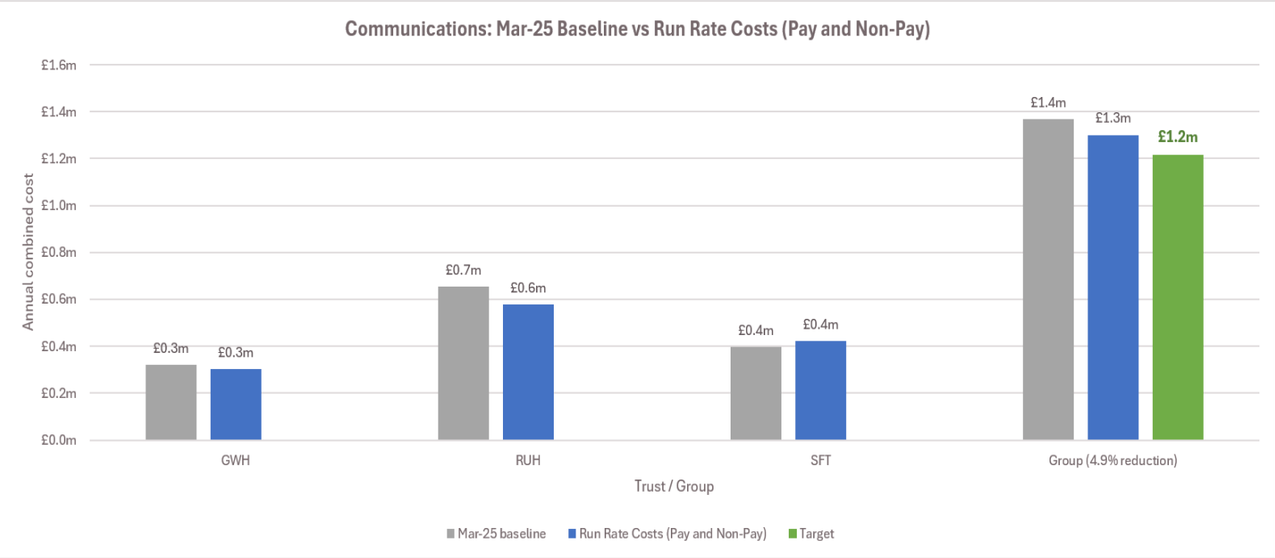


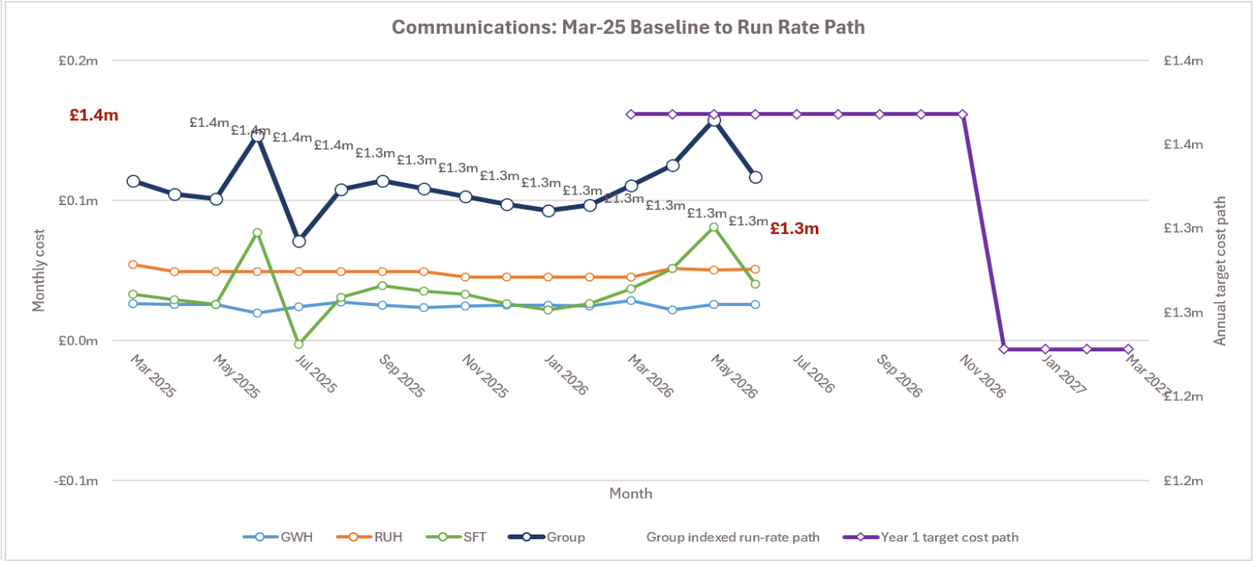
- On track for delivery, with benefits realisation and effectiveness to be reviewed once the final structure has been implemented and embedded.

Finance Update – Communications

Financial Delivery RAG Rating

SRO – Emma Mooney – (Director of Communications)





- Year 1 savings to be delivered by holding current vacancies, and non-pay.
- Year 2 savings to be delivered through restructure.
- Plan to commence consultation for Levels 2-4 by end-Sept 26.
- Plan for remaining consultation activity to be completed by end-March 27 (B7 and below).
- Currently, overall confidence remains high that the £0.14m savings target will be delivered by March 2027.

Consultation Update – Corporate Functions

People	• L4 Consultation closed, working through people impact at Band 8a's / 8b's • Planning for L5 consultation, with a targeted go live date of September
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 in September
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
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 for EA population – working through People impacts via selection process • Director role interviews taking place in August – outcome to be confirmed
Communications	• Change papers awaiting submission to all three care committees before planning consultation launch

Governance Structures and SLA's

Function	Governance Structure	SLA's	Notes
People			SLA in draft and feedback from DA
Procurement			
Digital			
Capital, Estates/ Facilities			Governance in draft – Feedback from DA to review number of meeting and engagement with MDs.
Finance			SLA in draft being finalize before
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

Corporate Services Employer Model – Timeline

Draft Problem Statement

“Corporate services are increasingly shared across BSW, but staff are employed through separate organisational arrangements. This creates duplication, inconsistent ways of working and unclear accountability. This is impacting our ability to operate effectively as one Group.”

ACTION CS group– Simon Wade (CFO) has been asked to implement budget control in one organization by the end of March 2027

Problem Statement Feedback

- Current problem statement felt too organisation-focused and did not sufficiently reflect the staff experience.
- Accountability is often difficult to exercise because managers lack access to systems, information and controls.
- Need stronger emphasis on access barriers, operational complexity, duplication and staff experience.
- Further work required to quantify impact, affected groups and measures of success.

Vision Statement

BSW Hospitals Group will operate a corporate services employer model that combines the efficiency and consistency of a shared service with the responsiveness and relationships needed locally. Through aligned processes, empowered leaders and a strong One Group culture, we will create an outstanding colleague experience, enabling our people to thrive and providing the foundation for the delivery of exceptional patient care

Corporate Services Employer Model – Timeline

JUNE

Task and Finish Group established – first meeting 26 June 2026

AUGUST

Corporate Services Employer Model Workshop 4 August 2026

AUGUST

Template Business Case drafted August 2026

SEPTEMBER

Task and Finish Group – 4 September 2026, draft business case to be divided between group for their relevant areas

SEPTEMBER

Business Case to be ready for sign off End of September 2026

Temporary Staffing Update – Bank Partners

Headline performance

- 7,003 of 8,899 active workers registered, representing 78.69% of the active worker pool.
- Between 1st August 2026 to 14th August 2026, 10,116 shifts requested across bank and agency routes, compared with an August comparator of 10,419, indicating broadly stable demand.
- 64% of shifts filled, compared with 72% previously, an 8-percentage reduction.

Agency fill has not increased:

- 184 agency shifts were filled during the 14-day period, compared with an averaged 313 shifts last year, a reduction of 41%.

Early performance indicates strong worker registration and no increase in agency reliance. The immediate priority is to improve the overall fill rate (85 percent target) through close contract performance management, targeted action on unfilled shifts and continued worker mobilisation.

Temporary Staffing – Continued

Governance

- Weekly implementation meeting continue for August and September between Resourcing and Bank Partner.
- Bank Partner the daily staffing calls at each Care Organisation.
- Monthly contract performance meetings scheduled for the 16th September. Chief Nursing office will support delivery and review performance against the agreed measures.
- Financial monitoring will be in place, to track against the proposed financial opportunity. This will be reported retrospectively, as part of the performance meetings from September onwards.

Ownership

- The parent company of Pulse Healthcare Ltd (trading as Bank Partners), is expected to change ownership. The Procurement team reviewed the letter and procurement advice **(Appendix C)** No raised no concerns about the proposed change, which is expected to take effect later in August.

BSW Hospitals Group Board

Agenda item	7.2 Strategic Delivery
Report title	EPR Programme Update
Date of meeting	3rd September 2026
Sponsor	Jonathan Hinchliffe, Group Chief Digital & Information Officer, SRO EPR
Prepared by	Claire Strathern, EPR Programme Director
Approval Process: (where has this paper been reviewed and approved)	• EPR Assurance Committee (31st July 2026) • Group Executive Committee (11th August 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 EPR Programme status remained AMBER for the July 2026 reporting month, with continued effort to

maintain delivery momentum (please see Appendix A – EPR Programme Update).

Whilst the programme has successfully moved into the fix window of system testing and data migration activity is progressing, continued delivery confidence is highly dependent on resolving critical risks around integration, pathology and data migration requirements for the next scheduled test cycle.

The key messages are:

1. **System Testing** – this has largely progressed as planned, with a completion rate of 99% and pass rate of 85% (as of 20 august) which is high for a first test cycle. Programme leadership has escalated a risk relating to circa 80 scripts not yet run due to outstanding build requests with senior Oracle Health stakeholders to secure executive-level engagement to drive resolution with appropriate urgency. This directly impacts the ability to meet the system test exit criteria.

   The programme completed the test fix window with a work off lan we are taking into Integration Test 1. There are no open critical Test Issues currently, demonstrating the effectiveness of the system test cycle. IT1 entry has been delayed , there is an agreed plan with mitigations with Oracle Health The expected start of IT1 is early October 2026.

2. **Trial Load 1 Testing** – is progressing with data loads now complete across all three care orgs. Issues were identified through the loads, and the team continue to mitigate time lost, however there remains a pressure on remaining testing time for the first trial load. The PAS Build team continues to work through readiness for Trial Load 2 and PAS automation readiness activities. There remains known Trial Load 1 exit criteria constraints for GWH and Trial Load 2 entry criteria constraints for RUH.

3. **External dependencies and concurrent programmes** - the programme has entered a critical delivery phase, with key activity across testing, training, organisational readiness and sustainment planning progressing towards the first scheduled Go-Live. This is taking place in the context of increasing demand for change at both care organisation and enterprise level.
   While the wider ambition for change is positive, the cumulative impact of concurrent initiatives and continued additional change requests is placing further pressure on already constrained workforce, operational and infrastructure capacity at a critical point in the EPR delivery timeline. This reinforces the need for enterprise-wide prioritisation with executive control to manage conflicts, align existing dependencies, and protect fixed, time-bound milestones to sustain delivery confidence.

4. **Organisational Readiness** – green shoots of organisational momentum across the BSW Group are in evidence as preparations for the single EPR mature. Care organisations are progressing activity-reduction planning, securing training facilities, improving data quality, and strengthening clinical safety governance. Operational taskforces are delivering tangible outputs, system list sign-off is advancing, and reporting rationalisation has streamlined more than 2,000 reports. Device validation is on track for October, supported by a new readiness reporting methodology to improve real-time visibility. While risks remain—particularly CSO capacity, pathology dependencies, training backfill, and legacy system change-freeze—the programme is demonstrating clear alignment, growing readiness, and sustained progress toward safe deployment. The release of workforce as SMEs in particular remains a key delivery dependency with continued executive support required to prioritise EPR activity in parallel to operational pressure. There has been significant stakeholder engagement. We have demonstrated the system to 401 staff across 59 locations. Moving forward, we will have weekly EPR Guru Clinics on every site to ensure we are accessible to staff with queries; can myth bust and engage with people.

5. **Activity approach** – An Activity Approach Workshop was held on 3 July to agree on the key design decisions required to maintain delivery momentum, including the proposed activity approach for the EPR go-live period. Care organisations are now developing this approach within their own teams and divisions, ensuring it is shaped by local operational realities and embedded into organisational planning. This work will culminate in a single, Group-aligned activity-reduction approach to be taken to ORA for sign-off in

October, with the intention that the agreed model is fully aligned to and incorporated within the BSW Group business-planning rounds for 2027/28.

6. **Workforce & capacity issues** – programme resourcing remains sufficient for the next phase of delivery, with efforts to close remaining gaps in SME resources continuing. The previously reported challenges in the PAS Inpatients (IP) workstream have been mitigated through the redistribution of deliverables across other workstreams and additional resources secured.
   Tiger Teams resource is now onboarded to support Pathology capacity challenges.
   Clinical engagement continues to remain constrained by capacity and availability due to competing priorities, but there has been progress to recruit to specific clinical resource gaps which should provide protected capacity for the programme.
7. **Training** – The Learning Management System contract with Clariti is now fully signed, and Clariti is actively engaging with the training teams as the BSW Hospitals Group instance is set up, and development begins. Lead trainers are in post with defined portfolios, and a digital skills assessment survey launched across the Group to understand baseline capability and shape training plans will continue. Clariti will present their implementation approach and early progress at ORA in September. Training room planning across all three care organisations has progressed at pace, with early identification of suitable spaces, this is a strong foundation that will stand the organisations in good stead for the intensive training period and go-live.
8. **Finance** – discussions with regional colleagues underway to explore options to mitigate the additional £10.5M pressure on FY2027/28. Investment appraisal is being worked with regional digital and finance colleagues for submission to NHS England for potential ring-fenced capital funding.

RECOMMENDATION

The Group Board is asked to:

1. To note the BSW EPR Programme update and continue to support continued prioritisation of this programme across the BSW Hospitals Group.

APPENDICES

[List any appendices, A, B, C, with title and one line on what each provides.]	
A – EPR Programme Update	The formal summary report submitted to EPR Joint Committee for July 2026 period.
B – EPR Go Live Activity Approach Workshop	Summary slides to articulate the structure of the workshop, why advanced activity planning matters and summary of key design decisions discussed and agreed.



EPR Programme Update

Claire Strathern, EPR Programme Director
July 2026

BSW HOSPITALS GROUP

Great Western Hospitals NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust

Salisbury NHS Foundation Trust

EPR Programme | Summary Progress July Report



Headlines & Progress



Risk & Issues

Headlines

Testing– System testing and data migration Trial load 1 testing progress continuing to plan.

Learning Management System – contract now signed with Clariti and kick off meetings are in flight. Work commenced to set up BSW instance and commence development.

BSW Resources
Programme team now seeing expected levels of vacancy and attrition.

Change Requests – Configuration Change Requests (CCR's) critical to go live are being actively monitored and strict criteria for acceptance has seen a significant drop in the number being raised pre-Go Live.

Rationale / Next Steps

- System testing commenced on 25th June 2026 and we are currently in the fix window of testing. Test execution is complete with the exception of test scripts that were blocked by CCRs or Test Issues (TIs). Plan in place to ensure exit criteria is met. Test issue resolution is being actively managed day to day with focus on Critical and High TI resolution. Data Migration Trial Load 1 technical activities are on track to commence screen validation and data validation in the coming 3 weeks. There remains one known issue for GWH data that will impact their exit criteria but it is being actively addressed to resolve ahead of Trial Load 2.
- **Next steps:** Commence data validation and screen validation for all three Care Orgs.

- Programme team resourcing now sufficient for next phase of programme however final gaps in SME resourcing continue to be resolved and GWH and RUH programme managers have interim cover but require local resource in post to drive organisational readiness and first round of internal recruitment was not successful. PAS IP workstream issues have been mitigated through distribution of deliverables across other workstreams and further resources secured.
- **Next steps:** Remaining SME vacancies actively being recruited and local programme manager vacancies may require Care Org support to release suitable local resource to forefill the requirement.

- Organisational readiness groups now well established however consistency of attendance across all three orgs still not being achieved. Activity planning workshop held in London on 3rd July 26 with triumvirate attendance from SFT and GWH in attendance (RUH were unable to free suitable reps for the workshop). There is a high risk logged around EPR prioritization challenges across the orgs against operational pressures.
- **Next steps –** With the programme plan and key dates now socialised across the organisations, critical activities requiring organisational assistance are being planned and actioned.

- Training workstream and OCM capability from Clariti now commenced. Lead trainers now in position with allocated training portfolios. Training room conversations across all three care orgs in flight and require solutions to be finalised in coming month.
- **Next steps –** Allocate training spaces at care orgs. Finalise elearning lesson plans for development.

Risks

The programme has 130 open risks; an increase of 15 compared to last month. There are 2 black risks and 22 red risks - using the 5+5+5 scoring system.

- Risk 172 - PACS / RIS Project - GWH
- Risk 324 - Interface Testing

Issues

The programme has 40 open issues; an increase of 1 compared to last month. There is 1 black issues and 24 red issues.

- Issue 114 - POA CR sign off, workflows and test scripts

First in Type Tri-Trust EPR Programme | Assurance Next Steps

Programme Fundamentals and governance

Programme Milestones and gateways)

Risk and Issues

Our people - Communication & Engagement

Description & Activities

In July 2026 the overall programme status remains AMBER. The programme continues to progress System testing and data migration activities to plan and are progressing key org readiness activities. Key risks being closely monitored across integration, pathology and key PAS and Data migration requirements for the next cycle of testing.

By July 2026

- LMS installed and eLearning development commenced
- Immunology work off plan on track
- Cutover managers procurement commenced
- System testing and TL1 on track
- Start Stop Continue in flight and organisational readiness activities on track

By Aug 2026

- System testing successfully exited
- Configuration changes required for Integration Testing 1 (IT1) complete
- Cutover managers procurement complete
- Trial Load 1 on track for exit
- Organisational readiness activities on track with critical activity planning and validation resources secured
- Training activities on track for eLearning development and schedule validated ready for release

By Sept 2026

- IT1 testing entered and progressing to plan
- Cutover manager commenced
- Pre-requisite build for Data migration Trial Load 2 complete and entry criteria met
- Organisational readiness activities on track with critical activity planning agreed and in flight
- Training activities on track for eLearning development and schedule validated ready for release including ESR validation activities

Strategic Risk Mitigated

Singular EPR Plan	Plan in place to have critical path & plan including Berkley assurance activities
Gateway activity delays	Plan track enable and improve approach in situ with task forces to optimise DCWs, Workflows and CCRs
Our people	Drive resource plan, Approach designed for greater engagement

Workstream RAG Breakdown

#	Status
8	Red
16	Amber
8	Green

Implementation Resource Required

#	Role
33	Key vacancies in SMEs, Technical roles and Clinical Informatics roles

Our People (Change & Engagement)

#	Digital Champions
RUH	180*
SFT	177*
GWH	303*

*Signed up but not yet confirmed

BSW HOSPITALS GROUP

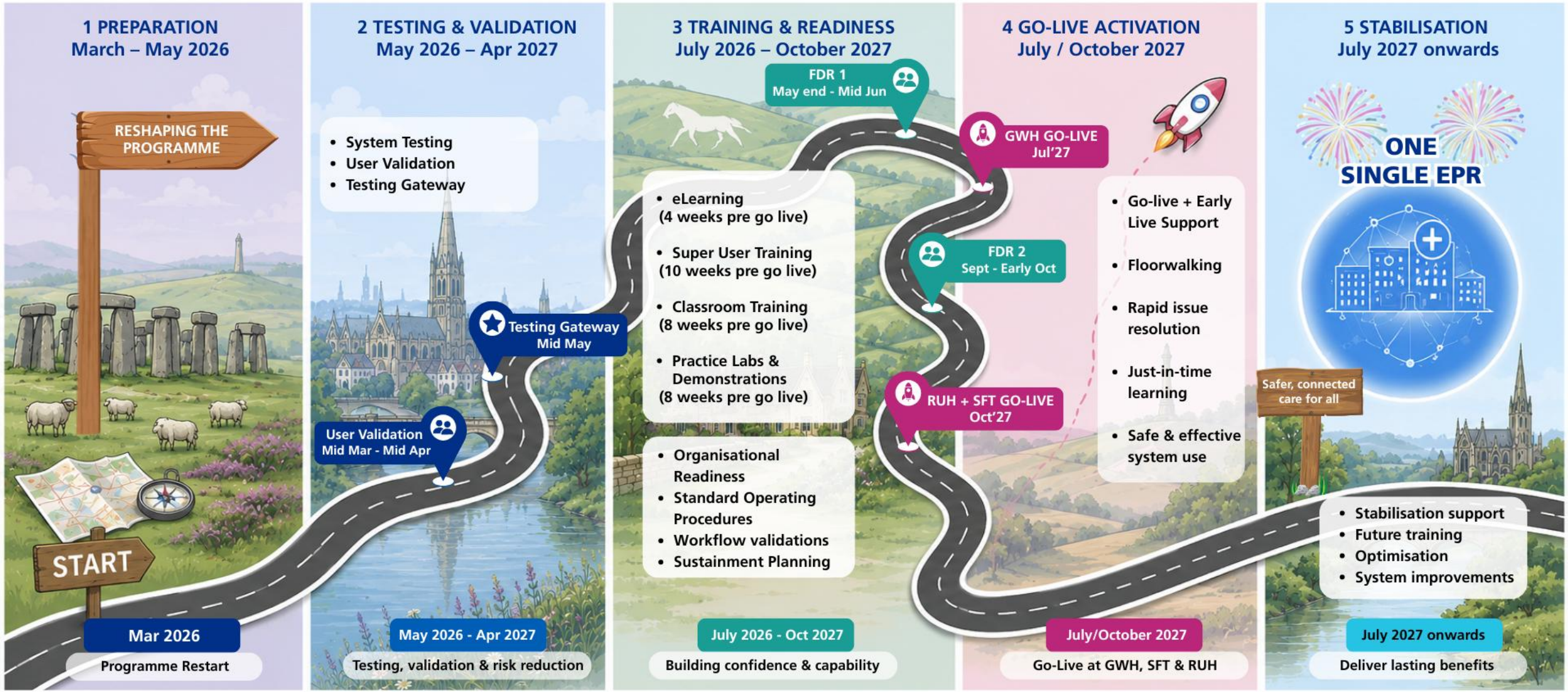
Great Western Hospitals NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust

Salisbury NHS Foundation Trust

BSW HOSPITALS GROUP

The Road to EPR



BSW Hospitals Group Board

Agenda item	8.1
Report title	Group Board Assurance Framework
Date of meeting	03 September 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Mark Ellis, Chief Risk Officer
Approval Process: (where has this paper been reviewed and approved)	Risk & Assurance Committee (August'26)

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

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

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

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title

KEY MESSAGES

This paper presents the Initial Group Board Assurance Framework following scrutiny by the Risk and Assurance Committee on 19 August 2026. The Committee took limited assurance at this stage, reflecting the developmental maturity of the framework rather than a judgement on the severity of the principal risks or the effectiveness of all mitigating work under way.

The August review identified priorities for the next stage of development: strengthening the evidence beneath controls and assurances; ensuring that mitigating actions and timescales are sufficiently specific and responsive; completing the connection between the BAF and the Group Risk Register; and introducing an explicit assurance-level judgement for each principal risk.

Links from the BAF to relevant risks on the Group Risk Register have now been completed. Current Care Organisation exposures are above inherited appetite or tolerance in several priority areas, including cyber security, avoidable harm, financial sustainability, estates and waits/transformation.

The Board is asked to confirm the three Care Organisation Chief Operating Officers as the senior responsible owners for R6 and the three Care Organisation Chief Nursing Officers as the senior responsible owners for R8. A Board workshop on 1 October 2026 will develop a refreshed Group risk appetite. Executive proposals on the assurance level for each principal risk will be incorporated in the next reporting cycle.

RECOMMENDATION

The Group Board is asked to:

1. Approve and adopt the Initial Group Board Assurance Framework as the Group's baseline strategic risk and assurance framework.
2. Approve the three Care Organisation Chief Operating Officers as the senior responsible owners for R6 Reducing Waits.
3. Approve the three Care Organisation Chief Nursing Officers as the senior responsible owners for R8 Reducing Avoidable Harm.
4. Note 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.

APPENDICES

Appendix A: Inherited risk appetite by Group BAF risk - reproduces the Care Organisation appetite positions inherited at Group formation as the baseline for the Board workshop on 1 October 2026.

Purpose

The Board Assurance Framework (BAF) is a strategic tool used by Boards to identify, assess and monitor the key (Principal) risks to achieving an organisation's strategic objectives.

Status of the Initial Group BAF and planned refresh

The Board Assurance Framework presented in this report is, by design, an Initial BAF. It has been produced to give the Group Board and its committees a documented strategic-risk position at the point of Group formation, by drawing the ten emerging Group strategic risks together from the strategic risks already held by the three Care Organisations. It is explicitly a baseline and a transitional artefact — the starting point of an iterative process, not a settled or final framework.

The Initial BAF will be refreshed in parallel with the development and publication of the Group strategy, which is expected in September 2026. As the Group's strategic objectives are articulated and agreed, the principal risks to their achievement will be (re)defined against them; risk appetite will be set through the Group risk appetite development session held alongside the strategy; and the residual scoring of each principal risk will be completed and calibrated on the additive 5+5+5 model. This strategy-aligned refresh is the mechanism by which the framework matures from a consolidation of Care Organisation views toward a set of independently articulated Group principal risks, and is the route to "Established" reporting maturity.

It is therefore anticipated that other than by exception the coverage gaps identified in this report will be closed through this process rather than addressed in isolation. In particular, the absence of a Group-level principal risk for collaborative partnerships and system working — an exposure currently carried at Care Organisation level (for example SFT's partnership, ICS and Place risk, and GWH's partnership and inequalities risk) but with no equivalent in the Initial BAF — is expected to be resolved as the Group's strategic objectives for place-based and system working are defined, since a principal risk can only be articulated once the objective it threatens has been agreed. The same applies to the other identified gaps: estate and fire safety, environmental sustainability and net zero, and health inequalities.

Where the refresh concludes that an exposure is more properly held at Care Organisation level than as a Group principal risk, that determination will itself be recorded, so that the eventual coverage of the Group BAF is the result of a deliberate act of articulation and not of omission.

Method

This report establishes a documented baseline for the Group's strategic risk position at the point of formation. It does three things: First, it maps the strategic (Board Assurance Framework) risks held by each of the three Care Organisations into the ten strategic risks of the Initial Group BAF, and makes explicit where a Care Organisation risk has no equivalent at Group level. Second, it sets out, for each existing strategic risk, where the Care Organisation's risk appetite currently sits, expressed as an appetite category rather than a score so that the inherited position can later be compared against the Group appetite once agreed. Third, it assesses the actual (residual) risk scores now carried, against

existing appetites, to show what level of risk the Group is in practice tolerating, where risks sit inside or outside tolerance, and which areas are furthest from previously stated appetite.

The report is deliberately a baseline. The Group has not yet agreed a refreshed Group risk appetite. Appendix A reproduces the inherited Care Organisation appetite positions. The current analysis shows several exposures above those inherited appetite or tolerance positions, most notably cyber security, avoidable harm, financial sustainability, estates and waits/transformation. These comparisons are indicative because the inherited appetites differ between Care Organisations and the Group uses a different scoring model. The Board workshop on 1 October 2026 will develop the refreshed Group appetite. Until then, the interim principle in the Risk Management Strategy continues to apply: any risk scoring 12 or above on the 15-point residual scale requires active Board-level oversight, and no risk is tolerated without explicit acknowledgement at the appropriate level.

Areas furthest from previous appetite

Current Care Organisation exposures are furthest from inherited appetite in cyber security, avoidable harm and financial sustainability. Cyber security represents the largest overall gap, with material exposures across all three Care Organisations, while financial sustainability is the most consistently breached area, with each Care Organisation carrying a residual score of 14.

Waits and transformation also remain outside inherited tolerance in several areas, although comparison is complicated by materially different Care Organisation appetites. For R1, R2, R3 and R9, the inherited appetite is identifiable but the report does not provide sufficient current residual-risk information to determine the tolerance gap. R7 has no inherited appetite and requires an explicit Group position.

Principal risk	Current residual score	Severity / appetite required	Inherited appetite baseline	Position against inherited appetite
R1 Becoming an Effective Group	10	High / Cautious	Cautious	Within inherited appetite
R2 Taking Our People With Us	11	High / Cautious	Cautious (consistent)	Within inherited appetite, at the top of the High band
R3 Delivering Digital Maturity	12	Significant / Open	Predominantly Cautious, with one Varied/Open element	Outside Cautious appetite; within tolerance only for the Open element
R4 Transforming Models of Care	12	Significant / Open	Spans Minimal to Open	Mixed: outside Minimal and Cautious; within Open
R5 Increasing Sustainability	14	Significant / Eager	Cautious, with Balanced and Open elements	Outside all inherited appetite positions
R6 Reducing Waits	12	Significant / Open	Spans Minimal, Cautious and Open	Mixed: outside Minimal and Cautious; within Open
R7 Improving Value and Productivity	14	Significant / Eager	No inherited appetite	Not assessable against inherited appetite; explicit Group appetite required
R8 Reducing Avoidable Harm	12	Significant / Open	Spans Minimal to Open	Mixed: outside Minimal; within Open
R9 Improving Staff Satisfaction	10	High / Cautious	Cautious (consistent)	Within inherited appetite
R10 Cyber Security	13	Significant / Eager	Spans Minimal to Cautious	Outside all inherited appetite positions

Interpretation uses the proposed additive model: scores 3-5 require Averse appetite, 6-8 Minimal, 9-11 Cautious, 12 Open and 13-15 Eager. A risk is within tolerance only where the inherited appetite is at least the stance required by its current residual score. R10 is shown as 13 in the BAF all-risks summary; the detailed R10 page shows 12 and should be reconciled before issue.

Estates and fire safety remains a significant exposure outside the current set of ten principal risks: RUH 3.4 is scored 20, SFT risk 4 is scored 16 and GWH SR7 is scored 12. This should remain visible to the Board and be reconsidered through the strategy-aligned BAF refresh.

Conclusion

The Initial Group Board Assurance Framework achieves its intended purpose. It provides the Group Board with a single, documented view of the principal strategic risks facing the newly formed Group, establishes a clear baseline against which future development can be measured, and makes explicit both the areas of alignment and the areas requiring further articulation as the Group matures. It also provides transparency over inherited risk appetite positions and highlights those strategic risk areas where current exposures exceed established tolerances.

The analysis demonstrates that the ten principal risks within the Initial BAF provide a coherent framework through which the majority of strategic risks currently held by the three Care Organisations can be understood and overseen at Group level. Where gaps in coverage exist, these have been explicitly identified and will be addressed through the planned refresh aligned to the development of the Group Strategy and Group Risk Appetite Statement.

As such, the Initial BAF represents a proportionate and effective assurance tool for the Group at this stage of its development. It establishes the foundations for consistent strategic risk oversight while providing a clear route to further maturity as the Group's objectives, appetite and governance arrangements become established.

Appendix A: Inherited risk appetite by Group BAF risk

This appendix reproduces the appetite positions inherited from the three Care Organisations. They are retained as a baseline only. The Board workshop on 1 October 2026 will confirm a refreshed Group risk appetite. The main report identifies where current exposures sit above inherited appetite or tolerance and explains the limitations of comparing Care Organisation and Group scoring models.

Group BAF risk	CO source	Care Organisation appetite (category)	Inherited appetite range
R1 · Effective Group	SFT 6	Cautious	Cautious
R2 · Taking Our People With Us	RUH 2.1	Cautious	Cautious (consistent)
	RUH 2.2	Cautious	
	GWH SR2	Cautious	
R3 · Delivering Digital Maturity	RUH 3.6	Varied (Cautious storage / Open use)	Cautious, with one Varied/Open element
	RUH 3.8	Cautious	
	SFT 1	Cautious	
	SFT 3	Cautious	
	GWH SR8	Cautious	
	GWH SR10	Cautious	
R4 · Transforming Models of Care	RUH 3.3	Open	Spans Minimal – Open
	SFT 2	Minimal	
	SFT 11	Minimal	
	GWH SR5	Open	
R5 · Increasing Sustainability	RUH 3.1	Cautious (financial) / Balanced (spend to improve patient safety)	Cautious, with Balanced & Open elements
	RUH 3.2	Cautious & Open (assets/estates)	
	SFT 9	Cautious	
	GWH SR6	Cautious	
R6 · Reducing Waits	RUH 1.2	Open	Spans Minimal – Cautious – Open (three levels)
	RUH 1.3	Open	
	SFT 8	Minimal	
	SFT 12	Minimal	
	GWH SR4	Cautious	
R7 · Improving Value & Productivity	—	No equivalent CO strategic risk – appetite to be established	To be established at Group level
R8 · Reducing Avoidable Harm	RUH 1.1	Open	Spans Minimal – Open
	GWH SR1	Minimal	
R9 · Improving Staff Satisfaction	RUH 2.1	Cautious	Cautious (consistent)
	SFT 7	Cautious	
	GWH SR3	Cautious	
R10 · Cyber Security	RUH 3.7	Cautious	Spans Minimal – Cautious
	SFT 5	Cautious	

Group BAF risk	CO source	Care Organisation appetite (category)	Inherited appetite range
	GWH SR9	Minimal	

Averse	Minimal	Cautious	Open	Eager

Draft additive scoring model

Inherent Risk Matrix (L + C, max 10)

Score each cell as Likelihood + Consequence. The cell value is the inherent risk score.

↓ Likelihood	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain	6	7	8	9	10
4 Likely	5	6	7	8	9
3 Possible	4	5	6	7	8
2 Unlikely	3	4	5	6	7
1 Rare	2	3	4	5	6

Low (2–3) | Moderate (4–5) | High (6–7) | Significant (8–10)

Residual Score → Severity & Appetite Stance

Residual = L + C + Control Effectiveness (CE rated 1 highly effective to 5 ineffective).

Residual score	Severity band	Appetite stance	Within tolerance?
13 – 15	Significant	Eager	*Eager only*
12	Significant	Open	*Open or Eager*
9 – 11	High	Cautious	*Cautious or above*
6 – 8	Moderate	Minimal	*Minimal or above*
3 – 5	Low	Averse	*Within all stances*

A risk is within tolerance when residual ≤ the appetite ceiling for its stance, and outwith when residual exceeds it.

Residual Risk Scale (3 – 15)

Continuous scale showing severity bands and the Group Board oversight threshold.

Board oversight threshold (≥ 12)

Low | Moderate | High | Significant

3 4 5 6 7 8 9 10 11 12 13 14 15

Worked example: *R10 Cyber Security — Likelihood 4 + Consequence 5 + CE 4 = residual 13 → High, Board oversight required, within tolerance only if appetite is set at Eager.*

Risk Appetite Descriptors (unchanged from SFT — model-agnostic)

Averse	Avoidance of risk and uncertainty is key objective.
Minimal	Preference for safe options leading to only minimum risk exposure; low likelihood of occurrence after controls.
Cautious	Preference for safe options though accept there will be some risk exposure; medium likelihood after controls.
Open	Willing to consider all options and choose the one most likely to result in successful delivery; recognise that there could be high-risk exposure.
Eager	Willing to be innovative and take on a very high level of risk but only in the right circumstances.

BSW Hospitals Group

Initial Board Assurance Framework

updated August 2026

Note on this update: This version incorporates evidence from relevant meetings. Scores and assurance judgements are provisional Board-level assessments pending SRO validation and 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	*[TBC]*	→	*None directly mapped in the August 2026 GRR.*	*Group governance is live, but strategy, risk appetite, decision-map testing and independent assurance remain incomplete.*
R2	Taking Our People With Us	CPO	8	**11**	7	*[TBC]*	→	*Workforce plan delivery; Temporary staffing; GWH-1382; GWH-1493.*	
R3	Delivering Digital Maturity	CDIO	8	**12**	9	*[TBC]*	→	*Insufficient digital, data and technology resource to meet increasing Group demand; CST programme - digital enablement investment; LAN refresh and network infrastructure resilience; Insufficient clinical informatics capacity and capability across the Group; RUH-3243.*	EPR delivery, technical debt, specialist vacancies and affordability remain material dependencies.
R4	Transforming Models of Care	CCTIO	8	**12**	8	*[TBC]*	→	*SFT-7946; SFT-8780; SFT-8926.*	Transformation architecture is developing; benefits baselines, clinical capacity and system dependencies remain gaps.
R5	Increasing Sustainability	CFO	10	**14**	9	*[TBC]*	→	*GRP-FIN-01; RUH-3165; GWH-1576; SFT-8759; SFT-8791; GRP-FIN-02; GWH-1608; RUH-3289.*	Cash risk, material forecast deficits, recovery-plan uncertainty and capital constraints require Board oversight.
R6	Reducing Waits	COOs	9	**12**	9	*[TBC]*	→	*None directly mapped in the August 2026 GRR.*	GWH is materially off plan across UEC, elective and cancer

Ref	Strategic Priority	SRO(s)	Inherent	Residual	Target	Assurance Level	Trend	GRR Ref	Key gap / status
									trajectories; recovery depends on capacity, workforce and system action.
R7	Improving Value and Productivity	CFO	10	**14**	9	*[TBC]*	→	*CST programme - finance tracker and savings forecasting; SFT-8800.*	CIP maturity improving but require shift to focus on delivery confidence.
R8	Reducing Avoidable Harm	CNOs	9	**12**	8	*[TBC]*	→	*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.*	
R9	Improving Staff Satisfaction	CPO	7	**10**	6	*[TBC]*	→	*None directly mapped in the August 2026 GRR.*	Change uncertainty, workforce pressure, vacancy and turnover hotspots threaten experience and retention.
R10	Cyber security	CDIO	9	**13**	11	*[TBC]*	→	*None directly mapped in the August 2026 GRR.*	

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	**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* **R7 -**Improving Value and Productivity *Score: [14] → CFO* **R10 -**Cyber Security *Score: [13] → CDO*
SIGNIFICANT Residual 9–11	**R1 -**Becoming an Effective Group *Score: [10] → CSO* **R2 -**Taking Our People With Us *Score: [11] → CPO* **R8 -**Reducing Avoidable Harm *Score: [12] → CNOs* **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 *None directly mapped in the August 2026 GRR.*	Last Reviewed *[Date]* *Next Review: [Date]*

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:
Pending -covered in part by candidate GR-05 (Group governance maturity, to be confirmed)

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]	***[TBC]***	→
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 ● Safe to start ongoing assessment – beyond first Group Board meeting.	*Oversight, monitoring and challenge functions* ● Pilot Risk and Assurance Committee oversight of governance development through to go-live ● Group Audit Committee review of internal control arrangements once formed ● Company Secretary monitoring of compliance with Standing Orders and SoRD across the three COs ● External governance review (planned, post go-live) to confirm arrangements are operating as intended	*Independent assurance: audit, regulator, peer review* ● Internal Audit review of governance framework (planned, autumn 2026) ● External Well-Led review (planned Q4 26/27) ● NHS England oversight via the System Oversight Framework ● External Auditor Annual Report on governance and value for money

Gaps in Controls and Assurance

Gaps in Controls and Assurance. Evidence and external events reviewed: Group Board and committee arrangements commenced in July 2026. Regulatory correspondence on GWH performance challenged the effectiveness of governance and assurance, increasing the need to evidence Board ownership, clear committee remits, tracked actions and delivery challenge. Remaining gaps: formal strategy and risk appetite, and independent operating-effectiveness assurance.

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	September 2026	*Under development*

Group risk appetite statement developed and agreed by the Group Board	Group CRO	September / October 2026	*Under development*
First Group Internal Audit plan agreed	Group Audit Committee Chair	October 2026	*Not started*
Functions and Decision Map reviewed against operating experience and updated	Group Company Secretary	December 2026	*Not started*

R2	Taking Our People With Us	SRO CPO	Strategic Objective Taking Our People With Us	GRR Reference *Workforce plan delivery; Temporary staffing; GWH-1382; GWH-1493.*	Last Reviewed *[Date]* *Next Review: [Date]*

Risk Description There is a risk that the Group fails to carry its workforce through the changes required to deliver the Group Strategy, caused by insufficient engagement, communication and change management capability, resulting in staff disengagement, cultural fragmentation, deteriorating morale and an inability to deliver the Group's objectives.

GRR cross-reference:
Pending -overlaps with candidate GR-04 (Workforce Sustainability and Pipeline)

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[8] *Max 10 (Likelihood + Consequence)*	**[11]** *Max 15 (L + C + Control Effectiveness)*	**[7]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***[TBC]*** *Substantial / Reasonable / Limited / Minimal*	→ *Stable (initial position)*

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 ● Development and implementation of Group people delivery plan ● Development and implementation of a Group communications and engagement plan Director of Comms ● Joint staff-side and Trust partnership arrangements in operation across the three Cos ● Change management capability and capacity across the Group ● Care Organisation POD and Group POD ● Executive leadership	*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 ● EPR Programme Bpard ● Clinical Transformation Programme Board oversight of consequential changes ● Care Organisation governance arrangements ● UEC Board ● Elective Recovery Board	*Independent assurance: audit, regulator, peer review* ● NHS Staff Survey national benchmarking ● Internal Audit review of change management arrangements ● External cultural review or 360-degree assessment (option for the Board to consider)

Gaps in Controls and Assurance

No agreed Group-level set of culture and engagement indicators yet in place. HR change management capacity has been flagged at SFT (SFT-8780) and may apply across the Group.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Approve and publish a single Group engagement and change plan, including audience segmentation, feedback loops, measurable outcomes and reporting to the People and Culture Committee.	Group CPO	August 2026	*Under development*
Set of Group culture and engagement indicators agreed for People and Culture Committee	Group CPO	September 2026	*Under development*
First Group-wide pulse survey completed and reported	Group CPO	November 2026	*Under development*

R3	Delivering Digital Maturity	SRO CDIO	Strategic Objective Delivering Digital Maturity	GRR Reference *Insufficient digital, data and technology resource to meet increasing Group demand; CST programme - digital enablement investment; LAN refresh and network infrastructure resilience; Insufficient clinical informatics capacity and capability across the Group; RUH-3243.*	Last Reviewed *[Date]* *Next Review: [Date]*

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:

Aligns with candidate R10 Cyber Security and Digital Infrastructure Resilience and should cross-reference Group Digital Service risk register covering technical debt, unsupported systems, EPR delivery, infrastructure resilience, clinical system continuity, data quality, interoperability and capital affordability.

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*	***[TBC]*** *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	August 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	In progress
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	In progress

R4	Transforming Models of Care	SRO CCTIO	Strategic Objective Transforming Models of Care	GRR Reference *SFT-7946; SFT-8780; SFT-8926.*	Last Reviewed *[Date]* *Next Review: [Date]*

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:
Pending -overlaps with candidate GR-05 (UEC Demand and Patient Flow) for flow-related elements

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*	***[TBC]*** *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*

Resource requirements scoped, identified, and confirmed	Group CCTIO	May 2026	*Overdue*

R5	Increasing Sustainability	SRO CFO	Strategic Objective Increasing Sustainability	GRR Reference *GRP-FIN-01; RUH-3165; GWH-1576; SFT-8759; SFT-8791; GRP-FIN-02; GWH-1608; RUH-3289.*	Last Reviewed *[Date]* *Next Review: [Date]*

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.

GRR cross-reference:
Pending -directly aligns with candidate GR-02 (Financial Sustainability)

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*	***[TBC]*** *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 ● Group financial plan for 2026/27 in place, with CO-level budgets and delivery responsibility ● Monthly reporting cycle ● Group efficiency programme ● Cash flow forecasting and treasury management at Group level ● Deficit support funding and ICB transitional funding arrangements confirmed??	*Oversight, monitoring and challenge functions* ● Four tier reporting and scrutiny structed introduced with monthly financial reporting to Group Executive Committee and Group Board ● External turnaround team? ● Group CFO review of CO-level forecasts and risk-adjusted positions ● Internal Audit financial controls reviews ● 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

Gaps in Controls and Assurance

Gaps in Controls and Assurance. Evidence and external events reviewed: NHS England correspondence dated 26 June 2026 raised concerns about finance, operational performance and governance at GWH. Subsequent recovery work concluded that breakeven was not realistic on current evidence and identified a most-likely GWH deficit of about £25m. Group discussions identified material cash pressure, potential revenue-support applications, uncertainty over income and the need for consistent forecast assumptions. Remaining gaps: recovery trajectories, quantified recurrent/non-recurrent delivery, clear interventions and independent delivery assurance.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Present a single Group financial sustainability report to Group Board, including risk-adjusted forecast, cash runway, recurrent delivery, downside scenarios, accountable interventions and recovery confidence.	Group CFO	September 2026	Reporting included in August papers
Report monthly workstream-level CIP delivery confidence, validated net and recurrent savings, milestones, corrective actions and benefits evidence to the Financial Sustainability Committee.	Group CFO	Monthly from August 2026	Committee and reporting established
Medium-term financial plan (3-year) presented for Group Board agreement	Group CFO	March 2027	

R6	Reducing Waits	SRO CO COOs (x3)	Strategic Objective Reducing Waits	GRR Reference *None directly mapped in the August 2026 GRR.*	Last Reviewed *[Date]* *Next Review: [Date]*

Risk Description There is a risk that the Group fails to reduce patient waiting times to meet constitutional and national operational standards, caused by demand exceeding capacity, workforce constraints and pathway inefficiency, resulting in harm to patients, regulatory intervention and reputational damage.

GRR cross-reference:
Pending -overlaps with candidate GR-05 (UEC Demand and Patient Flow) on the urgent and emergency side

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]	***[TBC]***	→
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

Gaps in Controls and Assurance. Evidence and external events reviewed: The NHS England letter of 26 June 2026 identified early-year variance in UEC, elective and cancer performance. Recovery discussions describe sustained emergency demand, capacity and workforce constraints, RTT recovery requiring additional activity, and cancer dependencies in diagnostics and key specialties. EPR go-live planning also requires temporary activity reduction and patient-impact mitigation. Remaining gaps: funded recovery trajectories, system demand actions and evidence of delivery against milestones.

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	*First iteration complete*
Harmonised approach to long waiter harm review agreed across the three COs	CO CMOs / Group Quality Director	October 2026	*Not started*
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 Op DoFs (x3)	Strategic Objective Improving Value and Productivity	GRR Reference *CST programme - finance tracker and savings forecasting; SFT-8800.*	Last Reviewed *[Date]* *Next Review: [Date]*

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:
Pending -links to candidate GR-02 (Financial Sustainability)

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*	***[TBC]*** *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

Gaps in Controls and Assurance. Evidence and external events reviewed: Financial recovery meetings report high-risk CIP delivery, constrained implementation capacity.. Remaining gaps: delivery..

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Approve a Group productivity and value dashboard with common definitions, benchmarks, and benefits evidence.	Op DoFs (x3)	September 2026	*Under development*
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** *[Date]* *Next Review: [Date]*

Risk Description There is a risk that the Group fails to maintain and improve patient safety standards, caused by workforce pressures, governance immaturity during the transition period and the challenges of integrating safety systems across three sites, resulting in avoidable harm to patients and potential regulatory intervention.

GRR cross-reference:
Pending -operational harm risks remain primarily on CO registers; Group-wide aggregation under development

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*	***[TBC]*** *Substantial / Reasonable / Limited / Minimal*	→ *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 ● 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 oversight at Group level ● Patient Safety Specialists and Group-level patient safety leadership ● Group Quality Director coordination of safety reporting and themes ● Safeguarding Committee 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

Aggregate Group-level safety position and themes not yet reported as a single picture. Variation in PSIRF implementation maturity across the three COs. Workforce pressure on safety (links to R2 and R9) is a persistent driver. Safety Improvement Plan harmonisation is not yet in place.

SMART Actions to Close Gaps

SMART Action	Owner	Due Date	Status
Group safety scorecard agreed for Quality Committee reporting	Group Quality Director / CNOs	September 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 *[Date]* *Next Review: [Date]*

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:
Pending -overlaps with R2 and candidate GR-04 (Workforce Sustainability and Pipeline)

INHERENT SCORE	RESIDUAL SCORE	TARGET SCORE
[7] *Max 10 (Likelihood + Consequence)*	**[10]** *Max 15 (L + C + Control Effectiveness)*	**[6]** *Planned destination*
RISK APPETITE	**ASSURANCE LEVEL**	**DIRECTION OF TRAVEL**
[Provisional] *To be agreed at Group risk appetite workshop*	***[TBC]*** *Substantial / Reasonable / Limited / Minimal*	→ *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
Group staff experience indicator set agreed for People and Culture Committee	Group CPO / Site HRds	September 2026	*Under development*
Health and wellbeing offer reviewed for harmonisation opportunities	Site HRD for Culture & OD	November 2026	*Not started*

R10	Cyber Security	SRO CDIO	Strategic Objective Delivering Digital Maturity	GRR Reference *None directly mapped in the August 2026 GRR.*	Last Reviewed *[Date]* *Next Review: [Date]*

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*	***[TBC]*** *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	November 2026	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	August 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*

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

Agenda item	8.2
Report title	Register of Declared Interests
Date of meeting	3 September 2026
Sponsor	Mark Ellis, Chief Risk Officer
Prepared by	Caroline Coles, Company Secretary GWH
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	

BOARD ASSURANCE FRAMEWORK LINK

BAF risk R1	**Becoming an effective group**

KEY MESSAGES

A Declarations of Conflict Register for the Group Board has been prepared. This is a live document which will be held by the Company Secretary.

Boards members are invited to make any changes by contacting the Chief Risk Officer prior to publication in mid-September.

RECOMMENDATION

The Group Board is asked to:

Note the current Register of Interests and provide any amendments under separate cover to the Chief Risk Officer.

APPENDICES

Appendix 1 : Register of Interests

Declarations of Interest Group Board of Directors - 1 September 2026					Dates	Type of interest							
First Name	Last Name	Position Title	Interests to declare	Description of interest / Action taken	To	Clinical Private Practice	Strategic Decision Making	Outside Employment / Directorships	Gifts and Hospitality	Loyalty	Shareholdings	Membership of Committees / Charites / Networks etc	Personal connections
Voting Board Members													
Angie	Ansell	Interim CNO, SFT	N										
Kathryn	Bateman	Chief Medical Officer, GWH	N										
Chris	Burton	Non Executive Director 2025	Y	Bristol Beacon, Silver Patron, Music Concerts	Ongoing							X	
Paul	Cain	Non Executive Director	Y	Director and shareholder Avant Health Ltd	Ongoing			X			X		
Cara	Charles-Barks	Chief Executive	Y	Group CEO for Royal United Hospitals, Great Western Hospitals and Salisbury Foundation Trust. Chair of NHS Quest, a leadership/development provider. Appointed Honorary Colonel of 243 Multi-role Medical Regiment, part of the Army Reserve Medical Services. Chatham Row Management Company Ltd, Director	Ongoing			X		X			
Faried	Chopdat	Non Executive Director	Y	Non Executive Director Grant Thornton UK Equarios Ltd - Director Blossom CIC - Non-Executive Director	Ongoing			X				X	
Paul	Fairhurst	Non Executive Director	Y	Trustee of Designability (UK Charity) Trustee of Back-Up (UK Charity)	Ongoing							X	
Luisa	Goddard	Chief Nurse	N										
Simon	Harrod	Non Executive Director	Y	Trustee of Amesbury History Centre	Ongoing							X	
Richard	Holmes	Non Executive Director	N										
Nick	Johnson	Managing Director, SFT	N										

Peter	Knell	Non Executive Director	Y	Executive Finance Director Tricuro Limited	Ongoing			X					
Jason	Lugg	Chief Nursing Officer, RUH	N										
Joy	Luxford	Non Executive Director	Y	OnSecurity Technology Ltd. - Husband runs an IT Cyber Security Business that the Trust contacted in May 2025 to raise an order for services. This was done on normal business terms without any awareness or influence from me in my position as Non-Executive Director at the Trust or from my husband in his position as a Director of the company. Iconoclast Global Limited. - Director Alliance Homes, a housing registered provider - Non-Executive Director Chair of the Audit and Risk Committee since 01/04/25. ICAEW, a chartered accounting body -Member B&NES Council -Co-Chair of the government backed Pride in Place initiative for Twerton	Ongoing			X				X	X
Becky	Maxwell	Chief Medical Officer, RUH											
Duncan	Murray	Chief Medical Officer, SFT	Y	Director, Owner and shareholder. Wife is also director. -DM Clinical and Professional Services Ltd	Ongoing			X					X
Bernie	Morley	Non Executive Director from April 2023 to 31 March 2026 Bernard Morley Limited (Consultancy)	Y	Chairman of trustees and research committee, Bath Institute of Rheumatic Diseases Member of Court of University of Bath The Corsham School Trust Academy - Chair of Trust and local governing body BIRD - possible research grants Consulting work with a number of universities including Bath, Bath Spa and Brunel Bernard Morley Ltd - Director	Ongoing			X				X	
John	Palmer	Managing Director, RUH	N										
Richard	Samuel	Non Executive Director	Y	Director, shareholder - Provides advisory services to NHS organisations, commercial organisations and pharma companies RO5 Consulting Ltd Dorset Hospitals NHS Foundation Trust Wife is Deputy Director of Finance	Ongoing			X					X
Lisa	Thomas	Managing Director	Y	Governor of Lavington Secondary School - Vice Chair Vice Chair Dauntsey Academy, Lavington Primary School	Ongoing							X	
Simon	Wade	Group Chief Financial Officer	N										

Paul	von der Heyde	Chair	Y	Professional – non financial Chairman Board PAPAA Enterprises Limited The virtually dormant trading subsidiary of Psoriasis and Psoriatic Arthritis Alliance	Ongoing			X					
				Professional – non financial Chairman Board of Trustees Psoriasis and Psoriatic Arthritis Alliance A National charity focused on advice to those suffering from the condition	Ongoing			x					
				Professional- non financial Chairman Trustees Worshipful Company of Furniture Makers Charitable Fund A charity supporting those employed or who have been employed in the furniture and furnishing industry and their connections providing grants and donations to cover welfare, education or excellence needs	Ongoing			x					
				Professional - Financial Director and shareholder Herswell Coaching and Consulting Limited A management consulting and behavioural advice business	Ongoing			×			x		
				Professional – non financial – resigned 24th May 2026 South West Social Mobility Commissioner South West Social Mobility Commission	24-May-26			x					
				Professional - Financial Director Howlands (Furniture) Limited This is the holding company for a group which carries out both high quality and value office furniture and property management based in High Wycombe.	Ongoing			×					
				Professional – financial Director and minority shareholder Sweetfish Limited Software development specialising in correct protocols and charging delivery	Ongoing			×			×		
				Professional - Financial Chairman Burbidge & Son Limited Design and manufacture of fitted kitchen and bathroom furniture	Ongoing			×					
				Indirect My wife is a fundraiser. I have no direct relationship with the Centre and am not engaged in the fundraising or other activities. Conquest Centre An charity supporting those with disabilities based in Norton Fitzwarren,	Ongoing								×
Non-Voting Board Members													
Bernie	Bluhm	Chief Operating Officer, RUH	N										
Neil	Clark	Associate Non Executive Director	Y	BooByBiome LTD - Shareholder	Ongoing						X		
Judith	Dyos	Chief Strategy Officer	N										
Mark	Ellis	Chief Risk Officer	Y	Director: STL - wholly owned subsidiary of SFT SSL - JV between SFT and STeris	Ongoing			X					

Benny	Goodman	Chief Operating Officer, GWH	Y	Director of Cornbow Properties Ltd Chair of Trustees for Finchampstead Baptist Church, which runs a combined Church and Community Centre/coffee shop/sports facility in Finchampstead, Berkshire.	Ongoing			X				X	
Judith	Gray	Chief People Officer	Y	Trustee for ICP Support. ICP is a charity which supports women and their families who develop intrahepatic cholestasis of pregnancy Son is a Senior Manager for our external auditors, Deloitte Gympanzees Trustee	Ongoing							X	X
Andrew	Hollowood	Chief Clinical Transformation Officer	Y	Wife is GP in Hartcliffe, Bristol Daughter Foundation Doctor, Southmead Hospital, Bristol Daughter GP trainee, Severn Deanery	Ongoing 3 Aug-26 4 Aug-26								X
Jonathan	Hinchcliffe	Group Chief Transformation and Innovation Officer	Y	St Vincents Consultant, Delivery Consultant	31-Aug-26			x					

BSW Hospitals Group Board

Agenda item	9.1 (a)
Report title	Audit, Risk & Assurance Committee Assurance Report - GWH
Date of meeting	24 June 2026
Sponsor	Paul von der Heyde, Chair
Prepared by	Helen Spice, NED – Chair of Audit, Risk & Assurance Committee
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	

BOARD ASSURANCE FRAMEWORK LINK

BAF risk ID	Principal risk title
[e.g. BAF 03]	[Principal risk title from the BAF]

KEY MESSAGES

There were no significant issues to report. Overall, the Committee was able to provide the Board with reasonable assurance regarding the adequacy and effectiveness of the Trust's governance, risk management and internal control arrangements.

The Annual Report and Accounts were approved under delegated authority and met the deadline for submission to NHSE.

RECOMMENDATION

The Group Board is asked to note the report.

APPENDICES

None

Audit, Risk & Assurance Committee Assurance Repot

Key discussion points and matters to be escalated from the committee meeting.

Alert

No matters requiring Board attention or action.

Advice

- The Board is advised that the Annual Governance Statement includes references to the financial sustainability challenges.
- External Audit issued a modified opinion relating to a pension disclosure matter and reported a significant weakness in financial sustainability through its Value for Money assessment. Management actions are in place to address the findings.
- Internal Audit identified data management as an area requiring improvement and the Committee will continue to monitor progress against agreed actions.
- The Committee will oversee the embedding of the new Group risk management and governance arrangements to ensure risks continue to be effectively identified and managed.

Assure

- The Committee approved the Annual Report and Accounts under delegated authority and was assured that they had been prepared in accordance with statutory requirements and subjected to external audit scrutiny.
- The Committee received positive assurance from Internal Audit on the Board Assurance Framework review, the Data Security and Protection Toolkit review and Local Counter Fraud arrangements.
- Improved governance arrangements for monitoring audit actions have resulted in a significant reduction in overdue actions.
- Overall, the Committee was able to provide the Board with reasonable assurance regarding the adequacy and effectiveness of the Trust's governance, risk management and internal control arrangements.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board or Directors**	**Agenda item:**	**9.2 a1**
Date of Meeting:	**September 2026**		
Title of Report:	**RUH Charities Committee Upward Report**		
Status	**For discussion and assurance**		
Author	**Sumita Hutchison, Charities Committee Chair**		

Key discussion points and matters to be escalated from the meeting held on 18th June 2026

ALERT: Alert to matters that require the Board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- **Green Heart Programme:** The Committee reviewed the charity risk register and noted an increase in the Green Heart risk score following concerns regarding potential donor sensitivity and external interest. The Committee heard that proposed changes to the Green Heart footprint had not yet been formally communicated to donors and recognised the potential impact on donor confidence and charitable fundraising. Assurance was provided that work is underway with Trust colleagues to develop appropriate communications and engagement plans.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- **Charity Operating Model:** The Committee reviewed the 2026/27 Charity Operational Budget and requested further information regarding the proposed reclassification of certain operating and governance costs. Members supported the principle of improving transparency and benchmarking but noted further work is required before any accounting treatment changes are implemented. Ongoing scrutiny of the sustainability of the charity operating model will continue.

- **Investment Governance:** The Committee received an update regarding investment management arrangements and supported further exploration of potential collaborative opportunities across BSW charities to ensure value for money and maximise investment returns. Any future arrangements will require robust governance and oversight.

ASSURE: Inform the Board where positive assurance has been achieved

- **Fundraising and Financial Position:** The Committee received assurance regarding the charity's overall financial position and fundraising performance. Members noted growth across several income streams, positive progress in philanthropy and major giving, increasing donor numbers and continued work to unlock previously slow-moving charitable funds through improved engagement with clinical services.

- **PET-CT Appeal:** The Committee received assurance regarding progress against the PET-CT appeal, noting achievement of the first fundraising milestone and continued progress towards the overall campaign target.

- **Governance Review:** The Committee completed its review of both the Charitable Funds Standing Financial Instructions and the Committee Terms of Reference, approving the updated documents and receiving assurance that the charity's governance framework remains appropriate and under regular review.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- The Committee reviewed the charity risk register. The principal risk discussed related to the Green Heart Programme and the potential impact on donor confidence arising from uncertainty regarding future plans and communications. Members also reviewed risks associated with forecasting the timing of charitable income, including legacy income and pledged donations. No new high-level risks requiring escalation beyond these matters were identified.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

- The Committee noted encouraging progress in charitable grant deployment, with increased engagement from clinical services resulting in a stronger pipeline of proposals and improved utilisation of charitable funds to support patient care and staff wellbeing.

APPROVALS: Decisions and Approvals made by the Committee

The Committee approved:

- Updated Charitable Funds Standing Financial Instructions.
- Charity Operational Budget for 2026/27.
- Continuation of the 25% levy.
- Service Level Agreement and associated recharge arrangements.
- Charitable grant requests for ICU EEG monitoring equipment, cardiology equipment, automated dispensing cabinets and ultrasound devices

The Board is asked to:

- Note the assurances provided by the Charities Committee regarding the charity's financial position, the ongoing management of the Green Heart risk, and work to strengthen investment governance and long-term sustainability.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board or Directors**	**Agenda item:**	**9.2a2**
Date of Meeting:	**September 2026**		
Title of Report:	**RUH Non-Clinical Governance Committee Upward Report**		
Status	**For discussion and assurance**		
Author	**Sumita Hutchison, Charities Committee Chair**		

Key discussion points and matters to be escalated from the meeting held on 17 June 2026

ALERT: Alert to matters that require the Board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- **Estates Capital Funding and Backlog Maintenance:** The Committee reviewed the Estates capital plan and noted the significant gap between required and available capital funding. Members were advised that estate deterioration continues to outpace available investment, with funding prioritised towards critical infrastructure and statutory compliance risks. The Committee acknowledged that current capital allocations are insufficient to address the underlying level of risk and noted that this remains reflected within the Board Assurance Framework and risk register.

- **Digital Infrastructure and Technical Debt:** The Committee discussed increasing risks associated with ageing digital infrastructure and technical debt, including a significant number of end-user devices exceeding supported life and not meeting NHS cyber security standards. Members noted the importance of developing clearer quantification of these risks to support future investment decisions.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- **Operational Risk Management:** The Committee reviewed a newly escalated risk relating to blood sample labelling processes. Further investigation has been requested to better understand underlying causes and identify any additional mitigating actions required.

- **Health, Safety and Emergency Preparedness:** The Committee received updates relating to fire safety, water safety, violence prevention and emergency preparedness. Members noted ongoing work to strengthen business continuity arrangements and embed emergency preparedness processes more widely across the organisation.

ASSURE: Inform the Board where positive assurance has been achieved

- **Governance Transition:** The Committee received assurance regarding the transition of non-clinical governance responsibilities into the emerging BSW Group governance structure. Members were satisfied that proposed

governance arrangements remain proportionate, maintain appropriate accountability and provide robust routes for assurance and oversight.

- **Board Assurance Framework:** The Committee reviewed the Board Assurance Framework and was satisfied that risks remained appropriately described, aligned and controlled, with no material gaps identified.

- **Information Governance:** The Committee received a positive update regarding information governance performance, noting significant improvement compared to the previous year, a reduction in audit findings and successful achievement of the Data Security and Protection Toolkit "Standards Met" rating. The Committee received assurance regarding the organisation's information governance arrangements.

- **Environmental Cleaning Standards:** The Committee received assurance that environmental cleaning performance has improved, with sustained compliance across high-risk clinical areas over a number of months. While recognising that performance remains vulnerable to operational pressures, members supported a reduction in the associated risk score.

RISK: Advise the Board which risks were discussed and if any new risks were identified

The Committee reviewed the corporate risk register and highlighted the following principal risks:

- Insufficient capital funding to address the scale of backlog maintenance and infrastructure requirements.
- Digital infrastructure risks arising from ageing equipment, technical debt and cyber security compliance requirements.
- Emerging operational risks associated with blood sample labelling processes.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

- The Committee recognised the significant improvement in Information Governance performance, including achievement of the Data Security and Protection Toolkit "Standards Met" rating and a reduction in audit findings.
- The Committee also welcomed the sustained improvement in environmental cleaning standards across high-risk clinical areas.

APPROVALS: Decisions and Approvals made by the Committee

The Committee approved:

- Approved the Data Security and Protection Toolkit submission.
- Reviewed and noted proposals relating to governance transition arrangements and digital governance transition.

The Board is asked to:

- Note assurance on governance transition arrangements and the ongoing risks

arising from estates capital funding constraints and digital infrastructure.

Appendix H

Report to the Care Organisation Management Committee

Care Organisation	Salisbury
Committee	Clinical Governance Committee (becoming Quality and Safety Committee)
Meeting date	30 June 2026
Author	Duncan Murray, Chief Medical Officer / Committee Chair
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance and Action
Linked to Strategic Priority(s)	Quality, safety and patient experience; workforce and clinical sustainability; operational performance
Linked BAF principal risk(s)	To be mapped against BAF: patient safety and quality; urgent and emergency care flow; maternity/neonatal services; medicines management; statutory/mandatory training
Reporting period	Clinical Governance Committee meeting held 30 June 2026

1. Executive summary

CGC scrutinised the Quality and Safety cycle of business, quarterly risk and patient safety reporting, the corporate risk register, the Integrated Performance Report, annual clinical audit and NICE reports, learning from deaths, maternity/perinatal surveillance, statutory and mandatory training, safeguarding, medicines safety, and Clinical Management Board escalation reports. The committee reviewed the Corporate Risk Register using the 5+5+5 model, focusing particularly on the effectiveness of controls. The overall result of this review was a lowering of residual risk scores with two risks (OMFS service capacity and digital VTE risk assessment recording) being removed form the CRR. Overall, the Committee noted areas of positive assurance, but draws the Management Committee's attention to continuing pressure in maternity, urgent and emergency care flow, 62-day cancer performance, aseptic services, ED pharmacy cover, spinal injury training assurance, and follow-up appointment processes.

2. Alert, Advise, Assure

2.1 Alert

- Aseptic services: the service remains fragile and high risk. External audit was due on 1 July, the service is in stage 2 performance compliance, additional posts are being supported, but refurbishment work has no confirmed timeline; the Committee should seek confirmation of risk grading, escalation route and recovery timeline.
- Maternity and obstetric theatre capacity: significant obstetric theatre capacity challenge remains, causing increased patient safety risk; an options paper is in progress. Medical compliance to BAPM standards remains at 43% due to seven-day resource and cover allocation, with a medical workforce review in progress but the action plan due in April not yet met.
- Urgent and emergency care/front door risk: the Trust was in critical incident, with risk in front door areas and heat-related operational pressure. Bed occupancy was 97.1% against a 96% target and there was an issue of escalation beds for Management Committee attention.
- 62-day cancer performance: April data showed improvement, but performance remains below both plan and target for 62-day cancer; this was identified in the meeting-end escalation summary as a significant concern.
- ED pharmacist: absence of an ED pharmacist is a national standard gap. Funding and redeployment options are being explored, and will be reported through divisional governance mechanisms.

2.2 Advise

- Spinal injury training: the training programme for immediate management of suspected spinal injury after inpatient falls is progressing, with study days planned for September, October and November and a target of training approximately 65% of staff in key areas. A formal paper is required to define standards, role-based thresholds and the assurance framework for Clinical Effectiveness Steering Group review.
- Audiology national incident: all children in the reported cohort have been followed up, with fewer than five suffering minor or moderate harm. Audiology has been asked to look further back and the recall process is in progress.
- Mandatory and statutory training: all control and process actions from the internal audit have been completed and embedded, but assurance remains a live risk: compliance was about 75% at 30 June, with level three the lowest scoring element, and there was concern about the robustness of software/system monitoring.

- Risk register methodology: 5+5+5 scoring is being implemented across BSW Group, starting with the Corporate Risk Register and then Divisional Risk Registers, but the continued rollout date is not yet clearly defined. Several risk scores and controls require refinement before onward reporting.
- Follow-up appointments: a paper on follow-up processes and validation is expected from NP for the July Quality and Safety Committee meeting.

2.3 Assure

- Quality and Safety cycle of business: the Committee noted the draft cycle of business and agreed that future escalation from Clinical Management Board is still to be determined; some reports may come to Quality and Safety Committee as AAA escalation reports.
- Clinical audit and NICE: the Annual Clinical Audit Report, Forward Plan and Annual NICE Report were noted. Divisions can monitor audit performance through Power BI dashboards and specialty reporting in AMaT; a further slide on out-of-date audits/NICE guidance and mitigations will support divisional oversight.
- Learning from deaths: the Q4 Learning from Deaths report included learning examples, which were welcomed.
- Safeguarding adults: reliable oversight of safeguarding training is now in place, with ownership moving to divisions and line managers; staff briefing and guidance are being coordinated in response to recent MCA and deprivation of liberty legal changes.
- Maternity surveillance positive controls: one-to-one care in labour and supernumerary labour ward coordinator status were maintained at 100% in May; neonatal death rate was below national rate.

3. Risk review

Note: the minutes record that risks over 10 go to Care Organisation Management Committee and risks over 12 to Group Board. The formal 5+5+5 scores from the spreadsheet are not included in the minutes, so the table below records the Committee view and required action rather than inventing scores.

3.1 Risks formally escalated to the Managing Director

Risk ID & Title	5+5+5 score	Controls assessment	Reason for escalation
6412: Risk of harm to women and babies through lack of dedicated second obstetric theatre	For review outside of meeting	Partially effective	Significant obstetric theatre capacity challenge remains, causing increased patient safety risk

3.2 Narrative on escalated risks

- Rising caesarean section rates result in increased frequency of concurrent urgent obstetric theatre demand. Suboptimal second theatre provision, and uncertainty about availability of main theatres results in delayed decision making, which could adversely impact maternal and foetal outcomes. An options paper for second theatre provision is being developed.

3.3 Risks reviewed for context

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
SFT6412 – second obstetric theatre / related controls	Clinical quality	4+5+4=13 Re-score requested	Under review	Committee felt overall risk score too high and control score too high; evidence of times to access second theatre requested.
SFT7807 – management of patients with specialist mental health needs	Clinical quality	4+3+3=10	Under review	Score felt accurate; controls may be lowered with rewording.
SFT8364 – reduction in OMFS service capacity	Operational	4+3+3=10 Likely 7 after review	Effective enough for removal from CRR	Likelihood 2, impact 3, controls 2; proposed removal from Corporate Risk Register.
SFT8264 – management of patients with reduced mental capacity	Clinical quality	4+3+3=10	Under review	Limited assurance on awareness of new legislation; controls require review.
SFT8846 – transition of CNO	Workforce	4+3+3=10	Improved with interim appointment	Risk reduced because interim CNO is in place. NJ to review
SFT8102 – central booking workforce	Operational	Appropriate	Not stated	To F&P

instability				
SFT7782 – digital recording of VTE assessment	Clinical quality	To be reduced	Improved	Controls to move to 1; proposed removal from Corporate Risk Register.
SFT8706 – quality and safety compromise due to financial recovery	Clinical quality	4+3+2=9	Under review	Actions need rewriting and risk renamed; possible second risk relating to financial challenge.

4. Good practice and innovation

- Health inequalities: good work across the Trust was detailed in the Health Inequalities Annual Report; the Committee suggested considering whether comparable reports are produced across the Group and sharing with Group NEDs.
- Clinical audit maturity: divisional oversight of audit performance through Power BI and AMaT supports more active scrutiny at divisional governance meetings, with networks continuing across Bath, Swindon and wider audit teams.
- Safeguarding and MCA response: the adult safeguarding team is coordinating guidance with local authorities and alliance partners, including recorded webinars, to respond to changes in legal requirements.

5. Committee approvals and recommendations

5.1 Approved by the Committee

- Minutes of the previous meeting were approved as an accurate record.
- The Clinical Audit Forward Plan 2026/27 was presented for approval and noted by the Committee.

5.2 Recommended to the Management Committee

- Note the escalation matters listed above and seek assurance on ownership, timescale and recovery trajectory for maternity risk, aseptic services, ED pharmacy cover, urgent/emergency care flow, 62-day cancer performance and spinal injury training.

6. Looking ahead

- July Quality and Safety Committee: paper on follow-up processes and validation from NP, including follow-up appointment booking processes.
- October Quality and Safety Committee: oversight of lessons learned, including never events, with particular reference to clinical monitoring and documentation.
- Future cycle: spinal injury training assurance framework; tissue viability deep dive in October; further review of glaucoma/cataract/laser waits in September; continued maternity/BAPM/Badgernet oversight.

Appendices: none proposed at this stage. A risk register extract should be appended once formal 5+5+5 scores and abbreviated risk descriptions have been confirmed.

Appendix H

Report to the Care Organisation Management Committee

Care Organisation	Salisbury NHS FT. Item 9.3a2
Committee	People and Culture Assurance Committee
Meeting date	25 Jun 26
Author	P A Cain, Non-Executive Chair
Reports to	Care Organisation Management Committee
Onward routing	Appendix to Managing Director's Report for Group Executive Committee and Group Board
Status	For Assurance / ~~For Decision~~ / For Information
Linked to Strategic Priority (s)	tbc
Linked BAF principal risk(s)	Tbc
Reporting period	30 Apr 26 – 25 Jun 26

1. Executive summary

There were two main themes covered - preparation for handover and assurance. For the former it was AGREED that the Committee was ready for transition to the new governance structure. In terms of ASSURANCE there is good progress in recording Safeguarding training although more work is needed before the risk is proven to be reduced. Freedom to Speak Up is strongly ASSURED but there are changes at national level and the way forward in the Group structure is not finalized and we must protect the strong FTSU ethos. Two areas of good practice were noted – the People Promise and Trust's work experience program. Both of these should be considered at Group level, although as the CPO was present at the meeting this may already be in progress. There are no decisions or risks for elevation.

2. Alert, Advise, Assure

2.1 Alert

There are no matters to alert the Care Organisation Management Committee.

2.2 Advise

- The People governance structure was briefed, including the introduction of a Care Organisation People and Organisational Development (POD) meeting in response to concerns. The TORs had been updated and were APPROVED with one outstanding

action to resolve any differences between the TORs of each Group member. Initial handover between Chairs was completed and will continue into the new cycle as the Chairs swap. It was AGREED that sufficient progress has been made to be confident that the Committee is ready to start in its new form in Jul 26 but may need to evolve with further experience.

- The Committee AGREED to close the Audit and Fraud Report audit, noting the approval of a 12-month extension for the outstanding workforce controls actions and the absence of a live medical rostering system which created challenges for compliance with national Guardian of Safe Working reporting requirements. Progress should be monitored through the People and Culture Committee with oversight via Management Committee.

- The Workforce Operational Plan was reviewed. There was some improvement with ongoing work to improve workforce control, agency compliance, and alignment with financial and staffing plans. An action was AGREED to investigate whether benchmarking data for recruitment and workforce can be obtained from sources other than Model Hospital, specifically for comparison with similar trusts like Dorset County or Kings Lynn.

- The IPR showed limited movement over the last two months across key workforce indicators, including vacancy levels, sickness absence, and turnover and the effect of ongoing pressures were noted.

- The Tent Talks and Open Day received strong positive feedback.

- A proposed People prioritisation framework was discussed and APPROVED with the addition of a more explicit reference to culture. The framework sets out four levels from highest priority - Protecting the Trust; Transforming services; Sustaining strategy and improvement; and Other. These provide transparency of support and workload management during transition.

2.3 Assure

- The Committee noted the ASSURANCE provided by the closure report from the MLE review relating to Safeguarding training process but added a follow-on action requesting that training completion rates were monitored and progress reported quarterly to the committee to ensure risk 8344 could be closed.

- The Freedom to Speak Up report was APPROVED noting worker safety and wellbeing concerns are increasing, reflecting a national trend and aligning with wider observations on rising anxiety and stress levels. The closure of the National Guardian's Office and transition of reporting arrangements to NHS England, with all FTSU data to be centrally collated and triangulated nationally, was highlighted. An action was AGREED to ensure the triangulation of FTSU data with patient experience and patient safety teams as well as strengthening triangulation between clinical and non-clinical speaking-up intelligence.

3. Risk review

3.1 Risks formally escalated to the Managing Director

No new risks to be elevated.

Risk ID & Title	5+5+5 score	Controls assessment	Reason for escalation

3.2 Narrative on escalated risks

No new risks to be elevated.

3.3 Risks reviewed for context (scoring 10–11)

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
8780: Capacity of HR and change management resources to support transformation	[Strategic / Operational / ~~Compliance~~]	11	[~~Effective~~ / Partially effective / ~~Ineffective~~]	Scoring and controls reviewed and agreed
7472: Failure to deliver a sustainable Workforce – Corporate Risk register entry	[Strategic / Operational / ~~Compliance~~]	10	[~~Effective~~ / Partially effective / ~~Ineffective~~]	Scoring and controls reviewed and agreed
8653: Temporary staffing service is unable to provide basic and extended hours coverage due to insufficient staff	[~~Strategic~~ / Operational / ~~Compliance~~]	10	[~~Effective~~ / Partially effective / ~~Ineffective~~]	Scoring and controls reviewed and agreed
8344: Mandatory / Statutory training reporting from MLE lacks assurance in accuracy	[~~Strategic~~ / Operational / Compliance]	7	[~~Effective~~ / Partially effective / ~~Ineffective~~]	Score reviewed down from 10 by ODP Management Board and agreed by Committee. Further reduction requires

Risk ID & Title	Category	5+5+5 score	Controls assessment	Committee view
				evidence of training completion.

4. Good practice and innovation

- People Promise – Significant progress over the four-year program, including delivery of more than 30 projects and improvements reflected in staff survey results. Transition to BAU needs to be aligned with a new Group People Plan. The Committee were impressed by the efforts and expressed a desire to see this continue on in some form which the Group will need to take forward. This should be monitored to ensure gains and best practice are not lost.

- An update on the Trust's work experience program highlighted significant expansion since 2019. Participation has increased from 19 schools and 60 individuals to 44 schools and over 200 participants, with a strong increase in representation from local comprehensive schools and the wider community. The activities of the team are commendable and other Group members may wish to consider a similar approach if not already doing so.

5. Committee approvals and recommendations

5.1 Approved by the Committee

- TORs APPROVED 25 Jun 26 and readiness for the new governance structure AGREED
- Closure of the Audit and Fraud Report audit AGREED with one follow on monitoring action.
- The Freedom to Speak Up report was APPROVED with an action to increase triangulation.
- People workload prioritization matrix APPROVED to support transparency of activity during transition.

5.2 Recommended to the Management Committee

- *There are no escalations to the Management Committee for decision or action.*

6. Looking ahead

DRAFT People Committee Forward Planner 2026 - BSW Hospitals Group											
Item / Report	Governance Purpose (Information/Discussion/ Assurance/Approval)	Frequency	Speciality	Lead	Jan	Mar	May	Jul	Sep	Nov
Governance										
People Services Audit Progress Update	Assurance	Annual	Corporate Governance				✔			✔
People Services Audit Completed Actions Review	Assurance	Annual	Corporate Governance			✔				
Board Assurance Framework (BAF)	Assurance	Quarterly	Corporate Governance		✔	✔		✔	✔	
Risks 15+ Report	Assurance	Quarterly	Corporate Governance		✔	✔		✔	✔	
Committee Terms of Reference	Approval	Annual	Corporate Governance				✔			
Meeting Effectiveness	Information	Annual	Corporate Governance				✔			
Forward Planner Review	Approval	Annual	Corporate Governance							✔
People Services										
Annual Leadership Report	Assurance	Annual	HR Design					✔		
Annual Education & Training/Mandatory Training Report	Assurance	Annual	HR Design		✔					
Annual Health & Wellbeing Report	Assurance	Annual	HR Design							✔
Care Organisations Staff Survey Update (Headlines)	Assurance	Annual	HR Design			✔				
Care Organisations Divisional Staff Survey Update (Headlines)	Assurance	Annual	HR Design			✔				
Care Organisations Staff Survey Update (Action Plans)	Assurance	Annual	HR Design				✔			
Care Organisations Divisional Staff Survey Update (Action Plans)	Assurance	Annual	HR Design				✔			
EDI Annual Report	Approval	Annual	HR Design						✔	
Annual Employee Relations Report	Assurance	Annual	People Operations					✔		
People Services KPI/SLA's Dashboard	Assurance	Bi Annual	People Operations				✔			✔
People Services KPI/SLA's Dashboard	Assurance	Bi Annual	HR Design				✔			✔
People Services KPI/SLA's Dashboard	Assurance	Bi Annual	Workforce Management				✔			✔
Annual Resourcing Plan	Information	Bi Annual	People Operations							✔
Annual Workforce Plan	Assurance	Bi Monthly	Workforce Management		✔	✔	✔	✔	✔	✔
Strategic Workforce Plan	Assurance	Annual	Workforce Management					✔	✔	
Workforce IPR	Assurance	Bi Monthly	People Operations							
Annual Flu Report	Assurance	Annual	HR Design					✔		
People Services DPR	Assurance	Bi Annual	All			✔			✔	
People Services Improvement Projects	Approval	Bi Monthly	All							
People Plan Update	Approval	Bi Monthly	All		✔	✔	✔	✔	✔	✔
People Services Items (Directly to Joint Committee)										
People Services Procedural Report	Assurance	Bi Monthly	People Operations		✔	✔	✔	✔	✔	✔
Reports from External to People Function										
Annual Job Planning	Assurance	Annual	Other	CMO		✔				
Annual NETS Survey Results	Assurance	Annual	Other	CMO/CNO			✔			
Annual Guardian of Safe Working Report	Assurance	Annual	Other	CMO				✔		
10 Point Plan - IWLD	Assurance	Annual	Other	CMO					✔	
Annual Undergraduate Report	Assurance	Annual	Other	CMO						✔
Annual Postgraduate Report	Assurance	Annual	Other	CMO						✔

Appendices (optional)

None.

BSW Group Board

Agenda item	9.3 B
Report title	Proposed SFT Constitutional Amendment: Senior Independent Director and Deputy Chair
Date of meeting	3 September 2026
Sponsor	Nick Johnson, Managing Director
Prepared by	Kylie Sanders, Head of Corporate Governance SFT Caroline Coles, Company Secretary GWH
Approval Process: (where has this paper been reviewed and approved)	Approved at SFT CoG 20th July 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

KEY MESSAGES

This paper seeks Board approval for 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 and Board Standing Orders and supports good governance, succession planning, and alignment with the NHS Foundation Trust Code of Governance, particularly in the context of the developing BSW Group governance arrangements.

Approval by both the Council of Governors and SFT Board of Directors is required under paragraph 43.1 of the Constitution. This paper was supported by the SFT Council of Governors on 20 July 2026 and the Board is therefore is asked to approve the proposed constitutional amendments, which are intended to clarify existing governance arrangements rather than introduce any substantive change to the statutory responsibilities, powers, or accountabilities of the Board of Directors, Council of Governors, or Trust members.

RECOMMENDATION

The SFT Board is asked to:

[State clearly what is being asked, using Receive / Note / Approve / Endorse.]

1. **APPROVE** 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.

APPENDICES

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

Salisbury NHS Foundation Trust

Salisbury NHS Foundation Trust

Proposed Constitutional Amendment: Senior Independent Director and Deputy Chair

Meeting	Group Board 3 September 2026. Item 9.3B
Paper for	Discussion and approval
Lead	Head of Corporate Governance
Version	v0.2
Classification	Official

1. Purpose

This paper invites the SFT Board to consider and approve a proposed amendment to the Trust's Constitution that resolves an internal inconsistency in the provisions governing the **Senior Independent Director (SID)** and the **Deputy Chair**, and that permits these two roles to be held as separate positions.

2. Background – the inconsistency

The current Constitution (V.2.6) addresses the Senior Independent Director role in two different places, and the two are not aligned:

- **Paragraph 26.1 (binding body of the Constitution)** merges the SID function into the Deputy Chair role. It provides that the Board appoints a Deputy Chair who "shall also have the functions previously exercised by the Senior Independent Director." On this reading, there is no separate SID — the function sits with the Deputy Chair.
- **Annex 8, section 2.2 (Board Standing Orders)** retains a free-standing SID office, stating that the Board "should… appoint a Non-Executive Director to be the Senior Independent Director," with its own resignation and replacement mechanics — treating SID as a distinct role that a non-executive director can hold and step down from independently.

These provisions cannot operate together cleanly. Under Annex 8 a non-executive director could resign as SID while remaining Deputy Chair, directly contradicting the merger of the two roles in paragraph 26.1. Annex 8 standing orders are expressly *not* part of the Constitution (paragraph 1.5), so paragraph 26.1 prevails — but the residual Annex 8 wording is a drafting inconsistency that should be corrected.

A related, minor issue is terminology: the body of the Constitution refers to the "Deputy Chair," whereas Annex 8 refers in places to the "Vice Chair." These are intended to mean the same role but are not harmonised.

3. The case for change

There are three reasons to act now:

- **Clarity and good governance.** The Constitution should describe each board role unambiguously. The current drafting leaves it unclear whether the Trust has a standalone SID or a combined Deputy Chair / SID.
- **Alignment with the Code of Governance.** The NHS Foundation Trust Code of Governance envisages a clearly identified SID. Separating the role from the Deputy Chair allows the Trust to follow that expectation where it wishes to.
- **Group transition.** As BSW moves to its Group structure, board roles are under review and joint or group appointments are anticipated. Flexibility to hold the SID and Deputy Chair as separate positions supports robust succession planning and avoids concentrating governor-facing and board-facing functions in a single individual.

  This amendment also aligns the appointment of Vice-Chair with the practice at other Group organisations, strengthening the role of the Council of Governors in relation to Non-Executive Directors leadership appointments.

4. The proposed amendment

The amendment does two things: it re-establishes the SID as a discrete office within the binding body of the Constitution, and it expressly allows the SID and the Deputy Chair to be held by the **same or by different** non-executive directors. Both appointments are made by the Board, from among the non-executive directors, in consultation with the Council of Governors.

Revised Paragraph 26 (proposed):

26. Board of Directors – Deputy Chair and Senior Independent Director

26.1 The Council of Governors shall appoint one of the Non-Executive Directors to be the Vice-Chair, for such period not exceeding their term of office as a Non-Executive Director.

26.2 The Board of Directors shall appoint one of the non-executive directors as the Senior Independent Director, in consultation with the Council of Governors. The function of the Senior Independent Director is, in particular, to act as a means of communication between the non-executive directors and the governors, and to provide a sounding board for the Chair.

26.3 The roles of Vice-Chair and Senior Independent Director may be held by the same non-executive director or different non-executive directors, as the Board of Directors determines following consultation with the Council of Governors.

26.4 A non-executive director may resign from the office of Vice-Chair or Senior Independent Director at any time by giving notice in writing to the Chair, without thereby resigning as a non-executive director. The Board of Directors may thereupon, in consultation with the Council of Governors, appoint another non-executive director to the office in question.

Consequential amendment to Annex 8 (proposed):

Annex 8, section 2.2 is amended to remove the conflicting free-standing appointment and to cross-refer to paragraph 26, so the two parts of the document can no longer contradict one another. The same change harmonises the “Vice Chair” / “Deputy Chair” terminology.

Annex 8, section 2.2 (proposed)

Vice-Chair

The Council of Governors shall appoint a Vice- Chair in accordance with paragraph 26 of the Constitution.

Senior Independent Director

The Board of Directors shall appoint a Senior Independent Director in accordance with paragraph 26 of the Constitution. The Deputy Chair and the Senior Independent Director may be the same person or different persons, as provided in paragraph 26 of the Constitution.

5. Effect of the amendment

- Resolves the contradiction between paragraph 26.1 and Annex 8 section 2.2.
- Establishes the SID as a clearly defined office in the binding part of the Constitution.
- Permits the Deputy Chair and SID to be held separately, while retaining the flexibility to combine them.
- Aligns the “Deputy Chair” and “Vice Chair” terminology.
- Makes no change to who appoints these roles: in both cases the Board, from the non-executive directors, after consultation with the Council of Governors.

6. The Council of Governors’ role in approval

Under paragraph 43.1, an amendment to the Constitution requires the approval of more than half of the members of the Council of Governors voting, and more than half of the Board of Directors voting.

This amendment is not considered a significant change to the Constitution, as it does not alter the statutory roles, powers or accountabilities of the Board of Directors, Council of Governors or members. The amendment clarifies and aligns internal governance arrangements, including the appointment of the Vice Chair and Senior Independent Director, and resolves an existing inconsistency. Accordingly, approval by the Board of Directors and Council of Governors under paragraph 43.1 is sufficient. The amendment will be reported to members for transparency at the next Annual Members’ Meeting.

7. Recommendation

The SFT Board is asked to **APPROVE** the proposed amendment to paragraph 26 and the consequential amendment to Annex 8, section 2.2, as set out in section 4. The revised constitution will then be published on the Trust’s website.

BSW Hospitals Group Board

Agenda item	10.3
Report title	Questions from Members of Public
Date of meeting	3 September 2026
Sponsor	Paul von der Heyde, Group Chair
Prepared by	Caroline Coles, Company Secretary GWH
Approval Process:	Chief Nurse, GWH

☐ 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.

APPENDICES

None

Questions from Member of the Public submitted to BSW Hospitals Group Board

Answers provided in italics

Great Western Hospitals NHS FT from Derek White, Trust Member in respect of the CQC report for many years states that GWH "Requires improvement"

The CQC published the Trust's updated ratings on the 10 July 2026 which rated the Trust overall as 'Good' with Maternity and Urgent and Emergency Care (UEC) rated as "Requires Improvement". This is a significant achievement for the Trust and demonstrates significant focus on driving quality and high standards of care for our patients. There are specific actions in place to drive the improvement in Urgent Emergency Care (UEC) and Maternity to ensure they achieve the rating of good at the next inspection.

1. **How do you know your organisation has an effective quality/patient safety management system?**

   In line with best practice and national guidance the Trust has the following structures in place to monitor patient safety and outcomes:

   Patient Safety Incident Framework (PSIF) to focus on all events that don't go well and ensure learning is embedded, including a weekly Trust wide learning from incidents meeting.

   Clinical audit, including participation and benchmarking with national audit programmes, mortality reviews and learning from deaths.

   Nursing audit and ward accreditation programmes.

   Monthly review of quality metrics through the Trusts Integrated Performance Report.

   Governance structures that provide assurance, oversight and scrutiny.

   Local and national benchmarking of quality metrics.

   Listening to patients and their feedback and triangulation with the metrics.

External scrutiny by our regulators such as CQC NHSE and the Integrated Care Board (ICB), who sit on our quality meetings, also helps ensure we are monitoring quality outcomes effectively.

2. Can you show the documented processes, owners, controls, performance measures, risks, audits, management reviews and evidence of effectiveness?

Yes. The Trust has a governance structure that captures this, monitors it for effectiveness and can supply as evidence if required. There are electronic systems in place to support the oversight of compliance with the processes. CQC inspections ask for the evidence of the above following all inspections.

3. Is quality being managed as a system, or is it being pursued through a collection of projects and initiatives?

Quality is managed as an integrated system rather than through a collection of standalone projects. The Trust triangulates information from multiple sources, including quality, safety, operational, workforce and patient experience data, to provide a comprehensive understanding of performance at service, divisional and organisational level.

Oversight and assurance are provided through the Quality and Safety Committee, which reviews themes, trends, risks and outcomes across the organisation and seeks assurance that appropriate actions are in place where concerns are identified.

Where improvement is required, the Trust uses its Improving Together quality improvement approach to support sustainable change. This has been applied to areas such as falls and deconditioning, as well as the current 'What Matters to You' campaign, which is helping to strengthen personalised care by ensuring services are designed around patients' individual needs and preferences.