TRUST BOARD

Thursday 11 June 2026, 9.30am to 12.45pm
By MS Teams

AGENDA

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

		PAGES	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Apologies from Cara Charles-Barks, Andy Hollowood	Verbal	PVDH	-	09:30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	PVDH	-	-
3.	**Minutes of the previous meeting (public)** Paul Von der Heyde, Chair • 9 April 2026 (draft)	✓	PVDH	Approve	-
4.	**Outstanding actions of the Board (public)**	✓	PVDH	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	None	PVDH	-	-
6.	**Staff Story – Improving breast feeding to new mothers** Kath Townsend, Infant Feeding Specialist Midwife	✓		Receive	09:40
7.	**Chair's Report** • **Fit & Proper Person Test Compliance 25/26** Paul Von der Heyde, Chair	✓	PVDH	Note	10:15
8.	**Chief Executive's Report** • **GWH Medium Term Financial Plan (MTFP) – Contract conditions and the Trust's response** Cara Charles-Barks, Chief Executive Lisa Thomas, Managing Director	✓	CCB/ LT	Note	10:25
BREAK (10 minutes) at 11.00 to 11.10am					
9.	**Integrated Performance Report** • Performance, Population & Place Committee Board Assurance Report (April 2026) – Bernie Morley, Non-Executive Director & Committee Chair	✓	BM	Assurance	11:10

		PAGES	BY	ACTION	TIME
	• Quality & Safety Committee Board Assurance Report (April & May 2026) – Claudia Paoloni, Non-Executive Director & Committee Chair	✓	CP	Assurance	
	• People & Culture Committee Board Assurance Report (May 2026) – Julian Duxfield, Non-Executive Director & Committee Chair	✓	JD	Assurance	
	• Finance, Infrastructure & Digital Committee Board Assurance Report (April & May 2026) – Faried Chopdat, Non-Executive Director & Committee Chair	✓	FC	Assurance	
	• Integrated Performance Report	✓	All	Receive	
10.	**Charitable Funds Committee Board Assurance Report (May 2026)** Julian Duxfield, Non-Executive Director and Committee Chair	✓	JD	Assurance	11:40
11.	**Staff Survey Results 2025** Jude Gray, Chief People Officer Angela Morris, Senior People Partner, Medicine Division *(received at People & Culture Committee 27 May 2026)*	✓	JG/AM	Assurance	11:50
12.	**Resident Doctor Peer Lead Board Report** Kathryn Bateman, Chief Medical Officer Lynsey Hewitson, Chief Registrar & Eleanor Tindall, Chief Registrar *(received at Medical Staff Support Group 3rd June 2026)*	✓	KB/LH	Approve	12:10
13.	**Delegation of authority for approval of Annual Report & Accounts 2025/26** Simon Wade, Chief Financial Officer	✓	SW	Approve	12:30
14.	**Statutory Governance Framework Report to support the implementation of BSW Hospitals Group** Simon Wade, Chief Financial Officer and Caroline Coles, Company Secretary	✓	SW/CC	Approve	1245
CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**					
15.	**Ratification of Decisions made via Board Circular/Workshop** Caroline Coles, Company Secretary	None	CC	Approve	-
16.	**Urgent Public Business (if any)** To consider any business which the Chair has agreed should be considered as an item of urgent business	Verbal	LC	-	-
17.	**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”*	-	-	-	-

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

Present:

Liam Coleman (LC)	Chair
Kathryn Bateman (KB)**	Chief Medical Officer
Cara Charles-Barks (CCB)	Chief Executive (part)
Chris Burton (CB)	Non-Executive Director
Faried Chopdat (FC)**	Non-Executive Director/Deputy Chair
Julian Duxfield (JD)	Non-Executive Director
Mark Ellis (ME)	Chief Risk Officer
Luisa Goddard (LG)	Chief Nurse
Sandra Gordon (SG)**	Non-Executive Director
Jude Gray (JG)*	Chief People Officer
Jonathan Hinchliffe (JH)*	Chief Digital & Transformation Officer
Andrew Hollowood (AH)*	Chief Clinical Transformation Officer
Bernie Morley (BM)	Non-Executive Director
Claudia Paoloni (CP)**	Non-Executive Director/Senior Independent Director
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Paul von der Heyde (PVDH)	Chair Designate, BSW Hospitals Group
Simon Wade (SW)	Chief Financial Officer

In attendance:

Neil Clark (NC)*	Associate Non-Executive Director
Caroline Coles (CC)	Company Secretary
Rob Presland (RP)	Deputy Chief Operating Officer (deputising for Benny Goodman)
Samaher Sweity (SS)*	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Tania Currie	Head of Patient Experience & Engagement (item 006/26)
Gemma Cruz	Matron, Critical Care Unit (item 006/26)
Emma Shaw	Ward Manager, Critical Care Unit (item 006/26)
Kat Simpson	Director of Midwifery & Neonatal Services (item 011/26)

Apologies:

Emily Beardshall (EB)*	Acting Chief Officer of Improvement & Partnerships
Judy Dyos (JDy)	Chief Nursing Officer
Benny Goodman (BG)	Chief Operating Officer
Lisa Thomas (LT)	Managing Director

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

Number of members of the Public: None

Matters Open to the Public and Press

Minute	Description	Action
001/26	**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.	
002/26	**Declarations of Interest** There were no declarations of interest.	

DRAFT

Minute	Description	Action

003/26 **Minutes of the previous meeting (public)**

The minutes of the Board meeting held in public on 12 March 2026 were adopted and agreed as a correct record, subject to the following amendments:

Attendance - amend register to registrar

Minute No. 187/25 – Chief Executive's Report
First paragraph, second sentence to be amended to read: "A financial variance of £8.5m was reported, however it was noted that the Group remained on track to meet a revised forecast outturn of -£42m, against a stretch plan agreed with NHSE at the start of the year of -£14.6m."

Minute No. 190/25 – Charitable Funds Committee Board Assurance Report
Sixth paragraph, first sentence to be amended to read: "Chris Burton, Non-Executive Director raised a question regarding the continuation of funding for the Defence Medical Welfare Service."

004/26 **Outstanding actions of the Board (public)**

The Board received and considered the outstanding action list. No updates or amendments were provided.

005/26 **Questions from the public to the Board relating to the work of the Trust**

There were no questions from the public to the Board.

006/26 **Care Reflection – Critical Care**

Tania Currie – Head of Patient Experience & Engagement, Emma Shaw – Ward Manager, Critical Care Unit, and Gemma Cruz, Matron, Critical Care Unit joined the meeting to present this item.

The Board received a care reflection story on a patient experience which described a sudden and life-threatening illness, the fear and vulnerability experienced, and the exceptional care, compassion, and professionalism of the clinical team, which was credited to saving the patient's life and supporting his full recovery and return to normal activities.

Questions were raised by the Board members regarding diagnosis, communication, and whether the patient had sufficient understanding of his condition, with assurance given that staff were transparent and that the severity of illness can limit patients' ability to retain information.

The Board reflected on the importance of compassionate care, realistic expectation-setting, and learning from positive feedback as well as concerns. It was also confirmed that the experience had been widely shared with staff through training and governance forums.

The Chair thanked Tania Currie, Gemma Cruz and Emma Shaw for their presentation of a patient experience which members found inspiring and reflective of high-quality critical care.

The Board **noted** the staff story.

007/26 **Chair's Report**

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

- Sarah Marshall had resigned from the role of Wiltshire Northern Constituency Governor Representative.
- Chris Burton, Non-Executive Director also attended the Board Safety Visit to Ampney Ward on 4 March 2026.

Minute	Description	Action

The Board also received the annual review of the Declarations of Interest of Trust Board Directors as at March 2026. It was noted that this was a live document, and Board members were reminded of the need to keep it regularly updated, as there was a requirement for it to be published on the Trust website.

The Board **noted** the report.

008/26 **Chief Executive's Report**

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

Cara Charles-Barks, Chief Executive reported that the organisation was emerging from a challenging winter period and outlined key areas of risk, including ongoing pressures in urgent and emergency care and elective services. Corridor care remained a significant concern and RTT performance had deteriorated, with an increase in waiting lists, and it was reported that an agreed recovery plan was in place.

The financial position remained in line with forecast, with the Trust reporting a £12m deficit, consistent with the system-wide forecast. The Trust remained in segmentation rating 3 under the NHS Oversight Framework. Work was underway to review performance against the framework to support improvement in quality, performance and financial sustainability.

It was reported that staff survey results showed a strong response rate and compared favourably with peers. Areas for improvement were acknowledged, including support for staff from global majority backgrounds and strengthening career progression opportunities.

The Board noted that strategic priorities remained unchanged, with progress noted in clinical transformation, corporate services consultation, and quality initiatives, including reduced inpatient falls and maternity and neonatal improvements.

Board members queried the potential impact of ICB service changes, including the Referral Support Service. It was confirmed that the full impact was not yet known, with planned executive discussions with the ICB to clarify risks and mitigation. Concerns were also raised regarding organisational resilience, staff wellbeing, and sustained critical incidents. The Chief Executive acknowledged these risks and outlined a refreshed urgent and emergency care recovery programme focused on improved flow, reduction in corridor care, strengthened discharge processes, and increased use of community and virtual capacity.

Liam Coleman, Chair, noted that hospital at home and virtual ward capacity was currently operating at around 50–60%, which may not fully reflect the level of use anticipated across the system. Cara Charles-Barks, Chief Executive, outlined a number of challenges which included variation in commissioning models, differing clinical risk appetites, limited IT interoperability, and restricted access to consultant oversight. It was noted that higher utilisation achieved elsewhere suggested these challenges could be addressed. The Board agreed that a collaborative improvement approach with system partners to tackle these barriers was required.

Chris Burton, Non-Executive Director, asked what the Trust was doing internally to eliminate delays in patient care and how the Board would gain sufficient assurance in the new arrangements, given that urgent and emergency care is a key risk requiring improvement ahead of winter. Cara Charles-Barks, Chief Executive confirmed that Board oversight would be strengthened through Managing Director reports, risk and assurance reporting, and regular deep dives on performance and improvement actions. It was noted that at GWH, the Right Care Transformation programme continued to progress, supported by a communications campaign, strengthened clinical leadership, and leadership development activity. This would be closely monitored and reported to ensure readiness ahead of the autumn period.

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Minute	Description	Action

Claudia Paoloni, Non-Executive Director raised concerns about the impact of corridor care and planned capacity expansion on staffing, questioning whether the GWH's core establishment, historically under-resourced, was being reconsidered to ensure safe monitoring within financial constraints. Luisa Goddard, Chief Nurse confirmed that robust safe staffing processes were in place and assured the Board that the modular unit would not open until fully staffed. It was also confirmed that staffing headroom was being reviewed to improve resilience ahead of next winter, with patient safety prioritised.

Bernie Morley, Non-Executive Director, queried how negotiations with HCRG were being coordinated to address system flow issues and ensure a consistent, effective partnership, noting this remained a key risk. Cara Charles-Barks, Chief Executive, confirmed that discussions were being led through executive-to-executive engagement with the ICB to clarify contractual expectations and strengthen accountability, supported by system recovery forums and Chair and CEO meetings with partners.

Mark Ellis, Chief Risk Officer, provided an update on governance readiness for the new Group structure, including the introduction of a "safe to start" gateway process to assess readiness across governance arrangements, organisational culture, and key risks. Early feedback highlighted the need for greater detail at care organisation level. This process was overseen by the executive-led governance task and finish group, with scrutiny from the NED reference group. The BSW Joint Committee would ultimately recommend to the three care organisation Boards whether readiness to proceed had been achieved.

The Chair provided an update on recruitment to Group Non-Executive Director roles, noting that following an expression of interest process, the required number of current Non-Executive Directors had applied. As a result, no external recruitment was required at this stage. The next step was to complete the relevant governance processes, including approval by the Councils of Governors.

The Board **noted** the report.

009/26 **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 February 2026.

Board Assurance Reports

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 23 March 2026 and the following was highlighted.

The Group's challenging financial position was reported as an escalating risk heading into the next financial year. It was noted that Non-Executive Directors had questioned whether current arrangements were sufficient and requested that consideration be given to establishing a dedicated Group Finance Committee to support sustained financial recovery and planning.

The Board also received an update on the Month 12 position and noted that, despite some fluctuations arising from escalation issues earlier in the year, confidence was high that the revised forecast outturn would be delivered as planned. The reported capital overspend was confirmed as agreed and planned within system discussions, rather than unplanned variance.

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Minute	Description	Action

The Board noted that the financial plan for the coming year was extremely challenging, with significant efficiency requirements and the need to reduce the pay bill by approximately £2m by year end. Turnaround support had been engaged to strengthen delivery and governance. It was further noted that delivery of the current year's plan alone would not resolve the underlying deficit, and that a balance was required between short-term actions and longer-term sustainability.

The Board **noted** the report.

Integrated Performance Report
The Board noted the IPR and key issues captured in the summary. Chris Burton, Non-Executive Director raised concern about the high number of patients waiting over 52 weeks and sought assurance on prioritisation and validation. It was advised that all patients were under clinical review and a fully validated position would be available following completion of the March 2026 data, together with ongoing actions to reduce very long waits. Other operational metrics, including cancellations, emergency performance, elective length of stay and diagnostics, were acknowledged as being managed through existing recovery plans.

People metrics were also discussed, including medical and dental staffing reported above plan. It was explained that this reflected strike cover, locally employed doctors and increased less-than-full-time working rather than substantive over-recruitment.

Chris Burton, Non-Executive Director also queried how performance objectives and metrics would operate within the developing Group model. It was confirmed these would be refreshed as part of the 2026/27 planning process and explored further at a forthcoming joint board session. Staff engagement during transition to a Group model was also discussed, with assurance provided that survey data showed improving understanding and that actions were in place to strengthen communication and engagement going forward.

Our Care
Quality & Safety Committee Chair Overview
The Board received an overview of the detailed discussions held at the Quality & Safety Committee (QSC) at its meeting on 19 March 2026 and the following was highlighted:

The Board noted sustained reductions in reported harms since 2024, including improvements in infection control, pressure ulcers, medication safety and learning from deaths, despite continued operational pressures. The Board also noted emerging signs of plateau and deterioration in some areas, attributed to sustained demand, discharge constraints and workforce capacity pressures.

Key challenges were highlighted in relation to patient deterioration and critical care pathways, including ongoing risks in stroke pathways, delays in escalation to ICU, and sepsis recognition. An external review into mortality associated with orthopaedic fractures had been completed, with initial recommendations received and work commenced on implementation, noting that some actions related to infrastructure issues.

The Board noted receipt of a letter from the National Critical Care Group which had highlighted delays to admission to ICU with reported high levels of organ failure. While the issues were known locally, it had reinforced the need for more decisive action and measurable improvement. Board members questioned how assurance would be maintained at Group level and how recovery actions would be monitored for impact. It was confirmed that escalation would be provided through rules-based performance triggers, risk registers, regulatory correspondence and group reporting, with additional assurance from strengthened risk oversight, deep dives and non-executive director engagement.

The Board **received** the report.

DRAFT

Minute	Description	Action
010/26	**Learning from Deaths Q3 2025/26**	

The Board received and considered the quarterly report on Learning from Deaths for the Trust.

Kathryn Bateman, Chief Medical Officer reported that the Summary Hospital-level Mortality Index (SHMI) data for the period October 2024 to September 2025 had remained within the expected range. An internal review of deaths had confirmed that the number of patients dying in hospital followed normal winter trends. Improvements in learning from deaths were reported, including strong engagement with Structured Judgement Reviews (SJR) and positive practice in involving families and patients in end-of-life care discussions, although communication remained an area for improvement. It was noted that some SJR meetings had been delayed due to critical incidents, but assurance was given that these were now back on track.

Clarification was provided that trust-level anomalies would continue to be identifiable through individual trust data within the revised reporting framework, supporting escalation through existing assurance processes. Ongoing work was noted to triangulate mortality data with discharge and readmission learning, and the importance of strengthening system learning and rapid adoption of best practice was emphasised. Planned joint learning from deaths meetings across the Group were noted as a key action to support this.

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

011/26 **Perinatal Service Update (April 2026)**

Kat Simpson, Director of Midwifery & Neonatal Services joined the meeting to present this item.

The Board received and considered an overview for the Board outlining initial feedback from the CQC inspection in January 2026, current position against national maternity reports and Trust position against Ockenden Immediate and Essential Actions (IEAs). The Board noted the current position and progress against national reports and the impact on the development of the perinatal services to make care safer, more personalised and more equitable.

Kat Simpson reported that although the draft CQC inspection report was awaited, verbal feedback had aligned with existing priorities and that early actions had been identified, which included strengthened telephone triage, exploring estate options to expand triage capacity, infection prevention improvements and changes to breast milk storage following engagement with service users.

The Board noted national changes to the Maternity Incentive Scheme (now the Perinatal Incentive Scheme) with a stronger focus on safety outcomes, governance and escalation. Gap analysis against the new standards was underway. A key challenge had been identified in meeting British Association of Perinatal Medicine (BAPM) staffing standards due to increased neonatal acuity, with an options appraisal in progress and acknowledgement that additional workforce investment would be required. Progress against Ockenden actions was noted, with no ‘red’ RAG actions and continued monitoring.

In response to a question raised by Samaher Sweity, Associate Non-Executive Director regarding patient involvement and equity, it was confirmed that service users were embedded within perinatal governance through established engagement groups, and that local and national data showed no disproportionate adverse outcomes for women from ethnic minority or deprived backgrounds.

Luisa Goddard, Chief Nurse also provided assurance that learning from coroner cases was embedded within perinatal quality governance and action tracking.

Minute	Description	Action
	The Board **noted** the report.	
	Consent Items *Consent Items Note – these items are provided for consideration by the Board. Members were asked to read the papers prior to the meeting and, unless the Chair / Company Secretary received notification before the meeting that a member wished to debate the item or seek clarification on an issue, the items and recommendations would be approved without debate at the meeting in line with the process for Consent Items. The recommendations would then be recorded in the minutes of the meeting.*	
012/26	**Ratification of Decisions made via Board Circular** None.	
013/26	**NHSE Licence Self-Certification – CoS7 (2026/27)** The Board received a self-certification for Board approval prior to publication. The self-certifications was: • Condition CoS7(3) – Providers providing Commissioner Requested Services (CRS) have to certify that they have a reasonable expectation that required resources will be available to deliver designated services. Simon Wade, Chief Financial Officer, reported that the financial plan 2026/27 productivity target figure identified in the "statement of main factors taken into account in making the above declaration" related to the RUH only and clarified that the correct figure for GWH should be £47.2m, representing 88.9% of turnover. ***RESOLUTION:*** ***The Board approves the annual self-certification for CoS7(3), subject to the amendment to the productivity target figure.***	
014/26	**Urgent Public Business (if any)** None.	
015/26	**Date and Time of next meeting** It was noted that the next meeting of the Board would be held on 11 June 2026 at 9.30am	
016/26	**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 12.25hrs

DRAFT

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – June 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**
None				

Future Actions				
None				

Report Title	UNICEF UK Baby Friendly Gold Initiative Gold Award			
Meeting	Trust Board			
Date	11/06/2026	Part 1 - Public ☐		Part 2 - Private ☐
Accountable Lead	Kat Simpson, Divisional Director Midwifery and Neonatal			
Report Author	Kath Townsend, Infant Feeding Specialist Midwife			
Appendices	1			

Purpose

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

Assurance Level

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

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

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

The UNICEF UK Baby Friendly Initiative Gold award is recognition of achieving sustainability of the Baby Friendly Standards in Maternity. 1 of 11 maternity units in England that has this award.

Report

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

The attached presentation cover the following areas:

- Background information on UNICEF UK Baby Friendly Initiative
- The Impact of Baby Friendly accreditation
- The Baby Friendly Journey
- Achieving sustainability and alignment with CQC domains and GWH Trust values, visions and priorities of the Trust.
- The Baby Friendly Gold award, report attached.

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

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

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

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

Explanation of above analysis:

The Baby Friendly Initiative promotes inclusion of all protected characteristics.

Recommendation / Action Required

The Board/Committee/Group is requested to:

For awareness and celebration of the success of the Great Western Hospitals NHS Foundation Trust Maternity Department

Accountable Lead Signature	Kat Simpson, Divisional Director Midwifery and Neonatal
Date	**04/06/2026**

The Gold Award

UNICEF UK Baby Friendly Initiative for Maternity

Kath Townsend

Infant Feeding Specialist Midwife

Improving together

UNICEF UK Baby Friendly Initiative

- Global programme of the World Health Organization (WHO) and UNICEF
- Aimed at improving practice in healthcare settings
- Based on implementation of evidence-based standards which leads to Baby Friendly accreditation
- Support for:
  - breastfeeding
  - building close and loving relationships
  - formula feeding.

Baby Friendly Impact

Why breastfeeding matters

- Building relationships
- Perinatal and infant mental health
- Infant and maternal health outcomes
- Health inequalities
- Food security
- Climate change

The Baby Friendly journey

Certificate of Commitment – Action planning

1 year

Stage 1 assessment – Building a firm foundation

2 years

Stage 2 assessment – An educated workforce

1 year

Stage 3 assessment - Parents' experiences

Re-assessment – Building on good practice

2 years

Achieving sustainability

- GOLD

Achieving Sustainability

Themes	Criteria
Leadership	▪ Baby Friendly lead with sufficient hours, education and support ▪ Baby Friendly Guardian in place ▪ Robust leadership structures ▪ Evidence of managers' education and engagement
Culture	▪ Mechanisms to support a positive culture ▪ Positive feedback from staff, managers and mothers
Monitoring	▪ Robust, consistent mechanisms in place to support monitoring ▪ Evidence of analysis and action planning ▪ Effective internal and external reporting
Progression	▪ Ongoing and responsive education programme ▪ Evidence of integrated working ▪ Demonstrates innovation and change

Leadership

NHS
Great Western Hospitals
NHS Foundation Trust

Team Work

Our leadership style is collaborative, compassionate, reflective, and evidence-driven. We work to empower staff across the service to deliver high-quality Baby Friendly care and sustainable service improvement.

- Leadership assessments
- Supervision 360 feedback
- Walking in our colleagues' shoes
- Visibility, networking and communication
- Feedback

The Gold Award May 2026

Report Title	Chair's Board Report			
Meeting	Trust Board			
Date	11/06/2026	Part 1 - Public	✓	Part 2 - Private ☐
Accountable Lead	Paul von der Heyde, Chair			
Report Author	Caroline Coles, Company Secretary			
Appendices	-			

Purpose

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

Assurance Level

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

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

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

Due process followed.

Report

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

This is a regular report for information and accountability, summarising Chair and Non-Executive Director (NED) activities and key events relating to the governor activities for the period May - June 2026. Activities relating to formal Committees of the Board are reported through custom reports.

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

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

Risk + Oversight	Risk Score

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

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

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

Accountable Lead Signature	Paul von der Heyde, Chair
Date	**01/06/2026**

Chair's Board Report

1. Introduction

1.1 I took up the post of BSW Hospitals Group Chair on 1 April 2026 and my initial period has been one of structured induction alongside an intensive focus on the transition to the Group model, in particular the appointment of Group Non-Executive Directors.

1.2 I am pleased to report that this process is now concluding. Both Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust have approved the Group NED appointments. The final approvals will be considered by the Royal United Hospitals Bath NHS Foundation Trust Council of Governors on 10 June 2026, at which point the appointment process will be complete.

2. Transition to the Group Board

2.1 This is the final meeting of the GWH Board in its current form. I want to be clear that the Trust retains full sovereignty as a statutory organisation; however, with effect 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 will convene together as a single Group Board.

2.2 A number of current GWH Non-Executive Directors will transition into Group NED roles. I would like to take this opportunity to thank all GWH Non-Executive Directors — those moving into the Group model and those concluding their service — for their dedication, professionalism and commitment to this Trust. The strength of governance at GWH is a direct reflection of the quality of the people around this table.

3. Tribute to Liam Coleman, Non-Executive Director and former Chair

3.1 Liam Coleman's tenure as a Non-Executive Director formally concludes on 30 June 2026. I wish to place on record, on behalf of the Board and the Councils of Governors, our deep gratitude for everything Liam has contributed to this organisation.

3.2 Liam served as Chair of Great Western Hospitals NHS Foundation Trust for seven years, and more recently as Joint Chair for both GWH and Royal United Hospitals Bath NHS Foundation Trust. He brought to that role an exceptional combination of integrity, strategic clarity and quiet but effective leadership. He guided this Trust through periods of significant operational pressure, complex strategic change and far-reaching system development — doing so always with skill, compassion and an unwavering commitment to the patients and communities we serve.

3.3 During my own induction as incoming Group Chair, Liam gave his time generously and unstintingly. His support has been invaluable and I am personally grateful for the manner in which he has facilitated this transition.

3.4 The Board is asked to join me in recording its sincere appreciation for Liam Coleman's exceptional and lasting contribution to Great Western Hospitals NHS Foundation Trust and to the wider BSW system.

3. Council of Governors

3.1 As the Trust moves into the Group model with effect from 1 July 2026, I confirm that the role and status of governors remains entirely unchanged. The Council of Governors continues as the Trust's statutory body, retaining all of its existing duties and functions under the NHS Act 2006 and the Trust's Constitution. Moving to a Group Board does not altern, diminish or transfer any of their responsibilities.

3.2 The Trust has received resignations of two governors: Caroline Borishade, Staff Governor (Allied Health Professional), and Ray Ballman, Appointed Governor (Swindon Borough Council). The Trust would like to extend its sincere thanks to both Caroline and Ray for their, dedication, and commitment during their term of office as Governors.

3.3 The Trust will be working through its usual governance processes to fill both vacancies in a timely manner. To note the vacancy for Swindon Borough Council (SBC) appointed governor will need to be filled by SBC as the appointing organisation rather than an election.

3.4 The following table outlines the key meetings, training and events during May-June 2026 that governors participated in:-

April to June 2026 – Governor Activity		
Date	**Event**	**Purpose**
20 April 2026	Board safety visit – Trauma ward	To help governors better understand how the hospital operates while gaining insight into patient safety and care quality.
30 April 2026	Councils of Governors briefing session on Group developments.	BSW Hospitals Group Development and Governance Discussions which included updates and discussion on our Model of Care Transformation, Financial Sustainability and the EPR Programme. Lead Governors also facilitated discussion groups on member engagement.
3 May 2026	Council of Governors (COG) pre-meet	Opportunity for governors to discuss up and coming COG agenda items.
7 May 2026	Engagement & Membership Working Group	To advise and support the Trust in increasing Trust membership and improving membership engagement
19 May 2026	Public health talk – Menopause and HRT	A Governor led event. David Griffiths, Consultant presented to members and governors.
26 May 2026	Council of Governors meeting	Regular meeting to update and discuss Trust issues. Additional to the standard agenda items there were reports on temporary staffing, changes to Trust Constitution and approval of appointments to the Group NED roles.
28 May 2026	Nominations & Remunerations Committee	To review Non-Executive Directors annual reviews.
28 May 20226	Public health talk – Dying Matters	A Governor led event. Rachel Clarke presented to members and governors
7 June 2026	Board safety visit – Jupiter	To help governors better understand how the hospital operates while gaining insight into patient safety and care quality.

Report Title	Fit and Proper Persons Regulation (FPPR) Annual Assurance Report 2025/26				
Meeting	Trust Board				
Date	11/07/2025	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Paul von der Heyde, Trust Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	-				

Purpose

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

Assurance Level

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

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

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

Due process followed in line with the NHSE Fit & Proper Person Test Framework

Report

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

The Fit and Proper Person Regulation (FPPR) requires all NHS Trusts to ensure Board directors are fit to undertake their roles. This is reinforced by the 2023 NHS England FPPT Framework, which strengthens consistency, accountability and transparency, and by CQC Regulation 5.

The framework applies to all Executive and Non-Executive Directors (including non-voting members) and introduces standard competencies, enhanced referencing, and improved record-keeping.

The Trust operates robust, well-established processes aligned to national guidance, including:

- Fit and proper checks within recruitment
- Annual self-attestation for all Board members
- Ongoing review of directors' fitness, including conduct and capability

- Clear procedures for managing concerns and appeals

The Chair is accountable for ensuring effective implementation and annual assurance.

Conclusion: The Trust is compliant with FPPR requirements, with processes in place that are consistently applied and reviewed annually.

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

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

Risk + Oversight		**Risk Score**
Key risks – risk number & description (Link to BAF / Risk Register)	n/a	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	None	
Next Steps	Annual Submission to NHSE	

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

Recommendation / Action Required
The Board/Committee/Group is requested to:
The Trust Board is asked to: ***(a) note the content of this paper; and,*** ***(b) record that the FPPT has been conducted for the period 2025/26 and that all current Board members satisfy the requirements.***

Accountable Lead Signature	Paul von der Heyde, Trust Chair
Date	**01/06/2026**

1. Introduction

1.1 The Fit and Proper Person Regulation (FPPR) requires all NHS Trusts to ensure Board directors are fit to undertake their roles. This is reinforced by the 2023 NHS England FPPT Framework, which strengthens consistency, accountability and transparency, and by CQC Regulation 5.

1.2 The framework applies to all Executive and Non-Executive Directors (including non-voting members) and introduces standard competencies, enhanced referencing, and improved record-keeping.

1.3 The Trust operates robust, well-established processes aligned to national guidance, including:

- Fit and proper checks within recruitment

- Annual self-attestation for all Board members
- Ongoing review of directors' fitness, including conduct and capability
- Clear procedures for managing concerns and appeals

1.4 The Chair is accountable for ensuring effective implementation and annual assurance.

2. Annual Submission 2025/26

2.1 The Chair is supported by the Chief People Officer and the Company Secretary to ensure appropriate processes are followed.

- For the year 2025/26, each individual director completed their annual self-attestation
- The Chair reviewed the signed declarations and determined that the Directors continued to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test.
- In addition, during the year 2025/26, the Chief People Officer has overseen the completion of pre-employment checks for new appointments and leavers and confirms that all checks meet the FPPT Framework.
- The outcome of the FPPT's have been saved on each personal file and uploaded onto ESR.
- All necessary individual annual checks have been completed, and the evidence reviewed confirms that all serving members of the Board are fit and proper.
- Between checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and bringing these issues on an ongoing basis and without delay to the attention of either the Company Secretary, Chief People Officer or the Trust Chair.

2.2 The requirements for the annual 2025/26 FPPT assessment have therefore been fully satisfied, and an overall summary will be submitted to the regional NHSE team confirming compliance with the framework within the required deadline of 30 June 2025.

3. Next Steps

3.1 Following the establishment of the BSW Hospitals Group and new Group-level roles, existing FPPT arrangements have been reviewed. A revised Standard Operating Procedure (SOP) has been developed to clarify responsibilities, governance, and the secure management of FPPT records.

3.2 It is recommended that, every three years, NHS organisations should have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. The Trust has factored an FPPT audit within the internal audit plan for 2026/27.

4. Recommendation

The Trust Board is asked to:

(a) note the content of this paper; and,

(b) record that the FPPT has been conducted for the period 2025/26 and that all Board members satisfy the requirements.

Report Title	CEO report				
Meeting	Trust Board				
Date	11/06/2026	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Cara Charles-Barks, Chief Executive				
Report Author	Cara Charles-Barks, Chief Executive				
Appendices	Appendix 1 - GWH Medium Term Financial Plan (MTFP) – Contract conditions and the Trust's response				

Purpose

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

Assurance Level

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

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

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

Report

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

The Chief Executive's report covers:

- Risks
- National update
- Group Development

Great Western Hospitals NHS Foundation Trust update:

- Operational update
- Quality

- Financial position
- Strategic priorities
- Workforce, wellbeing and recognition

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

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

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

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

Explanation of above analysis:

The report mentions our Staff Excellence Awards, one of the categories in the ceremony is 'Championing Health Equalities' which recognises the individual or team who has done the most in this area.

Recommendation / Action Required

The Board/Committee/Group is requested to:

Note the report

Accountable Lead Signature	Cara Charles-Barks
Date	**04/06/2026**

1. Risks

1.1 Financial position and 2026/27 plan

The Group entered 2026/27 with an improving but still high-risk financial profile. RUH closed 2025/26 with a year-end deficit of £20.5m against a forecast £34m, and is recognised nationally as one of the most improved providers for diagnostics, elective recovery and UEC. SFT have an efficiency programme of £32.5m that is fully identified but high-risk in delivery, internal turnaround support has been implemented to support delivery. GWH has commenced with external financial turnaround support arrangements to assist with the delivery of a challenging £47.2m efficiency requirement. Group-wide CIP delivery for 2026/27 will remain a Joint Committee focus throughout the year.

1.2 Urgent and Emergency Care (UEC)

UEC pressure remains the dominant operational and quality risk across the Group. RUH is now the most improved provider in England for average days to discharge (ranked 51st), is in the most-improved cohort nationally for four-hour performance (2024/25 v 2025/26) to further support pathway improvement; a 100-day UEC challenge will launch on 27 May. SFT continues to operate under sustained pressure, with ED 4-hour performance at 69.3% against a plan of 78% and bed occupancy above 96%. No-criteria-to-reside numbers remain elevated across all three sites.

Across the Group there is robust clinical oversight of corridor care in each Care Organisation and reporting is now underway in line with national requirements. As part of the BSW UEC Reset at system-level, elimination of corridor care is expected to be an output of reduced demand, improved flow within and out of Care Organisations. Internal actions to improve flow are overseen at UEC Improvement Boards with a focus on internal changes to support more timely discharges and reduced internal delays whilst in hospital and on leaving. GIRFT support in GWH and RUH has focused on Clinical Operational standards, and this is being replicated in SFT. Frailty at the front door and long length or stay reviews are areas of focus.

2. National update

2.1 Secretary of State for Health and Social Care

The Rt Hon James Murray MP was appointed as the Secretary of State for Health and Social Care on 14 May 2026. The Secretary of State is responsible for the work of the Department of Health and Social Care, including overall financial control and oversight of NHS delivery and performance and oversight of social care policy.

The Rt Hon James Murray has served as the Member of Parliament for Ealing North since 2019 and was previously Chief Secretary to the Treasury from 1 September 2025 to 14 May 2026.

2.2 Resident Doctors Industrial Action

Resident Doctors in England will take industrial action from 7.00am on Monday, 15 June to 6.59am on Friday, 19 June.

As in previous cases, in depth planning for the industrial action is being undertaken at each Care Organisation to ensure that disruption to services for our patients is kept at a minimum.

3. Group Development

3.1 Joint Committee

Our latest BSW Hospitals Group Joint Committee meeting was held on 20 May 2026 with focus being on discussion of Financial Sustainability & Recovery, Integrated Performance Report, Risk Register and Board Assurance Framework Development, the Roadmap for transition to Group Board, the Corporate Services programme, Temporary Staffing Model, and our Organisational Development Programme. A report from the May Group Joint Committee has been included with June Trust Board papers.

3.2 Leadership Team

The Group executive leadership team is almost fully established albeit with two interim positions still in place. Recruitment for the substantive Group Chief Digital and Information Officer is complete – following interviews held on 28 April, Jonathan Hinchliffe has been appointed.

In Care Organisations, interviews for the substantive RUH CMO post were held in early March, an offer has been made and we anticipate our new CMO starting in-post in August. Following the announcement of the planned retirement of Toni Lynch in June 2026, recruitment has been completed, with Jason Lugg being appointed as the next RUH Chief Nursing Officer.

Non-Executive Model. The Joint Committee reviewed and approved our planned NED model on 18th February; subsequently, the three Care Organisation Councils of Governors (CoGs) met, and each endorsed the recommended model. In readiness for our Group Board launch, we now are nearing completion of the Group-wide NED appointment process.

3.3 Group Governance and Assurance Arrangements and Transition Roadmap

The governance development work supporting support safe mobilisation of our new Operating Model is continuing, led by our Governance Working Group, meeting fortnightly. Supporting this work, the Non-Executive Governance Reference Group meets monthly. On 5 May, the NED team considered the Governance Roadmap, our Safe to Start Gateway tool, and detailed transition timeline. The team also discussed draft Standing Financial Instructions and the planned Scheme of Reservation and Delegation.

On 7 May, we achieved a significant milestone by signing a formal partnership agreement between our three Care Organisations. This was the final formal step in establishing our Group Board. Working as one Board will provide clear oversight, faster and better co-ordinated decisions and a consistent approach to risk, quality and safety, allowing us to work at scale, making joint investment and estates decisions for the benefit of our community.

In April and May, the pilot Risk and Assurance Committee met and continued its work shaping how group-level risk and assurance will operate ahead of go-live planned in July. A Shadow Risk & Assurance meeting is planned for 1 June, to test new ways of working.

3.4 Group Priorities and Prioritisation Approach.

Our five areas of prioritised focus for the Group and Care Organisations remain as follows:

1. Recovery (Performance & Finance)
2. EPR implementation
3. Transforming Models of Care through the acute services review and clinical services framework design
4. Completion of the Corporate Services Review
5. Developing our Group

The Group Leadership team meets weekly to ensure progress is maintained in these priority areas.

3.5 EPR Deployment Options Appraisal

The EPR programme team, led by Jonathan Hinchliffe, Chief Digital & Information Officer, has been working with suppliers and our Executive team on delivery planning. The Board met on Thursday 7 May and following discussions, approved a recommendation for Go Live phasing for the shared EPR Programme. The first Go Live will be in mid-July 2027 for GWH, with the second Go Live in late-October 2027 for both SFT and RUH concurrently.

3.6 Model of Care Transformation Programme

The Model of Care Transformation programme, led by Andrew Hollowood, Chief Clinical Transformation Officer, is in development: a clinical stocktake has been completed to inform the selection of first wave specialties to establish Clinical Transformation Groups to explore potential service models, using a set of design principles, founded on serving our population, supporting our teams and reduction of unwarranted variation.

A Steering Group and Working Group are in place, and the governance structure has recently been reviewed to include Elective Care and UEC as part of the Steering Group to enable sharing of best practice, reduce silo working and duplication of work.

3.7 Corporate Services Transformation Programme

Our Corporate Services Transformation Programme, led by Jude Gray, Group Chief People Officer, is making progress with the design stage for services completed and consultation exercises now underway. The Steering Group and Design Authority meet regularly, and designs have been approved for eight services. SLAs are being developed for each of the shared corporate services. The financial impact of the programme is

being tracked for each service, with clear targets set for 26-27 & 27-28. Detailed phasing of benefits is being planned by service leads.

3.8 Group Board Meetings

The 2026/27 Group Board dates including a series of Board development days are being scheduled. From July, Group Boards will be held on the first Thursday of the month.

3.9 Councils of Governors Workshop

A Councils of Governors development session was held on 30 April 2026 with the agenda for the day being co-designed by lead Governors to address priorities. The session was well attended and following introductions by Group Chair Paul Von Der Heyde and the Non-Executive Director team, there were updates and discussion on our Model of Care Transformation, Financial Sustainability and the EPR Programme. Lead Governors also facilitated discussion groups on member engagement.

Great Western Hospitals NHS Foundation Trust update

4. Operational update

4.1 Latest operational position

We have continued to see some very busy periods over the last few weeks, with large number of attendances to urgent and emergency care and high levels of pressure felt across all services.

We have supported staff to continue to care for patients during the recent very hot weather, with portable air conditioning units put on wards. The hot weather saw high numbers of patients present to our urgent and emergency care services with heat-related illnesses and injuries.

During this time we asked the public to use the right service for their needs – such as a minor injury unit, pharmacy or contacting NHS 111 in the first instance.

Reducing our waiting list continues to be a challenge, whilst we have a recovery plan in place we know that many patients are waiting much longer than we would like.

5. Quality

5.1 Our quality priorities in 2026-27

This year we have identified three long-term quality priorities, which focus on sustained improvement in core areas of patient care.

These priorities will be overseen by our Nursing, Midwifery & AHP Committee and Patient Quality Subcommittee, with updates on progress shared with the Quality and Safety Committee and the Governors Quality and Experience Group.

These priorities are:

Patient Safety – Safe use of oxygen
Improving the prescribing, monitoring and administration of oxygen to reduce avoidable harm. A focus on correct prescription, staff roles in administration, safe transfer practices and improved cylinder management will underpin this work.

Patient Experience – Improving the discharge process
Responding to consistent feedback from patients, carers and partners, this priority aims to ensure clearer communication, transparent responsibility within pathways, improved sharing of plans, and adoption of a new daily needs-assessment tool to support safer, smoother discharges.

Clinical Effectiveness – Reducing postpartum haemorrhage
Full implementation of the National Maternal Care Bundle to reduce maternal morbidity via standardised measurement, escalation, intervention and multidisciplinary learning.

5.2 Outpatient Transformation Programme

A new initiative aimed at strengthening outpatient services is being introduced across the Trust, with a small number of outpatient specialties taking part in the first phase of a structured 12-week Outpatient Transformation Programme. This will provide dedicated time and support for teams to review their services, explore challenges, and identify where changes can have the greatest impact.

Through the programme, teams will explore opportunities to:

- Optimise use of existing capacity
- Standardise follow-up processes
- Create additional capacity where possible
- Further improve patient experience through more efficient pathways

Alongside this work, a new Advice & Guidance (A&G) service and Single Point of Access model for referrals into secondary care are also being introduced, in line with national NHS England requirements.

This will establish a single, consistent entry point for outpatient referrals from primary care. The A&G service will enable GPs and primary care clinicians to access timely specialist advice from GWH consultants, helping to ensure patients are directed to the most appropriate care at the right time.

5.3 Listening to our patients

Patient feedback is essential in helping us understand what we are doing well and where we can improve.

Staff actively encourage patients to complete the Friends and Family Test (FFT) which helps us to identify issues and trends in what our patients are telling us.

We have appointed a new provider (IQVIA) to support our FFT – although the process remains much the same, the physical feedback cards that patients complete now have a new look.

5.4 Improving heart care

We became the first care organisation in the UK to offer a new, more advanced heart device that helps the heart beat more effectively, keeps patients safe from dangerous heart rhythms, and combines two treatments into a single lead. This means patients who need a defibrillator can now be treated with one device that also helps the heart pump more efficiently. We were chosen to introduce this innovation thanks to our cardiology team's leading role in global research and their track record in delivering and teaching the latest pacing techniques.

5.5 Supporting sleep apnoea

Last month the first patient in the south west received a new device to support sleep apnoea at Great Western Hospital. The device helps patients to breath safely during sleep without the need for a CPAP machine.

BBC Points West spoke to consultant Joe Sinnott and Lead Sleep Nurse Sam Backway as well as the patient to hear about how the device will change the lives of those fitted with it.

5.6 Fundamentals of care

Over a four-week period we renewed our focus on the essential elements of care that ensure our patients feel safe, supported, well-cared for and respected.

Clinical Practice Educators and specialist teams visited wards and departments, focusing on different topics each week relating to fundamentals of care.

They covered skin integrity and pressure ulcer prevention; personal care, continence care and mouth care; infection prevention and control and catheter care; and nutrition and hydration.

5.7 DVT assessment

To ensure patients receive quicker diagnostic scanning and can start treatment sooner, as well as reducing demand in our Medical Assessment Unit, DVT assessment has moved out of the hospital to a new outpatient clinic at the Swindon Health Centre.

Since the move, wait times for suspected DVT scans have reduced from up to two weeks to three days. Patients will now only see the team twice, rather than previously up to five times for the same assessments.

The pilot, which ran earlier this year, has now been extended to March 2027. Patients also fed back that staff were friendly and clear, putting them at ease and treating them with dignity.

5.8 What Matters To You

A national NHS campaign, ‘What Matters To You’ (WMTY), supports staff to promote careful, kind, human interactions and we are pleased that, after two successful pilot days, we will be rolling WMTY out across every ward in June.

Asking “what matters to you?” is about understanding what matters to an individual in their life, and particularly during a stay in hospital. It’s about having meaningful conversations with individuals, as well as their families and carers, asking questions like ‘how best can I support you in hospital’ and ‘is there anything worrying you today?’

Following a WMTY conversation, staff can start to understand how they can better support their patient. Examples including arranging for personal belongings to be brought in from home, signposting to social care support, detailing discharge plans or organising funding to improve the ward environment.

We will be rolling out WMTY across every ward, starting on Tuesday 23 June, and ahead of this will provide briefings for staff to find out more about what’s involved as we work to embed WMTY conversations so that they become business as usual for every staff member and patient.

6. Financial position

Our financial position for this year is incredibly challenging, with our plan for the year having a high efficiency savings target of £47.2m.

Teams have been proactive in developing ideas for how we can change the way we do things as we work to balance quality and safety with improving performance and saving money.

Our efficiency programme continues to focus on outpatients, theatres, and urgent and emergency care as the three areas we are aiming to transform.

7. Strategic priorities

We have identified a number of strategic priorities for this year. These are:

System & Place - as a community, we face significant challenges. We will create strong partnerships to deliver the best possible services for our patients

Our Behaviours - developing the way we work together to create respect in line with our STAR values

The Way Forward Programme – this is our strategic estates programme which will deliver an estate that is fit for the future pathways of care

Digital First – increasing digital maturity is essential for our services and future

To help us achieve our strategic ambitions, we will focus on a number of breakthrough objectives this year.

These are:

- Improving elective waiting times
- Reducing deconditioning
- Reducing corridor care
- Care is our top priority
- Increasing productivity

8. Workforce, wellbeing and recognition

8.1 Staff Excellence Awards

This year we had 318 nominations across the 11 categories of our Staff Excellence awards.

The finalists are:

Championing Health Equalities Award
Early Careers Team
Kayley Payne, Workforce Systems Specialist
Tania Currie, Head of Patient Experience and Engagement
Sarah Masson, Practitioner Psychologist

Rising Star Award
Nitish Datta, Clinical Teaching Fellow
Victoria Cooper, Specialty Doctor
Ellie Piper, Specialist Dietician
Ella Saunders, Trainee Apprentice Cardiac Physiologist

Hero Award: Beyond the call of duty
Anuja Ravindran, Clinical Practice Educator
Badri Chandrasekaran, Consultant
Sam Reynolds, Workforce System Specialist
Tincy Thomas, Staff Nurse

Improving Patient Experience Award
The Meadows
Cheryl Davidse, Speech and Language Therapist
Hayley Charity, Macmillan Cancer Nurse
Julie Herring, Patient Experience Coordinator

Improving Together Award
Sian Thomas, Head of Clinical Coding
Jane James, Clinical Physiology Trainer

Acute Physiotherapy Team
Never OK Task and Finish Group

Leading the GWH Way Award
Natalie Whitton, Specialist Doctor
Bushra Sohail, Consultant
Tsitsi Chirimuuta, Ward Sister
Sara Slade, Associate Specialist

Lifetime Achievement Award
Helen Pepler, Maternity Governance Facilitator Midwife

William McCrea, Consultant
Wendy Johnson, Associate Director of Safeguarding
Anne Lye, Patient Coordinator

Patient Choice Award
Catherine Edward, Bereavement Midwife
Della Mann, Staff Nurse
Catherine Taylor, Phlebotomist
Teal Ward

Star of the Year Award
Children's Unit
Hayley Palmer, Nutrition Assistant
Claire Wright, Martha's Rule Nurse Specialist
Riyaad Jondah, Ward Manager

Sustainability Award
Transport Team
Dermot McCusker, Simulation Technician, and the Clinical Teaching Fellows
Ann Diez, Practice Educator
Kathryn Harrison, Midwife

Team of the Year Award
Emergency Department and Children's Emergency Unit
Audiology department
Maternity Vaccination team
Cath Lab
Colposcopy team with gynaecology

The awards ceremony will take place on Friday 17 July.

8.2 STAR of the Month

Recent STAR of the Month winners are:

Stewart Thompson, Trust Equipment Manager, who was recognised for being exceptionally responsive with additional equipment needs during the recent winter period.

Marc Garcia, Anticoagulation Data Manager, who was recognised for his tireless work on a new IT system for the anticoagulation service.

Cara Charles-Barks
Chief Executive
BSW Hospitals Group
Email: cara.charlesbarks@nhs.net

28th May 2026

Sent via Email
Sue Doheny, Regional Director, NHSE South West
Jeff Buggle, Director of Finance, NHSE South West

Dear Sue and Jeff,

Great Western NHS Foundation Trust Medium Term Financial Plan (MTFP) Contract Conditions.

We are writing in response to the contract close down letter received on 22nd April 2026 which set out the formal response to our MTFP submitted on 18th March 2026. The letter confirmed that our plan was assessed as ***compliant with conditions***.

There were five conditions placed on GWH plan acceptance:

Finance	Clear plans to derisk savings plan, with agreed milestones and progress updates to be provided fortnightly. Clear plan to derisk the financial plan, with agreed milestones and progress updates to be provided monthly. The expectation is risks should be fully mitigated. Retriangulation of financial and workforce plans once savings proposals are confirmed, to ensure workforce assumptions remain robust and deliverable. Acceleration of contract finalisation, including resolution of any outstanding contractual issues and securing all necessary approvals to enable contracts to be signed without delay. Full implementation of all controls set out in the 2025/26 Financial Management Arrangements and continue with any recovery actions implemented during 2025/26. Establishment of a formal Cash Management Committee, with agreed terms of reference and agenda, aligned to best practice examples available on the ONF site. Organisations should appreciate that securing revenue cash support is likely to be challenging and therefore they should endeavour to manage cash constraints internally or with the use of system support. It is unlikely that any provider is able to access cash support greater than the value of its planned deficit. All investments and discretionary cost pressures over £50k should be subject to organisational, system and NHSE review in line with existing 'Triple Lock' arrangements. Development of sufficient mitigations to offset any financial impact should planned subsidiary savings be delayed or not approved during 2026/27.

	Success criteria: • CIP plans should be fully identified by the end of June 2026 and the percentage of CIP deemed high risk should be no more than 20% by the end of June 2026. • Retriangulation of finance and workforce completed by the end of June 26.
Workforce	Expect development of detailed workforce plans which underpins the submitted plan, triangulated with finance and activity and for these to be shared with the regional team in Q1.
Elective	To be subject to further discussion as part of regular performance management
Cancer	Do not meet 62 day target but this is an accepted position as there are external known circumstances impacting on meeeting targets

Please find an update on these conditions as requested including progress since our last correspondence.

Finance

Hunter Healthcare started at GWH from the 13th of April with a view to both reduce the risk in identified schemes and help identify further schemes to close the unidentified savings gap.

They have strengthened financial oversight with a standardised governance structure and approach. They target divisional delivery through their financial improvement cell approach which has been adopted across the group. There is a fortnightly governance rhythm to ensure pace and focus is maintained. Progress has been made in the number of green schemes as reported in the latest weekly tracker to region.

- Taking each of the conditions in turn:

Clear plans to derisk savings plan, with agreed milestones and progress updates to be provided fortnightly.	Financial Intervention Programme Board meets fortnightly focus on reducing run rate and CIP delivery. Linked into regional reporting. • Hunter Healthcare supporting identification of new schemes and assuring existing schemes. • Next milestone is 80% risk weighted average by 1st June.
Clear plan to derisk the financial plan, with agreed milestones and progress updates to be provided monthly. The expectation is risks should be fully mitigated.	Hunter Healthcare supporting identification of new schemes and assuring existing schemes.
Retriangulation of financial and workforce plans once savings proposals are confirmed, to ensure workforce assumptions remain robust and deliverable.	Financial and workforce plans currently triangulated at plan submission stage, triangulation of ongoing plan developments to be assured through financial recovery meetings (fortnightly) and F&P/People Committee

Acceleration of contract finalisation, including resolution of any outstanding contractual issues and securing all necessary approvals to enable contracts to be signed without delay.	Only one outstanding contract with Thames Valley which is expected to be shortly resolved.
Full implementation of all controls set out in the 2025/26 Financial Management Arrangements and continue with any recovery actions implemented during 2025/26.	Controls remain in place as well as additional controls including discretionary spend panel weekly. HMFA checklist completed.
Establishment of a formal Cash Management Committee, with agreed terms of reference and agenda, aligned to best practice examples available on the ONF site. Organisations should appreciate that securing revenue cash support is likely to be challenging and therefore they should endeavour to manage cash constraints internally or with the use of system support. It is unlikely that any provider is able to access cash support greater than the value of its planned deficit.	Cash Committee is in process of implementation at Group level
All investments and discretionary cost pressures over £50k should be subject to organisational, system and NHSE review in line with existing 'Triple Lock' arrangements.	Currently in place at GWH

The below table shows how our CIP programme is maturing both in delivery confidence and risk with £19m identified and the unidentified reducing to £13m.

	Live					
	Implemented	Fully Developed	Plans in Progress	Opportunity	Unidentified	Gross CIP
Organisation	£000s	£000s	£000s	£000s	£000s	£000s
Great Western Hospitals	£0.51(M)	£18.97(M)	£7.35(M)	£7.64(M)	£13.23(M)	£47.20(M)

Workforce

No changes to plan made. Expect development of detailed workforce plans which underpins the submitted plan, triangulated with finance and activity and for these to be shared with the regional team.	The triangulation of the plan is ongoing, as more schemes are developed which is closing the overall unidentified gap, there is greater triangulation as the workforce implications are completed and modelled through.

Elective

To be subject to further discussion as part of regular performanace management	The Trust remains committed to delivery of its plan for 2026/27, in achieving 67% RTT for 18weeks and elimination of 65week waits. Five workstreams underpin the recovery plan being

	implemented: Demand and Capacity Planning; Operational Grip; Internal Admin processes and Outpatients; Data quality, Validation and PTL accuracy, and Routines and Governance. In order to support delivery and strengthen oversight, grip and control, external resource has been engaged to lead the RTT Recovery. Initial work will focus on improving the governance and operational grip, creating clear accountability routines including weekly senior oversight and trajectory delivery, via the production of clear Divisional Operational Plans. Other external expertise has already been engaged (GIRFT), to build on last year's assessments, and review and support the Outpatient Transformation workstream. The Trust continues to work with regional colleagues via fortnightly meetings, into which the outputs of the five workstreams referred to above will be reported.

Cancer

Do not meet 62 day target but this is an accepted position as there are external known circumstances impacting on meeting targets.	Work in ongoing to improve Urology pathways with other NHS providers.

We will continue to provide updates on progress against the maturity of the CIP programme.

We appreciate your ongoing support and look forward to working with you and system partners to delivery this ambitious plan.

Your sincerely

Cara Charles-Barks
Chief Executive
BSW Hospitals Group

Great Western Hospitals NHS Foundation Trust,
Royal United Hospitals Bath NHS Foundation Trust,
Salisbury NHS Foundation Trust

cc. Lisa Thomas, Managing Director, Salisbury NHS Foundation Trust
Simon Wade, Chief Financial Officer, BSW Hospitals Group
Jude Gray, Group Chief People Officer, BSW Hospital Group

To: Cara Charles-Barks, CEO Great Western Hospitals NHS Trust

NHS England
South West Region
South West House
Taunton
TA1 2PX

22 April 2026

Sent via email

Dear Cara,

Great Western Hospitals NHS Foundation Trust

Acceptance Status: Accepted with conditions

I am writing in response to the submission **of your final medium-term plan for 2026/27–2028/29** and your **five-year- Integrated Delivery Plan**, and to set out next steps. Thank you for the extensive work across the organisation that has contributed to the development of these plans. Annex One of this letter summarises the key commitments your organisation has set out for delivery and any supporting actions to address key issues that have been agreed.

As we move into implementing the plans our shared focus moves firmly toward delivering the strategic shifts and long-term transformation required to reset NHS performance and build a sustainable, modern health and care service. The Medium-Term Planning Framework set a clear expectation that organisations will work over multiple years to restore constitutional standards, strengthen community-based care, and accelerate prevention and digital transformation. Planning over multiple years does not end with acceptance of the plan; as the focus moves to delivery, foundational work will continue as you work on understanding any changes in the demand and capacity of your services and population health needs.

Transforming our services remains essential to achieving the required outcomes for patients as well as productivity and efficiency improvements to ensure sustainability. We will continue to work with you to ensure your organisation has access to the development and improvement support needed to strengthen capability and capacity.

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Your submitted plan has been reviewed against the expectations set out in the national guidance and has been assessed as:

- **Compliant with Conditions**

Effective oversight of the delivery of these plans will be important to ensure that the ambitious trajectories are met. We will review progress against these plans with you through our Regional governance arrangements which include System Delivery Stocktake meetings, System Mid Year Review meetings, Provider Oversight meetings, Tiering and other performance and delivery meetings, to ensure that there is continuous oversight, alignment across organisations, and transparent governance.

We are aware that the data collection template for “Percentage of clinically urgent appointments seen on the same day” for the 2026/27 period is not expected until after the main planning round has concluded. With that in mind please note specific discussions may be needed around this area following issue of this letter.

Although the BSW Hospitals Group has submitted a breakeven plan across all three years, we have significant concerns regarding the current deliverability of the financial plan. The financial plan has significant delivery risks as the efficiency programme lacks the level of maturity and credibility required. Progress in developing a robust, evidence based efficiency plan has been limited. The plan includes a £117.34m efficiency requirement (7.1%), of which 18.2% remains unidentified and 54.7% is assessed as high risk, significantly undermining confidence in deliverability.

We will work with you over the course of 2026/27 to support you in delivering this plan which your Board has approved. It is important to note if you are unable to deliver against your commitments, this will lead NHS England to consider the full range of regulatory options available to us as part of any subsequent escalation.

Please let me know if you wish to discuss any of the above. I would be grateful if you could share this letter with your full Board.

Yours sincerely,

Sue Doheny
Regional Director

Copy to:
Simon Wade, Group Director of Finance
Jude Gray, Group Director of People
Lisa Thomas, Managing Director

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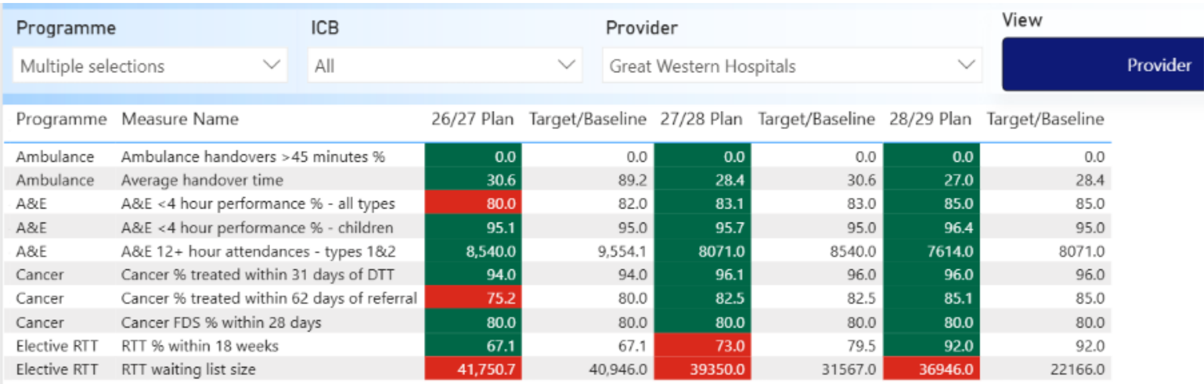
Annex One

Below is the outcome of your full submission and the compliance against the key ambitions within the three years until 2028/29:



Programme: Multiple selections | ICB: All | Provider: Great Western Hospitals | View: Provider

Programme	Measure Name	26/27 Plan	Target/Baseline	27/28 Plan	Target/Baseline	28/29 Plan	Target/Baseline
Ambulance	Ambulance handovers >45 minutes %	0.0	0.0	0.0	0.0	0.0	0.0
Ambulance	Average handover time	30.6	89.2	28.4	30.6	27.0	28.4
A&E	A&E <4 hour performance % - all types	80.0	82.0	83.1	83.0	85.0	85.0
A&E	A&E <4 hour performance % - children	95.1	95.0	95.7	95.0	96.4	95.0
A&E	A&E 12+ hour attendances - types 1&2	8,540.0	9,554.1	8071.0	8540.0	7614.0	8071.0
Cancer	Cancer % treated within 31 days of DTT	94.0	94.0	96.1	96.0	96.0	96.0
Cancer	Cancer % treated within 62 days of referral	75.2	80.0	82.5	82.5	85.1	85.0
Cancer	Cancer FDS % within 28 days	80.0	80.0	80.0	80.0	80.0	80.0
Elective RTT	RTT % within 18 weeks	67.1	67.1	73.0	79.5	92.0	92.0
Elective RTT	RTT waiting list size	41,750.7	40,946.0	39350.0	31567.0	36946.0	22166.0

Specific issues that require ongoing review and/or further system action are:

• CONDITIONS PLACED ON 18 MARCH PLAN ACCEPTANCE			
Plan area / Metric	**Outstanding Issues**	**Conditions**	**Success Criteria & Timescales**
UEC 4 hours	Not meeting 4 hours within year 1, need a plan to meet national standards	Factor in improvements to get to 80% in year 1	By Q1
Finance	Although the BSW Hospitals Group Trust has submitted a breakeven plan across all three years, there remains a material concern regarding the maturity and credibility of the efficiency programme. Progress in developing a robust, evidence-based efficiency plan has been limited. The plan includes a £117.34m efficiency requirement (7.1%), of which 18.2% remains unidentified and 54.7% is assessed as high risk, significantly undermining	Clear plans to derisk savings plan, with agreed milestones and progress updates to be provided fortnightly. Clear plan to derisk the financial plan, with agreed milestones and progress updates to be provided monthly. The expectation is risks should be fully mitigated. Retriangulation of financial and workforce plans once savings proposals are confirmed, to ensure workforce assumptions remain robust and deliverable. Acceleration of contract finalisation, including resolution of any outstanding contractual issues and securing all necessary approvals to enable contracts to be signed without delay. Full implementation of all controls set out in the 2025/26 Financial Management Arrangements and continue with any recovery actions implemented during 2025/26. Establishment of a formal Cash Management Committee, with agreed terms of reference and agenda, aligned to best practice examples available on the ONF site. Organisations should appreciate that securing revenue cash support is likely to be challenging and therefore they should endeavour to manage cash constraints internally or with the use of system support. It is unlikely that any provider is able to access cash support greater than the value of its planned deficit. All investments and discretionary cost pressures over £50k should be subject to organisational, system and	CIP plans should be fully identified by the end of June 2026 and the percentage of CIP deemed high risk should be no more than 20% by the end of June 2026. Retriangulation of finance and workforce completed by the end of June 26

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	confidence in deliverability.	NHSE review in line with existing 'Triple Lock' arrangements. Development of sufficient mitigations to offset any financial impact should planned subsidiary savings be delayed or not approved during 2026/27.	
Workforce	Do not currently have granular workforce plans.	No changes to plan made. Expect development of detailed workforce plans which underpins the submitted plan, triangulated with finance and activity and for these to be shared with the regional team.	Plans to be shared and agreed with NHSE by end April 2026
Elective	Not compliant with planning metrics	To be subject to further discussion as part of regular performance management	Monthly
Cancer	Do not meet 62-day target, but this is an accepted position as there are external known circumstances impacting on meeting targets		

Board Committee Assurance Report

Committee	**Performance, Population & Place Committee**	
Meeting Date	29 April 2026	
Committee Chair	Bernie Morley Non-Executive Director	
Link to Strategic Objective	Pillar 3: Better Together	
Link to Board Assurance Framework	BAF 3: SR 4 – Performance and SR5 - Partnerships	
Improving Together Pillar Metrics	Waiting List – over 52 week waiters	Cancer waiting times
	Emergency Care – demand in area / time in ED	Elective waits – reducing inequality
Improving Together Breakthrough Objective	Non-elective average length of stay	Wait to First outpatient appointment

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. Operational Highlight Report (see below)		
2. IPR - DM01	Substantial	No
3. IPR – RTT	Limited	No
4. IPR – Cancer Services	Partial	No
5. IPR – ED / 4 hours	Limited	No
6. IPR – Ambulance Handover	Partial	No
Quarterly 15+ Risk Report	Good	No
BAF	Substantial	No
UEC Plan / Progress update	Noted	
Partnership Report inc Community Update	Noted	
Health Inequalities Report	Noted	
NHS Performance NOF 25/26	Noted	

POINTS OF ESCALATION	RTT remains challenging. 832 patients over 52 weeks (485 worse than plan), 10 patients over 65 weeks (up 2 from prior month), of which 5 remain at risk of breaching in April.
KEY AREAS TO NOTE	**ED 4 hours:** Combined 4 hour performance was 68.6%, 0.7% worse than previous month and year end target was not met. Mean time in ED was 427 mins in March, similar to February. UTC had sustained performance at 164 mins in March, the lowest performance since Sep 2025. March saw 1000 more attendances than the prior month and increased staff sickness. **Ambulance handovers:** Average handover time was 48 minutes, above the 33 min trajectory for the 3rd consecutive month, however it remains a significantly improved picture on 12 months ago, despite an increase from 62 ambulances per day in March 2025 to 73 ambulances per day in March 2026. The average handover time in March 2025 was 1 hour 34 mins.

	Following 3 months of handover time under 33 minutes, handover times increased to 45 minutes on average for January, noting a continued material year on year increase in conveyance rates. **UEC Plan progress:** Mobilisation of the Rightcare Transformation Programme focussing on 2 headline workstreams: 1. Specialty bed realignment, matching clinical resource to bed base, and 2. Every minute matters targeting hospital flow Winter plan lessons learned was noted. **Cancer:** 28 day FDS at 80.4% up from 64.9% in Jan. 31 day at 85.3%, broadly flat with Jan. The 62 day standard is at 60.6% down from 61.6% in Jan. Expected to exceed 72% in March. Developing resilience across key pathways remains the priority into the coming year. **RTT** 58% of patients waiting under 18 Weeks (2% off plan) Pressures most prominent in General Surgery, Trauma and Orthopaedics and Gastroenterology. Recovery actions to focus on the following moving into new year: - Drive uplift in activity across non-admitted cohort - Additional validation support - Waiting list cleansing for internal referrals - Targeted reduction of un-outcomed appointments - Further ring-fencing of elective capacity to support recovery. **Partnerships** … Subcontract signed with HCRG. Metrics in place to hold GWH and HCRG to account. Formal contract meetings will commence in May. Neighbourhood health thematic workshops initiated to develop the model with all partners and a family hub opened in Penhill. Swindon priority areas are Frailty, Mental Health and Dementia and the intersection between these conditions and other long-term conditions. **Health Inequalities Report** Data compliant with national expectations of information for Board's was presented. Data is clearer and main points noted were that elective attendance and emergency attendance do not appear to be linked to deprivation decile. However smoking during pregnancy and tooth decay show strong correlations to deprivation. Focused work is underway in both of these areas.

	NHS Performance Assessment Framework Quarter 3 results were shared. Two domains have reduced in score. Access to services driven by RTT performance deterioration. Finance and Productivity driven by variance to financial plan. 3 domains have improved in score: - Effectiveness and experience of care - Patient safety and - People and workforce. We have dropped from 126 to 132 in the national ranking and received an Amber/Red rating for provider capability.
BOARD ASSURANCE FRAMEWORK & RISKS	In the last quarter: Risk 1542 (surgical patient flow) reduced from 20 to 16. Since last report there has been a downward trend in overdue risks and overdue actions. Work is proceeding on the new 5+5+5 risk model. BAF received and noted. No changes.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**DM01**: DM01 has reached 92.3%. MRI, CT and Dexa scans achieving national constitutional standard, each having no patients waiting over 6 weeks for their imaging.
REFERRALS TO OTHER BOARD COMMITTEES	None

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

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

Board Committee Assurance Report

Committee	Quality & Safety Committee	
Meeting Date	26.4.26	
Committee Chair	Claudia Paoloni, Non-Executive Director	
Link to Strategic Objective	Pillar 1 : Outstanding Care	
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality	
Improving Together Pillar Metrics	Reducing Harms	Patient Experience
Improving Together Breakthrough Objective	Falls Harm Prevention	

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. Falls (IPR breakthrough objective). Falls	Good	
2. IP&C (IPR breakthrough objective)	Partial	
3. Complaint Response Rate (Breakthrough Objective)	Partial	
4. Deep Dive:Nutrition 5. Deep Dive: MSSA Reduction project	Good Good	
6. IPR Maternity PQOM Maternity safety report	Good	
7. Freedom to Speak Up report 6months	Good	
8. Deteriorating patients, including Marthas. Law 9. Cancer Long waiters Report	Good Good	
10. Stroke Performance Report	Limited	
11. Safer Staffing-monthly update 12. GIRFT Update 13. 15+Risk report 14. Draft Quality Account Report	Note Note Note Approved	

POINTS OF ESCALATION	• **IPR: Reduction Total Harms:** slight deterioration across several metrics this month, whilst overall harms volume remains approximately the same in month.progress now appears to be static. Deteriorations in Pressure harms and Infection rates. With the new governance structure of group the IPR will be adapted to ensure alignment with the current needs/external reporting requirements. • **IPR: Infection Control:** It was confirmed the recent MRSA cases involved patients who were very high-risk and had complex wounds, but there was no evidence of direct transmission. As the learning identified relates to improving screening and decolonisation, including ensuring atypical sites such as abscesses are screened, there is a need to continue with targeted Infection Prevention & Control (IPC) work re: screening and decolonisation for high-risk patients. The appointment of a new Associate Director for IPC was welcomed, as it was felt this would result in strengthened leadership and an analytical focus. The issues that were linked to a change in supplier for the bedside hand-rub was acknowledged, and it was noted that the transition would provide an opportunity to reinforce the hand hygiene compliance/culture. A discussion took place re: the E. coli and C. diff rates, during which it was noted that the Trust had now exceeded its annual C. diff threshold but that no outbreaks or transmission had been identified. As the focus areas include prescribing of PPIs, laxatives, hydration and catheter care, work will be required

	on a medication review, hydration and early catheter removal to address the C. diff and E. coli risks. • **IPR: Breakthrough Objective: Falls** Five moderate-harm falls were recorded in the reporting period, which were largely consistent with known risk profiles and primarily occurred within the front-door areas. Assurance was provided re: the robustness of the weekly multi-disciplinary falls panel, quality of the case reviews and the systematic feedback of learning into the Divisions. • **Pressure Ulcers:** Work was continuing re: pressure ulcer prevention with an aim to eliminate all Grade 3 pressure ulcers, together with the ongoing replacement of the ED trolley mattresses that were no longer fit for purpose.
	• **Complaints and Concerns Response Rate**. The complaints performance remains stable, with a continued emphasis on 48-hour patient contact. The forthcoming launch of the “What Matters to You?” initiative was welcomed as a key step to improving communication and personalised care, alongside the positive developments such as the new Carers & Patient Information Hub. It was noted medication incidents with moderate harm were within the expected variation and that no new themes had been identified. • **DEEP DIVE REVIEW: NUTRITION** The Committee received a report which provided assurance on the current practice re: nutrition and hydration incidents. It was noted a 6 month review had identified 55 nutrition-related incidents that had mainly affected adult inpatients, but that there were no cases of severe harm and the majority were graded as low or no harm. There were two recurring theme:, • the first of which related to dysphagia where incidents arose from inconsistencies in the application of the Speech & Language Therapy advice. As a result, multi-disciplinary education and engagement with the ward and medical staff was being appropriately escalated to ensure adherence to the Speech & Language Therapy guidance. • The second theme related to the completion/implementation of the MUST malnutrition pathway, including delays, inaccuracies, and follow-up actions. The importance of MUST in prioritising dietetic referrals given the limited capacity was emphasised, with high-risk patients been seen promptly and the lower-risk patients being managed at ward level with support. The awareness campaigns and training have identified knowledge gaps that will inform future improvements. An overview was provided of the governance arrangement it was felt it would be beneficial for a broader, periodic assurance overview to be developed re: nutrition and hydration that incorporates incidents, patient experience, complaints themes, workforce capacity and the system-wide performance indicators. The Committee acknowledged the proactive approach that was being taken and was reassured that no serious harm had occurred, but it was agreed there needs to be a continued focus on education, governance, and assurance to further mitigate the risks. • **DEEP DIVE REVIEW: MSSA Reduction Project** Received an update re: the MSSA improvement work, which focused on the proactive measures being undertaken to address the MSSA rates that were above trajectory across the Trust, particularly within the Surgery & Planned Care Division. It was noted a significant contributory factor identified through an Improving Together A3 approach was the absence of an up-to-date policy that governed the ongoing peripheral cannula care, despite the existing guidance re: line insertion, and that a root cause

	analysis had highlighted risks associated with prolonged/unnecessary cannula use and inconsistent maintenance practices. A new evidence-based peripheral cannula maintenance policy has been developed and benchmarked against peer organisations, that has been informed by peer-reviewed evidence and agreed through the appropriate infection control governance before being launched on EOLAS. Extensive stakeholder engagement was undertaken, and a Trust-wide education programme was put in place, which was aimed at translating the policy into practice, refreshing staff knowledge and reinforcing best practice around assessment, documentation and the timely removal of cannulas. Early Divisional data following implementation showed there were no MSSA cases in the most recent reporting month, although it is acknowledged that ongoing monitoring of the MSSA rates will be required and that the findings will need to be reviewed to assess the sustained impact of the new policy and education programme. As it was felt the current documentation does not always clearly articulate whether cannula use was contributory, thus limiting the opportunities for targeted learning, it was felt the IPC teams would need to strengthen the MSSA investigation narratives to clearly identify any relationship to cannula use and feed any learning back into the education and audit processes. Assurance was provided that learning had been shared via the Infection Prevention Steering Group to support the spread beyond Surgery & Planned Care, and that the approach was aligned with the wider Trust commitments re: harm reduction, standardisation, and frontline ownership. The focus going forward will centre on sustaining the behavioural change, strengthening the escalation routes and embedding cannula care as a visible patient safety priority across all clinical areas.
	Maternity Integrated Performance Report • PQOM There are ongoing workforce challenges, particularly re: the funded establishment versus actual acuity and cot occupancy, which was resulting in a mismatch with the Birthrate Plus standards. As it has been recognised that a longer- term investment would be required a working group has been established to explore the options, the outcome from which will be brought back to the Committee through the appropriate governance route. There has been a temporary reduction in the training compliance for Obstetric and Anaesthetic staff, due to the annual trainee rotation. Staff are booked onto the required training and the compliance is expected to recover in line with the revised CNST Year 8 requirements. Safeguarding compliance continues to improve, with adult safeguarding nearing full compliance. Three moderate-risk patients were identified in March but were all either downgraded or had actions agreed following a review. The ongoing patient safety events remain largely unchanged with two cases subject to external review and one case scheduled for presentation at the Learning to Improve Group (LIG). A Emerging learning from the patient safety data has highlighted that neonatal thermoregulation is a contributory factor to potential avoidable admissions, which aligns with the existing quality improvement work re: hypoglycaemia. There were two reportable baby losses in March, neither of which required a full PMRT. As the five reportable deaths in February/March were related to parental termination requests due to foetal anomalies they will not have an impact on the avoidable stillbirth rates.

	revised CNST Year 8 guidance shift to six outcome-focused domains, the increased expectations for Board-level oversight and ensuring there was alignment with the Perinatal Quality Oversight Model was noted. It was also noted engagement with national events and the NHS Futures platform were supportive resources, and that the reporting frameworks and Board reports would be updated to reflect the revised CNST domains and evidence expectations. An update was provided re: the homebirth assurance following a previously reported gap analysis. An audit of the 2025/26 homebirths was underway, and a national review is anticipated later in the year. The clinical outcomes, including the OASI and PPH rates, remain in line with the benchmarks. It was noted that there has been an improvement in the PPH rates following the introduction of Carbetocin and that all reportable cases continue to be reviewed through MDTs. A serious incident involving an independently supported community birth was noted. The Trust is working with the relevant partners to review its own involvement and identify any local/system learning, following which an update will be provided at a future meeting that will include details of any identified learning. • **Maternity Safety** continued assurance that had been provided in relation to safety, quality and governance across the service. There has been a continued improvement in the workforce position with the successful recruitment of newly qualified and experienced Midwives strengthening resilience, particularly within Community Services and Triage. One-to-one care in labour remains under active monitoring, and local use of the "red flag" events has been retained as a meaningful safety metric despite no longer being mandated for national reporting. The Committee welcomed the decision to retain this measure as it was felt it was an important internal indicator of the staffing pressures and clinical risks. An update was provided re: the progress that had been made in Equality, Diversity & Inclusion, which included a strengthened anti-racist practice, leadership engagement and a staff listening event. The early evidence suggests this work is having a positive influence on staff experience with increased engagement, greater confidence in escalating concerns and an improved update re: the leadership and development opportunities. The reverse mentoring scheme was noted to be small in scale but impactful. A discussion took place re: the equity-related patient safety risks, in particular the recurring incidents that are linked to access to the translation and interpretation services. It was noted a more structured approach was now being taken to reporting, record review and collaboration with PALS. The developing equity and patient safety dashboard was welcomed; however, the limitations in the national dataset and the reliance on local triangulation was recognised. The incident reporting levels remain strong/consistent. It was felt that this reflected a positive safety culture, with incidents being reviewed daily and weekly; however, as there were some delays re: Datix closure it was acknowledged that further improvement is required despite the incidents being reviewed by the senior teams. Details of the learning from a 4 year review of uterine rupture cases was shared, and it was noted that this challenged the assumptions re: the risk factors and also reinforced the importance of embedding system-wide learning.
	• **Freedom to Speak Up 6 month report** 6 monthly update re: the Freedom to Speak Up activity for Q2 & Q3 of 2025/26. It was noted that 30 concerns had been raised, and that the common themes included inappropriate behaviours, bullying & harassment, patient quality & safety, and issues with policies and processes. These themes were consistent with the wider organisational intelligence. No cases of confirmed detriment were reported; however, it was emphasised that fear of detriment remains prevalent and continues to be monitored and escalated, where required. Staff feedback has reflected feelings of disrespect through incivility or

	bullying, lack of support or feedback from Managers, pressures impacting safety and wellbeing, and perceptions of unfair treatment. An overview was provided of the organisational-level concerns relating to leadership behaviours not always aligning with the Trust's expected behaviours, limited transparency following concerns being raised and an ongoing reluctance to speak up due to previous negative experiences. It was highlighted the successful implementation of the revised Freedom to Speak Up operating model will strengthen the independence of the Guardian role, improve consistency in case handling, and enhance senior leadership oversight and Board-level assurance. Early indicators show improved visibility of the Freedom to Speak Up service, clearer escalation pathways, and more structured follow-up, learning and dissemination of outcomes across the Trust. This has begun to rebuild confidence in the service, particularly amongst staff who had previously been reluctant to speak up. The mandatory speak up and listening training continues to be embedded. This is supporting earlier local resolution of issues, improving confidence amongst Managers in handling concerns appropriately, and reinforcing the importance of listening behaviours. In addition, learning from Freedom to Speak Up cases was now being more consistently linked to improvement activity, including targeted Guardian input into departments where recurring cultural or behavioural issues were identified. The Freedom to Speak up themes were also feeding directly into the wider cultural initiatives, expected behaviours roll-out and patient safety discussions, and will continue to be used to inform targeted cultural and improvement activity.
	• **Deteriorating patients including Martha's law** Committee received a report relating to the deteriorating patient agenda which outlined the scope, maturity and impact of the workstream, with a particular emphasis on the implementation of Martha's Rule .It was highlighted that the programme brings together multiple strands of work that is focused on prevention, early recognition and timely escalation of deterioration, and is supported by the clinical standards, workforce education and system processes. Assurance was provided that this work is embedded within the Trust's wider quality improvement framework and is increasingly reflected in frontline practice. It was noted that compliance with the NEWS2 assessments within one hour of admission had improved from 53% in Apr 25 to 72.4% in Jan 26, with an average response time of 35 minutes for patients with a NEWS2 score of 5 or above and 86% reviewed within one hour. This reflects the focused work by the Acute Care Response Team; however, it was acknowledged that despite this positive trajectory, the consistency continues to be affected by staffing capacity and competing clinical priorities, meaning all workstreams cannot always be delivered within the desired timeframes. The education/training activity includes simulation training, Trust-wide newsletters and formal ALERT and BERT courses with monitoring in place to identify gaps and target wards and matrons accordingly. The ongoing collaboration with sepsis and the AKI teams to align delivery of a new NICE- aligned sepsis tool was noted. Re: the progress with Martha's Rule, It was noted the staff escalation process and the patient/relative escalation route were fully operational, with early data showing that patients, families and staff are increasingly confident in raising concerns, and examples were highlighted where timely escalation had resulted in a senior clinical review and improved coordination of care. The gap between the current NEWS2 performance and the 95% standard was highlighted, together with the need to triangulate this work with the wider system issues, including timely ICU admission.

	• **Stroke Performance** The Committee received an update on the stroke performance and service delivery and noted that the service remains rated as Level E under the SSNAP assessment. This rating reflects significant fragility and risk, but assurance was provided that stroke remains a key priority for the Division. A recent regional visit provided helpful external input, and a Stroke Working Group is actively driving improvement. A new acute stroke pathway was implemented on 16 March which was delivering a marked improvement re: time to CT scanning. This was acknowledged as being a key achievement as there has been an increase in performance to 44% of patients receiving CT within 20 minutes, resulting in the achievement of an A-rated standard for this specific metric. Whilst this was a critical early step, it would not be sufficient on its own to address the overall performance issues. A discussion took place re: the workforce pressures during which it was highlighted that the Consultant posts were being fully covered by locums and substantive recruitment was still proving to be unsuccessful. This reflects the national shortages and local service pressures; however, some improvement is expected at Resident Doctor level, as specialist and specialty doctors are due to commence in post shortly. The Committee welcomed the support of a regional Stroke Consultant from the RUH, who will commence in May and will have a clear objective to support leadership. The ongoing difficulties re: therapy staffing were also highlighted, particularly the absence of an out-of-hour and weekend therapy provision which was recognised as adversely impacting patient flow, length of stay and outcomes. Whilst an investment case exists it cannot be progressed due to the Trust's current financial constraints. The risks relating to the imaging infrastructure were noted, specifically the reliance on a server-based 3D imaging system. Mitigating measures are in place whilst the service awaits transition to a cloud-based system to reduce risk. A discussion took place that focused on the sustainability/safety of the current service model, and it was noted that whilst the improvements in early CT scanning were seen as beneficial, there are ongoing concerns re: the remaining pathway metrics, consultant decision-making capacity and therapy provision. It was emphasised that the staffing shortages reflect a national issue with widespread consultant vacancies, and that the financial constraints prevent simple investment-based solutions. The Committee considered whether the current service remained safe and whether the Trust could continue to provide an acute stroke service at its present rating. It was confirmed the Executives/Division will continue to meet regularly to undertake a focused review of the stroke safety metrics and provide assurance on whether the service remains safe. Currently, the consensus was that the service remains precarious but that it will remain under continuous review, with safety as the overriding consideration. The Committee expressed concern re: the long-term sustainability of the current model and the risk that continual poor ratings will further undermine recruitment.
	• **Cancer Long waiters** The Committee received a report that provided an update on the long waiting cancer patients, which focused on the pathway delays, performance against the national standards and the actions that were underway to improve patient outcomes. The Trust continues to experience significant pressure in meeting the 62-day standard, with skin, urology and colorectal pathways contributing to most of the backlog. The skin cancer pathways remain the highest risk, with 338 long waits, and whilst this represents a

	marginal improvement from the recent 6-month average it remains a substantial concern. The key drivers of the delays were outlined as high referral volumes (particularly in skin), workforce shortages across clinical and operational roles, constrained diagnostic and clinic capacity, reliance on external providers (notably plastics), and inconsistent engagement with the patient tracking list processes due to leadership vacancies. It was noted that there had been a spike in concerns within the Quality feedback in January followed by a reduction to below average levels in February, and that there was an observed correlation between the specialty pressures and patient concerns. Whilst harm reviews are being undertaken in line with the policy the timeliness continues to be inconsistent and currently requires follow-up by the cancer team, and it is acknowledged that this is an area that requires strengthening. The Committee reflected on the wider national workforce challenges, particularly within Dermatology and Plastics, and the difficulties these create for recruitment/retention within the NHS. Concerns were expressed about the potential cumulative impact of the prolonged waits on patient outcomes and confidence in the services and there was a recognition that the current measures of harm may not fully capture the longer-term consequences. It was suggested that developing a more robust outcome and progression intelligence could strength future cases for investment and support more effective system level decision making. The Committee felt assured that the report reflected an appropriate and expected position for the long-waiting cancer pathways, and that comfort could be taken that there was a clear understanding of the risks, together with an established governance process and an active action plan, notwithstanding the continued challenges that are largely driven by the workforce constraints.
KEY AREAS TO NOTE	• **CQC Preparedness and Progress Report** The Trust continues to demonstrate a strong commitment to CQC compliance through proactive quality improvement initiatives, action planning, and strategic alignment with regulatory expectations. Despite recent inspections highlighting areas for improvement there has been clear learning and system wide engagement. Changes within the national setting of CQC leadership will likely result in more change within the CQC domain, which the Trust will need to engage with which may impact in increased workload.
BOARD ASSURANCE FRAMEWORK & RISKS	
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	

Board Committee Assurance Report

Committee	Quality & Safety Committee	
Meeting Date	21.5.26	
Committee Chair	Claudia Paoloni, Non-Executive Director	
Link to Strategic Objective	Pillar 1 : Outstanding Care	
Link to Board Assurance Framework	BAF 1 : SR 1 : Quality	
Improving Together Pillar Metrics	Reducing Harms	Patient Experience
Improving Together Breakthrough Objective	Reducing deconditioning	

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. Falls (IPR breakthrough objective). Falls-Deconditioning Response	Good	
2. IP&C (IPR breakthrough objective)	limited	
3. Procedural Safety Report Q4	Good	
4. IPR Maternity -PQOM -Maternity Safety Report -perinatal Mortality Review Tool Report Quarter 4, 5. Nursing & Midwifery Audit aand ward Accreditation	Good Good Good Good Good	
6. Clinical Audit and effectiveness report Q4	Good	
7. Corridor Care 8. Integrated Front door-Quality Report	Partial Partial	
9. Quality Account report	Approve	
10. Safer Staffing-monthly update 11. 15 + Risk Score	Note Note	

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<td>POINTS OF ESCALATION</td>
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IPR: Reduction Total Harms: (116) still significantly Less than. January 2025 (170 cases).
Areas of Concern:

The Stroke pathway. Is still raising concerns around bed capacity, medical capacity gaps and therapy availability. The Committee has limited assurance around d the current stroke pathway and service even though some improvement has been noted in access to diagnostic scanning.
Committee has noted and reduced assurance around current infection control measures and metrics around Methicillin Sensitive Staphylococcus Aureus (MSSA) and pseudomonas, despite mitigations and retraining, but slight reduction in klebsiella, MRSA and E.coli have been noted
Numbers of complaints received in month has increased but the positive reponse rate has remained stable in the Emergency department and UTC.
Complaints and Concerns Response Rate. The complaint response rate is 73 % , not at target rate but higher than in January 2025 when was 69%. Concerns remain significantly increased from 342 in December to 495.Improvement work includes initiatives to support divisional meetings to manage complaints in addition to the IT systems and processes

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	IPR: Infection Control: • Area of focus for next month-deep dive on hand hygiene and use alcohol rub. • Enhanced Education around catheter care **IPR: Breakthrough Objective: Reducing deconditioning in acute care** • New breakthrough metric for 2026/27 change to reducing deconditioning in patients, to be measured by: Within 4 months, 75% of patients on all wards will be dressed and sat out for lunch, unless clinically inappropriate (current performance 40%) Within 6 months, 50% of patients will have BMAT score documented and applied to patient care. Within 8 months, patients defined as having high risk of deconditioning such as enhanced care and frail patients will participate in a form of physical or cognitive therapy 2-3 times per week. • Good engagement with positive multidisciplinary feedback • Each division has 2 matrons leading on this, 2 or 3 areas doing intensive work are showing some signs of improvement • Key themes following ongoing audits into reason behind patients not being sat out and dressed, will be shared across divisions. • **Watch Metrics:Pressure Ulcers and Falls and Medication Errors** There has been a notable decrease in Hospital acquired pressure harm rates and Falls are relatively stable Falls will become a watch metric and managed by weekly falls panel and still be part of divisional quality meetings. Pressure harms will continue to be monitored and managed through Division and a focus to reduce grade 3 pressure harms is in place. Medication errors are slightly up, any of these which are 'moderate harm" are discussed in safety huddles .
	• **Complaints and Concerns Response Rate**. The complaint response rate has reduced to 76 % but remains higher than in January 2025 when was 69%. Still jnot at target rate. Concerns have however significantly increased form 342 in December to 522. Focus on improvement work around understanding and addressing key factors contributing to concerns and complaints
	Maternity Integrated Performance Report • Now reported metrics in line with perinatal quality surveillance model (PQOM) • The notable change is a move from retrospective surveillance to proactive risk based oversight. • Marthas rule introduced on 1st October 2025 to enable rapid reviews of patient concerns not addressed. In April no requests were made. • Maternity data reporting continues to be strengthened, with work continuing on coding issues and to improve quality of data. Collaboration within the group is proposed to align data and support consistency in maternity dashboard reporting across the group. • High-level multidisciplinary gap analysis of the national Maternal Care Bundle has been completed. Improvement action plans are underway across all elements,

	with named senior midwifery and medical leads. The National Implementation Toolkit will inform ongoing actions and support delivery through established working groups and thematic reviews. • CNST Year 8 represents a reset of the scheme, focusing on six core domains with emphasis on safety outcomes, equity, and service user experience. Following the national launch (April 2026), Trust safety action leads have been assigned and an initial overview completed. Improvement action plans are now in development across the service for completion within the reporting period. • A developing pattern of newborn hypoglycaemia and Hypothermia incidents has been identified, with no evidence of associated harm to date. Quality Improvement projects have commenced using the Improving Together methodology to standardise and strengthen screening and management processes, improving consistency, escalation, and safety across maternity and neonatal services. • Avoiding Term Admissions Into the Neonatal unit (ATAIN) performance continues to show a recurring theme of missed initial reporting; there has been no associated increase in incidents or adverse outcomes. Structured improvement work, led by the Fetal Surveillance Midwife, Practice Development Lead and PQSA Lead, is underway using the Improving Together methodology to strengthen the timeliness and consistency of incident reporting. • Neonatal Workforce staffing and training do not meet required standards, in part due to high cot occupancy rates and a gap in current budgeted workforce establishment to need. Additionally, changing national guidelines has impacted the medical workforce not meeting BAPM requirements. • Training across MSW, fetal surveillance and safeguarding are below target rates of completion, impacted by acuity work and medical workforce rotations • Lack of capacity for the provision of Category 3 and 4 Caesarean Sections continues to be regularly reported. Ongoing work by senior team underway to address safety concerns and review of theatre staffing. No safety incidents reported as a result. • Rates of PPH ≥1500 ml per 1,000 births demonstrate expected month-to-month variation and remain within statistical control limits. While Trust rates are intermittently higher than national and MBRRACE comparators, the six-month rolling average is stable with no evidence of a sustained upward trend. A recent short-term increase has been noted and is subject to ongoing maternity governance oversight and monitoring. All PPHs ≥1500ml receive a MDT review to identify learning and no care or service delivery issues have been identified. Introduction of Carbetocin at all Caesarean Births is expected to impact on our PPH numbers **Perinatal Mortality Review Tool Q4** Year 7 of the NHS Resolution CNST Maternity incentive scheme (MIS) was launched in April 2025. To support delivery of Safety Action 1 (use of Perinatal Mortality Tool to review eligible deaths) Trusts are required: • To notify MBRRACE-UK of all eligible deaths (100%) within seven working days ,To seek at least 95% of eligible parents' view of care and give the opportunity to provide feedback and raise any questions and comments they may have from 1st December 2024 onwards. • To commence the full multi-disciplinary review of each death using the Perinatal Mortality Review Tool (PMRT) within two months for 95% of all deaths of babies suitable for review using the PMRT, from 1st December 2024. This includes deaths after home births where care was provided by the Trust. • A minimum of 75% of multi-disciplinary reviews of all eligible cases to be completed using the PMRT within 6 months.

	• For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT. • 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. • To ensure all eligible families receive information on the role of MNSI and NHS Resolution's EN scheme. • To comply, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour, and to ensure Trust Board has sight of evidence of compliance with the statutory duty of candour. • Ensure that Trust Board has sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. • To ensure that Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. There was I incident appropriately referred to MBRACCE UK in Q4 and 4 closed incidents **CQC Verbal Report** • Received verbal initial feedback on CQC report into maternity services. Disappointingly, having received "requires Improvement"- • Of 33 Quality Statements, 5 flagged alert with one serious. Of these improvements already identified and in progress. • Challenges to report have been submitted
	• Received the gap analysis report following the national prevention of Future Deaths relating to another organisation and home birthing dentified some partial assurance gaps relating to electronic documentation, risk classification and local SOPs. Targeted recommendations to strengthen assurance around these areas has been undertaken.
	• **Procedural Safety Report** This report summarised the activity of the Procedural Safety Oversight Group (PSOG) following the report that was presented to Patient Quality Sub-committee in September 2025. The priorities of PSOG over the last quarter are listed below: • To provide oversight for the scope of procedural activity in the Trust. • To provide oversight on the implementation of Organizational and Sequential standards as per the National Safety Standards for Invasive Procedures 2 (NatSSIPs 2 – 2023). See Figure 1. • To provide oversight on Never Event (NE) incidents and other Patient Safety procedural related incidents. • To provide oversight on Patient Safety related training in the Trust. Quarter 4 highlights include: • No Never Events (NE) declared since June 2025. • Divisional categorisation of Major vs minor procedures progressing well

	• Patient Safety Level 2 training levels remains a concern • DCMO reaching out to SFT and RUH. • There is good Divisional oversight but ongoing challenges with compliance around WHO Checklist process.
	Nursing & Midwifery Audit & Waard Accreditation Framework **Current Position** • The ward audit programme is now well-established, with regular monthly and quarterly audits completed across all clinical areas. • Clear governance and monitoring arrangements ensure that audit outcomes are reviewed, themes identified, and actions tracked through Divisional and organisational structures. • Peer review processes are increasingly embedded, strengthening objectivity and promoting shared learning. • Audit data is being actively reviewed for quality, realism, and value, ensuring it drives meaningful improvement rather than compliance for its own sake. **Key Themes** • Leadership visibility and consistency strongly correlate with higher audit performance; where leadership presence is variable, audit outcomes reflect this. • IPC compliance is improving but remains inconsistent, particularly around hand hygiene and equipment cleaning. • Peer review is strengthening objectivity and shared learning, though some wards are still developing confidence in giving and receiving feedback. **Improvement Actions** • Feedback is routinely given to the Ward Manager and Matron following each ward accreditation assessment irrespective of whether they are compliant or not • Complete the yearly audit reviews to ensure they are credible and appropriate • Support Ward Managers with their improvement plans and identify blocks with the assessments • Continue to provide education and support when completing the ward accreditation The committee noted, however, there was Disparity in matron audit results on hand hygiene and the IPC assessment of improvements required in that practice and associated infection rates. Infection prevention Control Team (IPCT) are specifically working with wards around this
	Clinical Audit and Effectiveness Q4 Report Clinical Audit activity in Q4 provided reasonable to substantial assurance across the majority of national audits, with many services performing at or above national averages. Recurring themes identified relate primarily to gaps in clinical

	documentation (including discharge planning, reasonable adjustments, asthma care bundles, post-fall assessments and end-of-life documentation), limitations within digital systems that restrict identification of key patient groups at admission, and ongoing workforce capacity pressures. Several specialties demonstrated strong performance against national benchmarks. Paediatric Epilepsy services exceeded national averages for care planning, consultant review and specialist nurse input, while Acute Kidney Injury outcomes, including 30-day mortality, aligned with national standards. Oesophago-Gastric cancer services showed excellent diagnostic timeliness, maternity services performed largely within expected ranges with evidence of good practice, and diabetes services reported effective Type 1 pathways, transition arrangements and MDT working. Mortality indicators, where reported, remained within expected limits. Governance oversight was maintained through departmental and divisional sign-off processes, alongside routine reporting to Trust committees. While these arrangements were effective overall, delays in report sign-off and action plan closure increased during the year, largely reflecting clinical service capacity pressures. Approximately 20% of audits experienced delays in completing action plans, presenting a recognised governance risk entering 2026/27, although improvement in timeliness was observed towards the end of the year. Overall, audit findings reported reasonable assurance, with standards largely met and identified gaps being actively addressed through action plans. Substantial assurance was demonstrated in key areas including maternity and perinatal care, blood transfusion safety, radiology, specialist services, critical care, peri-operative pathways and cancer services. Where mortality indicators were reported, outcomes were generally within or better than expected national benchmarks.
	Corridor Care report The committee received a thorough and frank situational report on the quality impact of extended corridor care. The report confirms that corridor care continues to be utilised during periods of sustained operational pressure, particularly at the front door and during times of high bed occupancy. While its use remains an escalation measure of last resort, capacity issues within the Trust result in consistent use. The evidence demonstrates that corridor care represents a material patient safety risk, affecting older, frail and vulnerable patients. Identified risks span multiple harm domains, including falls, pressure injury, infection risk, deconditioning, loss of privacy and dignity, delays in care. Incident reporting and thematic reviews have not identified any Patient Safety Incident Investigations (PSIIs) directly attributable to corridor care; however, recurring low-harm incidents highlight clear risk signals. A small number of falls incidents included one severe outcome following prolonged corridor exposure. Pressure harm data indicates overall improvement compared to earlier years, though an increase during 2025/26 aligns with periods of sustained corridor care use. Infection Prevention and Control (IPC) surveillance identified 39 gram-negative bloodstream infections during winter pressures, with the majority of cases entering via the Emergency Department, where corridor care exposure was

likely. Patient experience feedback consistently describes corridor care as distressing, with concerns focused on privacy, dignity, environmental conditions and delays.

The report also demonstrates that patients who experience corridor care have a significantly longer length of stay than Trust averages, increasing the risk of deconditioning and delayed recovery. While direct attribution of mortality to corridor care remains challenging, national evidence supports an association between care in non-designated areas, prolonged stays, and increased mortality risk.

This report confirms that corridor care continues to present a material quality and safety risk, particularly for older and vulnerable patients. While significant mitigation and improvement activity is underway, the evidence reinforces the need to minimise corridor care wherever possible and to maintain senior oversight where its use cannot be avoided. Importantly, the emerging RightCare Programme is beginning to shape and align the Trust's collective approach to addressing system flow, demand, and capacity, and will provide a critical framework to support the elimination of corridor care. As such, reducing and ultimately eliminating corridor care has been identified as a breakthrough objective for 2026/27, underpinning the Trust's commitment to safe, dignified, and high-quality care for all patients.

Integrated Front Door -Quality Report

Report provides assurance on quality, safety, and performance across the Emergency Department (ED), Urgent Treatment Centre (UTC), Children's Emergency Unit (CEU), and Medical Assessment Unit (MAU).

Overall performance in Q4 reflects sustained operational pressure driven by high demand, increased acuity, and constrained inpatient flow, particularly impacting ED and MAU. Corridor care remained at high levels and continues to present a significant patient safety, dignity, infection prevention and fire safety risk. Further hampered by misalignment between demand and staffing resource in UTC and front door services and lack of inpatient flow impacting ED congestion.

Fire risk assessments have identified the use of ED corridors accommodating up to nine patients as a significant risk, with clear actions in place to reduce corridor capacity and further assessments underway within MAU.

Key performance metrics continue to reflect the impact of sustained demand and remain below agreed standards.

Time to triage and time to initial clinical assessment remained outside of national target across ED and UTC, with CEU demonstrating comparative improvement following the implementation of a single-stream model. Combined four-hour performance remained below target; however, UTC achieved sustained compliance, indicating that targeted pathway and staffing interventions can affect improvement.

Patient safety intelligence shows increased incident reporting, reflecting improved reporting culture alongside risk escalation. There was deterioration in falls and pressure harm performance in Q4, particularly within ED, strongly correlated with extended length of stay, corridor care, and frailty-related demand. Learning from serious incidents and deaths is being progressed through After-Action Reviews, with themes reinforcing the risks associated with corridor care, delayed treatment, and decision-making a pressured environment.

	Encouraging improvement is noted in the stroke pathway, where process changes have resulted in improved access to timely CT imaging. However, the pathway remains under significant challenge with metrics such as time to Stroke Clinician remain of concern. Complaint response performance improved significantly in Q4; however, the volume of overdue complaints and patient feedback continues to highlight concerns relating to waiting times, communication, and the care environment. The IFD Risk Register currently holds 13 open risks, with three rated 15 or above. These risks are predominantly demand-driven and centre on prolonged waits in chair and corridor spaces, ambulance handover delays, and flow constraints. All high-rated risks have active controls and clear mitigating actions overseen through Divisional governance structures. In summary, whilst there is evidence of focused improvement and emerging good practice, particularly in CEU, UTC, and stroke care, system-wide demand and flow challenges continue to pose a material risk to safety and experience. And workforce constraints are being reviewed with respect to numbers and skill mix.
KEY AREAS TO NOTE	
BOARD ASSURANCE FRAMEWORK & RISKS	Good assurance around the process and identification of strategic risk around Outstanding Patient Care • Risk score has increased from 16-20 due to operational pressures and the impact on quality metrics • 2 new assurance reports: deep dives into Pressure ulcers and Concerns, trends and Themes • New gaps added: corridor care/hip fracture mortality/pressure ulcer performance
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	PPPC- looking for assurance around delayed access to diagnostics and procedure date and impact on disease progression with risk of inoperability or poorer /more limited outcomes

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

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only

SUBSTANTIAL	• **CQC Preparedness and Progress Report** • The Trust continues to demonstrate a strong commitment to CQC compliance through proactive quality improvement initiatives, action planning, and strategic alignment with regulatory expectations.

GOOD

PARTIAL

	• Despite recent inspections highlighting areas for improvement there has been cl;ear learning and system wide engagement. Changes within the national setting of CQC leadership will likely result in more change within the CQC domain, which the Trust will need to engage with which may impact in increased workload.
	•
LIMITED	**Limited Assurance**: Governance and risk management arrangements provide limited assurance that the risks/gaps in controls identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance.

Board Committee Assurance Report

Committee	**People & Culture Committee**	
Meeting Date	27 May 2026	
Committee Chair	Julian Duxfield, Non-Executive Director	
Link to Strategic Objective	Pillar 2: Valued Teams	
Link to Board Assurance Framework	BAF: SR 2 (Culture), SR 3 (Workforce Planning)	
Improving Together Pillar Metrics	Sickness rates	Staff survey – recommend place to work
	Staff survey – addressing discrimination disparity	
Improving Together Breakthrough Objective	Staff Survey – respect from colleagues	

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. Fit and Proper Person Test (FPPT)	Good	
2. 2025 Trust Staff Survey Results	Good	
3. GWH Integrated Performance Report	N/A	
4. GWH Workforce Plan 2026/27	N/A	
5. Annual report for Education and Training	Good	
6. National Education and Training Survey (2025) – Undergraduate and Postgraduate Medical Education Oct 2025, undergrad 'substantial, Postgrad 'good' / June 2025 'partial'	N/A	
7. NETS results for AP/AHP/Midwifery & Nursing.	N/A	
8. Board Assurance Framework BAF2 – Valued Teams – Q4 2024/25	Substantial	
9. Shared People Services Governance Overview	N/A	

POINTS OF ESCALATION	None
KEY AREAS TO NOTE	The committee noted the 2026/27 GWH Workforce Plan. Whilst the indicative reductions to pay and WTE are established, and delivery mechanisms through the transformation programmes and control meetings have been identified, £8.6M of pay efficiency remains unidentified and at present the transformational workstreams have not scoped routes to reducing workforce and pay. Delivery of the plan (WTE, non-pay spend, and productivity/efficiency delivery) will be monitored both at the GWH Financial Intervention Programme Board (FIBP), BSW Group Financial Oversight meetings and at regional financial/workforce Oversight Meetings. The committee received the report from the National Education Training Survey (NETS), of undergraduate and postgraduate students and trainees undertaking a practice placement, training post or work-based learning in healthcare. This report demonstrated a significant improvement in 11/13 domains and the highest scores since 2022 in 10/13 domains. However, there is work to do to address concerns in bullying and harassment, discrimination, sexual safety and wellbeing. The NETS results for AP/AHP/Midwifery & Nursing showed an overall improvement compared with last year, however there remains a need for focused development across the individual disciplines included in the survey. There is a detailed set of action plans for Nursing, Midwifery, AP's and AHPs, ensuring that each profession has a clear and

	structured approach to addressing identified priorities and strengthening the learning environment.
BOARD ASSURANCE FRAMEWORK & RISKS	With the establishment of the BSW Hospitals Group and new group-level roles, existing FPPT arrangements have been reviewed. A revised standard operating procedure has been developed to clarify the procedure and the secure management of FPPT records. An internal review will be undertaken to provide assurance on compliance with the revised SOP and consistent record management across the Group. The committee reviewed the full 2025 GWH staff survey results and the actions proposed to address issues. Analysis of the survey data highlighted 'Care of Patients as a Top Priority' (Q25a) as an area that will further drive improvement in staff 'recommending the organisation as a place to work'. This question has been adopted as the breakthrough metric for 2026/7. Collaboration will take place between the three trusts about how staff survey results are assesses and how actions are determined and planned over the next 12 months. The committee received the annual Academy Report on training and education. This demonstrates our continued commitment to delivering a high-quality Learning and Development (L&D) service across Great Western Hospitals. Over the past year, the Academy has supported a wide range of L&D activity, including clinical skills training, resuscitation services, mandatory training and compliance, apprenticeships and early careers pathways, and library and knowledge services.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	GWH sickness absence remains low compared to the vast majority of other trusts. The rate reduced from 4.1% in February to 3.97% in March, with long-term absence remaining below target at 1.93% and short-term absence decreasing to 2.03%. The 'Improving Attendance' working group will continue to focus on improvement initiatives in this area.
REFERRALS TO OTHER BOARD COMMITTEES	

Key to committee assurance ratings
Ratings focus on overall assurance over effectiveness of controls'.
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GOOD	**Good Assurance**. Governance and risk management arrangements provide good levels of assurance that the risks/gaps in controls identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas.
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Board Committee Assurance Report

Committee	Finance, Infrastructure and Digital Committee
Meeting Date	27 April 2026
Committee Chair	Helen Spice, Non-Executive Director

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. BSW Financial & Recovery Workstreams Update	Limited	x
2. Month 12 Finance Position	Partial	x
3. Efficiency Program Update	Partial	x
4. Dorset and Wiltshire Fire & Rescue Service Audit Update	Good	x
5. Digital Risk Register	Partial	x
6. Data Protection, IT Resilience and Cyber Security Update	Unable to rate	x
7. Digital Strategic Plan	Good	x
8. Procurement Recommendation Reports	Approved	x

POINTS OF ESCALATION	The Committee approved contracts for Outsource Radiology Reporting and Water, Wastewater and Ancillary Services for onward approval by the Trust Board.
KEY AREAS TO NOTE	**BSW Financial Recovery:** The Committee noted that the Group is on track to deliver the 25/26 outturn as planned. The projected position for 26/27 for the a Group is a £163m underlying deficit which highlights the scale of the financial challenge across the group. This arises due to a reduction in transition support funding, deficit support funding and non recurrent measures used to meet the 25/26 plan. The overall CIP plan for 26/27 is £173m of which only £117m has been identified to date and is still in the early stage of development. Productivity is going to need to improve significantly to achieve the same level of activity with a reduced workforce. The Committee raised concerns on the reliance on system partners to deliver the plan and asked the Care Organisation to ensure that they put in place appropriate mechanisms to hold partners to account. The Hunter Healthcare team are going to be critical to achieve the outturn required. **GWH Month 12 Finance Position:** The outturn for the year was a deficit of £13.9m in line with the updated plan that had been agreed. It was recognised that strong performance in Q1 and Q2 had been offset by delivery challenges in the CIP programme and significant operational pressures over the winter. The Care Organisation will be focused in 26/27 on sustaining activity through the winter period. An underspend of £2.5m capital at year end related to PFI Lifecycle works. The Committee raised concerns that this material risk needs to be a continued focus in the year ahead with the importance of using the condition survey to highlight concerns. **Efficiency Programme Update:** The Care Organisation delivered £25.8m efficiencies for the year, a 40% increase from 24/25 but below plan and only 43% recurrent. The Committee recognised the considerable efforts made by the teams. The Committee asked for continued focus to continue the momentum from the final months of 25/26 into the 26/27 plans. There is a significant challenge in the plan for 26/27 of £47.2m. **Dorset and Wiltshire Fire and Rescue Service (DWFRS) Update:** The Committee received an update on the progress that has been made to address the concerns raised by DWFRS. DWFRS have confirmed that they are satisfied with progress following a visit in February and have transitioned to business as usual monitoring, The Committee were assured that the system and processes are now in place to complete the work required and recognised the improvements and progress that the team have made. **Data Protection, IT resilience and Cyber Security:** The Committee received an update on activity from January to March 2026. Extensive activity has been undertaken and

	monitoring is in place. However, the Committee was not able to obtain full assurance as their queries could not be answered by the representatives at the meeting so this area will be revisited at the next Committee. **Digital Strategic Plan:** The Committee reviewed the Digital Strategic Plan and were assured that appropriate plans are in place and actions are being progressed. Good progress has been made to reduce the clinical coding backlog but there continues to be concerns on staffing levels and the ability to maintain the current position.
BOARD ASSURANCE FRAMEWORK & RISKS	The Committee reviewed the Digital Risk Register. The Committee raised concerns about a potential gap in oversight and risk management due to the transition to a new governance structure although were assured that work was being done to establish the new structure. Concerns were also raised on the overall risk for cyber security and the visibility of EPR programme risks and the Committee requested additional assurance to be provided at the next meeting on these areas.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	None noted.
REFERRALS TO OTHER BOARD COMMITTEES	The Committee asked the Audit, Risk and Assurance Committee to ensure that all significant programme risks are appropriately captured, reflected in risk reports and escalated appropriately.

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

Committee	Finance, Infrastructure & Digital Committee
Meeting Date	26 May 2026
Committee Chair	Faried Chopdat, Non-Executive Director

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. Finance Risk Report incl Way Forward Program	Good	x
2. BSW Financial & Recovery Update	For noting	x
3. Month 1 Finance	Limited	x
4. Efficiency Program Update	Limited	x
5. 2026/27 Budget Plan	Approved	x
6. Debtors Report Update	Good	x
7. Overseas Visitors Report	Noted	x
8. Health & Safety Annual Report – for approval	For approval	x
9. Staff & Student AccomodationPfoject - for approval	For approval	x
10. BAF Strategic Report	Substantive	x

POINTS OF ESCALATION	None noted.
KEY AREAS TO NOTE	**BSW Financial Recovery:** A verbal update was provided to the Committee summarising the key messages from the Joint Committee which was held in the previous week: • The 2026/27 Efficiency Programme is progressing, with more developed and implemented schemes across all Care Organisations. • Despite improvements, a significant delivery gap remains between the total efficiency target (£117.3m) and risk-weighted delivery (£54.8m), especially at GWH. • Key risks include unidentified savings, high execution risk in service transformation, and reliance on system-wide factors beyond local control. • Focus is needed on closing the unidentified gap (particularly at GWH), converting risk-weighted schemes into actionable plans, and reducing dependency risk by clarifying local versus system responsibilities.
	Month 1 Finance Position: The Committee is assured that robust governance and external support are in place to address the current adverse financial position, including an overspend of £1.8m against plan in M01. Monitoring by Workforce and Financial Recovery Committees, reinforced controls on temporary staffing, and engagement of Hunter Healthcare to accelerate efficiencies provide some level of confidence that appropriate action is taken to address the financial challenges and escalating risk of the Trust. While the deficit is recoverable, this is dependent on rapid improvement in efficiency and workforce discipline to restore financial sustainability.
	Efficiency Program Update: The Committee is assured that robust governance, oversight, and external support are in place to address the significant £47.2m efficiency target. While the programme is at an early stage and currently below plan, delivery has improved compared to last year, with 67% of the target now identified. Ongoing financial improvement routines, scheme reviews, and the engagement of Hunter Healthcare are strengthening delivery confidence. The immediate focus is on maturing schemes and accelerating recurrent efficiencies to mitigate delivery risks and support financial sustainability. The Committee agrees with management's assessments of limited assurance due to scale and risk associated with delivery of the Cost Improvement Program.
	2026/2027 Budget Plan: The report provides assurance that the 2026/27 budget has been set using national planning guidance and robust Group-wide assumptions. Key risks and mitigations are identified, with a breakeven plan submitted. The process ensures risks are understood and monitored, and

	appropriate actions are in place, giving the Board confidence in financial oversight and stewardship notwithstanding the significant challenges to deliver this plan and the escalating risk relating to finances.
	Health & Safety Annual Report: The Committee is assured that robust governance and compliance processes are in place for Health, Safety, Fire, and Security. Key achievements in 2025/26 include completion of most strategic workstreams, new training initiatives, a reduction in RIDDOR-reportable incidents, and strong audit outcomes with 77% departments rated Amber or Green. Effective management of external inspections, preparation for Martyn's Law, and strengthened multi-agency partnerships further support a positive assurance position. The Committee approved the Health & Safety Annual Report.
	Staff & Student Accommodation Project: The Committee has thoroughly reviewed and challenged the proposal for the new Staff & Student Accommodation facility on the GWH Expansion Land. FIDC is satisfied robust governance, commercial due diligence, and legal assurance processes are in place, and is happy to recommend the proposal to the Board for approval.
BOARD ASSURANCE FRAMEWORK & RISKS	**BAF Strategic Risks:** The Board Assurance Framework (BAF) for Finance, Estates & Digital was reviewed, deemed adequate, and supports effective scrutiny by Committees and the Board. Individual Trust BAFs will be retired at Group Board go-live (1 July 2026), with a Group BAF to be used initially.
	Finance Risk Report including the Way forward Program: The Committee noted the Finance and the Estates and Facilities Risk Management reports respectively and was assured that the risk management process was adequate and effective.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	None noted.
REFERRALS TO OTHER BOARD COMMITTEES	None noted.

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Report Title	Integrated Performance Report (IPR)				
Meeting	Trust Board				
Date	11/06/2026	Part 1 - Public	☐	Part 2 - Private	☐
Accountable Lead	Benny Goodman, Chief Operating Officer Luisa Goddard, Chief Nurse Jude Gray, Chief People Officer Simon Wade, Chief Financial Officer				
Report Author	Rob Presland – Deputy Chief Operating Officer Ana Gardete – Deputy Chief Nurse Claire Warner – Deputy Chief People Officer Johanna Bogle – Deputy Chief Financial Officer				
Appendices	Use of Resources: • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

Purpose

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

Assurance Level

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

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

Justification for the identified assurance rating (whether substantial, good, partial or limited).

If 'Partial' or 'Limited' assurance has been indicated, please indicate steps to achieve 'Good' assurance or above, and the timeframe for achieving this:

Report

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

Our Performance

The latest round of resident doctor industrial action took place from the 7th to 14th April. This resulted in the rebooking of routine surgery for 24 patients (all non-cancer) and the rescheduling of 373 outpatient appointments, 25 of which were for new or suspected urgent cancer referrals.

Key highlights from our operational performance for April (March for Cancer) are as follows:

STRATEGIC Pillar Metrics

- RTT (Referral to Treatment) 52 Week Waiters

RTT performance decreased in April to 56.7%, a deterioration of nearly 1% when compared to the previous month. The overall waiting list size increased month on month by 3.6% and currently stands at 44,196 patients. However, this is 589 better than planned and the monthly trend of waiting list growth experienced since July 2025 has continued to stabilise in the last two months.

The volume of clock stops for patients who received their first definitive treatment was 15% lower than the previous month and the weekly run rate was 5% lower than in April of 2025. The combined impact of the Easter bank holidays and a 1 week period of industrial action impacted on treatment plans, especially for outpatients, whilst the month on month reduction in clock stop activity reflects the end of the enhanced waiting list validation effort initiated in March.

The total number of patients waiting over 52 weeks was reported as 1002, an increase of 214 from last month. These breaches were primarily seen across the Surgical and Planned Care Division in the following specialties: Urology, General Surgery and Trauma and Orthopaedics.

There were 19 patients reported at 65 weeks, an increase of 9 from last month.

Improvement in RTT performance is expected from May, supported by the implementation of a strengthened elective recovery plan across all Divisions. The Trust has appointed a Director of RTT recovery to support the recovery effort over the next six months and a visit is being scheduled with the national elective GIRFT team in May to provide critical friend external assurance on the detail and pace of delivery plans.

Current RTT performance is 3.5% below plan for April and the work taking place in May will provide the required assurance on the timescales to recover to plan, with May's operating plan requirement set at 61%.

- Cancer waiting times

Cancer performance for the 28-day faster diagnosis standard increased to 80.7% in March and therefore the Trust achieved the operating plan and met national constitutional standard for the financial year end.

Sustaining performance remains challenging in tumour sites such as Breast where waiting list initiatives continue for radiology to support diagnosis within 28 days. GWH has requested non-recurrent financial support from funds available from the Thames Valley Cancer Alliance to maintain progress on backlog clearance which should be confirmed during Quarter 1. Performance is expected to remain close to operating plan in the coming months, although seasonal demand pressures in tumour sites such as skin are likely to increase.

62-day performance for urgent suspected cancer referral to treatment improved from 60.6% to 72% following improvements in the diagnostic part of the pathway, although the end of year target of 75.5% was missed. The most challenged Tumour sites remain Urology, Breast and Plastics. Cancer pathways for Plastic patients remain a challenge to sustained recovery and a review of service level agreements is taking place with Oxford University Hospitals NHS Foundation Trust in May.

Cancer 31-day performance improved to 89.7% but is not achieving the 96% standard with surgical and outpatient capacity in Plastics, Urology and Breast being the top contributors to breaches.

- Time in Emergency Department

Combined 4-hour performance was 67.6% in April and a deterioration of 1% from the previous month. Current performance is 10.7% worse than the plan for April and a recovery plan is being developed with support from the GIRFT urgent and emergency care team to provide required assurance on delivery plans to recover to plan and reach the 80% operating plan trajectory for March 2027.

In April, UTC pathway changes were implemented which means that all children attending UTC are now seen directly via the Children's Emergency Unit. Across the front door there were 850 more attendances this April compared to April last year, which is growth of 7.7% and the equivalent of 28 additional patients per day. This increase continues to be seen in the Type 1 (main ED stream) with Type 3 attendances remaining high but lower than the previous month. Work is ongoing with the ICB and community service providers to improve availability and utilisation of alternatives to ED and oversight of delivery plans for reducing attendances is taking place at system partnership meetings such as the community services delivery group.

GWH recovery plans are being refreshed across the Type 1 admitted, Type 1 non admitted and Type 3 streams, with UTC performance this period being a top contributor towards the under-delivery of the 4 hour target. Performance in April was 86.9% against the 98% recovery plan requirement, predominantly due to staffing issues and associated breaches due to lack of 1st assessment capacity, typically on a Monday following weekends. A review of counter-measures is under-way and a Clinical Director for Urgent and Emergency care has been appointed to this new role to support the implementation of recovery plans.

Ambulance handover performance improved in April to 38 minutes average handover time, but this remains above the 33 minute trajectory for the fourth consecutive month. Ambulance conveyances remain higher than plan and GWH has experienced a 25% growth in conveyances during the winter period (October to March) compared to the same period a year before. The Trust is taking part in a review of call before convey pathways in May and counter-measures are being developed with community service partners to increase virtual ward occupancy levels which continue to be under-utilised at place level in Swindon. A clinically led audit of ambulance arrivals is also taking place in May to inform next steps on reducing demand and alternative streaming options.

OPERATIONAL BREAKTHROUGH OBJECTIVES

- Reducing corridor care (ED and Inpatients)

In the most recently available reporting week ending 11th May, there were an average of 111 patients per day who experienced corridor care for over 45 minutes as part of their attendance or stay in the hospital. This was the first period of special cause improvement in the 20 week reporting period. Counter-measures remain in development for this new breakthrough objective but include:

- Implementation of the Trust wide corridor care improvement plan to improve patient safety and experience
- Mobilisation of the Right Care programme focusing on two workstreams: specialty bed realignment to develop the bed base and medical workforce to match demand and the every minute matters workstream targeting various hospital flow improvement initiatives to improve alternatives to ED, reduce length of stay and reduce discharges at the point in which patients are clinically ready to be discharged
- Implementation of the NHS England and Getting it Right First Time (GIRFT) Clinical Operational Standards monitoring tool with a focus on improving clinical communication protocols and technology
- Review of discharge planning processes to inform best practice for Board rounds and redesign of the function of the complex discharge support team to improve support for Ward areas that have the top contributors towards no criteria to reside
- Ongoing improvements to the Acute medicine model with support from the GIRFT national team
- Mobilisation of the short stay medical assessment unit expansion plan by October to increase capacity and reduce corridor care in the medical assessment unit which is one of the top contributors towards current performance

- Elective Waiting List: Referral to Treatment Time (RTT) 18 weeks Performance

In April 56.7% of incomplete pathways on the RTT waiting list were under 18 weeks, which was 3.5% worse than the plan.

This new breakthrough objective is in development and actions for the next month include:

- Completion of capacity / demand planning to inform bottom up recovery plans by specialty by end of May
- Correction of identified issues in inappropriate clock starts and removal of false clocks from the waiting list by end of June
- Review of governance and a refreshed weekly Exec led turnaround meeting by June
- Improved operational grip and recovery plans with clear timed phasing of activity and clock stops by end of June
- Admin process improvement including outpatient dating and outcoming, internal referral processes and booking of first outpatient under 40 weeks by end of July

The Trust operating plan is for 67% performance achievement by the end of March 2027, with national policy targeting a return to the 92% constitutional standard nationally by March 2029.

ALERTING WATCH METRICS

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

Diagnostics – April DM01 performance was 92.3% and below the operating plan target of 94.5%. MRI, CT and Dexa scans are all achieving the national constitutional standard of 99%. Non obstetric ultrasound is the largest wait list size but modality performance remains stable at 93.8%. Endoscopy performance is the most challenged area with performance expected to remain variable in the short term as services continue to embed within the new CDC endoscopy unit in West Swindon. Ongoing operational stabilisation, alongside targeted recovery plans will be critical to improving compliance across the modalities of colonoscopy (83% performance) and flexi-sigmoidoscopy (73.7% performance). The Surgery division will also be leading on a plan to recover Cystoscopy performance during 2026/7, which is currently at 48.7%, albeit with low volumes on the wait list.

Our Care

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

Strategic Pillar Targets

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

The number of harms has decreased to 116 in April when compared to 125 in March. Hospital acquired COVID cases are no longer included in the harms data.

Complaint response rate has increased to 73% in April, compared to 68% response rate in March.

Breakthrough Objectives

The Breakthrough Objective for 2026/27 has changed from reducing harm from inpatient falls to reducing deconditioning.

Aim for 2026/27

- Within 4 months, 50% of patients on all wards will be dressed and sat out for lunch, unless clinically inappropriate.
- Within 6 months 50% of patients will have an accurate BMAT score documented and applied to patient care.
- Within 8 months, patients defined to have high risk of deconditioning such as enhanced care and frail patients will participate in a form of physical or cognitive activity 2-3 times per week.

Alerting Watch Metrics

The number of concerns received in month is 495 a decrease from 544 received in March.

The overall Family and Friends positive response rate for April is 84.7% which is down from March at 85.7% and below the internal target of 90.0%.

Methicillin-sensitive Staphylococcus aureus (MSSA) cases increased in April compared to March, while Escherichia coli (E. coli) cases reduced over the same period.

Non-alerting Watch Metrics

The number of complaints received in month has increased to 94, compared to 81 received in March. The number of complaints re-opened has remained at five in month.
The Emergency Department and Urgent Treatment Centre positive response rate has remained stable in month at 78.2% compared to 79.2% in March.

The number of falls has remained stable at 76 in month, compared to 77 in March. 1 patient experienced a fall that resulted in moderate harm or above in month. 5 patients have fallen more than once and decrease form 9 in March.

There were no cases of meticillin-resistant Staphylococcus aureus (MRSA) reported in the month. Klebsiella cases reduced compared to March, while C. difficile infections also declined following the increase seen in the previous period. Pseudomonas cases showed a small increase, with 1 case reported in the month.

The number of hospital-acquired pressure ulcers has decreased in month to 8 from 12 in March.

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

- Safer staffing fill rates remain above the National target of 85%.
- One Patient Safety Incident Investigation has been declared in April.

Our People

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

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

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

- **Staff Survey – Recommend as a Place to Work**
  Target: 63%
  Q2 Pulse Survey: **50.6%** (decline compared to Q1 54.7%)
  2025 Staff Survey score: **59.1%** (marginal decrease compared to 2024)
- **Staff Sickness Absence**
  Target: 3.5%
  March 2026 figure: **4.0%**, (improvement from previous month 4.1%)

- **Equality, Diversity & Inclusion (EDI) – Disparity in Experience**
  Target: 9.4%
  Q2 pulse survey: **15.6%**, (decline of 10.6% compared to Q1)
  2025 Staff Survey: **6.9%** (improvement from 11.9% in 2024)

Breakthrough Objectives

The 2025 Staff Survey results show a slight decline in the Trust's pillar metric "Recommend as a place to work," which reduced to 59.1%. This trend is reflected nationally and is likely indicative of the increasing operational pressures experienced both at GWH and across the NHS.

Following initial analysis of the results, the Trust is refocussing improvement efforts on Question 25a: "Care of patients / service users is my organisation's top priority," which sits within the same advocacy theme and is closely linked to staff willingness to recommend the organisation as a place to work. This question also deteriorated in 2025, reducing from 75.3% to 72.4%.

At the TMC away day in April, the group reviewed the Staff Survey breakthrough question, and agreed a focused programme of improvement activity aimed at strengthening organisational culture, staff experience, and confidence in the Trust's patient-centred approach. Work is now progressing to develop targeted countermeasures and delivery plans across the key themes of staffing, safety culture, and communication.

Sickness Absence

The Trust's ambition remains to create a healthy, supportive, and inclusive work environment. Sickness absence continues to improve, reducing from 4.1% in February to 3.97% in March, with long-term absence remaining below target at 1.93% and short-term absence decreasing to 2.03%.

The 'Improving Attendance' working group extends focus on new Trust improvement initiatives:

- Scenario-based training and podcasts for absence management
- Support managers to conduct 'rota health checks'
- Work with HWB colleagues on monthly promotional campaign to keep staff 'well at work'.

Vacancy Rate

Trust vacancy levels at Month 1 were 248 WTE (4.8%), excluding unidentified CIP held within the general ledger. Reporting is now aligned to funded WTE within the ledger system rather than the year-end planned establishment approach used during 2025/26, resulting in an increase in reported vacancy levels at the start of the new financial year. Work is ongoing through the workforce reduction programme to identify recurrent CIP opportunities and remove corresponding budgeted establishment. Against our planned establishment figure, vacancy is at 124 WTE.

Registered Nursing vacancy levels remain below historical levels, with Band 5 Nursing currently over-established by 19 WTE. Overall Nursing vacancy levels, including registered and unregistered staffing groups, are 52 WTE at Month 1. Vacancy management across non-clinical areas continues in line with the financial recovery programme and wider workforce

reduction trajectory for 2026/27, with our Admin & Clerical vacancy position at 68 WTE in April.

Workforce Plan

The 2026/27 workforce plan sets out a reduction trajectory from a March 2026 closing position of 5,422 WTE to a planned March 2027 position of 5,078 WTE. Delivery of this reduction will be driven through the Outpatients, Right Care and Theatres transformation programmes, alongside the Group Corporate Services Redesign programme, with continued focus on reducing temporary staffing usage and improving workforce productivity.

At Month 1, the Trust workforce position was 5,289 WTE against a planned position of 5,215 WTE, an adverse variance of +75 WTE. This reflects workforce growth following submission of the 2026/27 plan and non-delivery of planned CIP reductions within the first month of the year. Whilst agency usage remains below plan (-8 WTE), bank usage is above plan (+26 WTE) due to continued enhanced care requirements and additional staffing required to manage ongoing site pressures. Sustained delivery of the agreed transformation programmes will be required to achieve the planned workforce reduction trajectory during 2026/27.

Use of Resources

The Trust reported a **£3.5m deficit in M01**, representing a **£1.8m adverse variance to plan**, driven primarily by under-delivery of efficiencies and workforce pressures. The deficit is **recoverable**, but only with **rapid traction on efficiency delivery and tighter workforce discipline from M02 onward**. Current run-rate is unsustainable against plan without corrective action. External support (Hunter Healthcare) has been mobilised to accelerate delivery.

Income adverse (£0.4m adverse)
The variance reflects:

- **£0.5m shortfall in efficiency delivery** (outpatients £0.2m, specialty schemes £0.2m, coding £0.1m)
- **£0.3m depreciation funding shortfall** (offset in costs)

This was partially offset by:

- ERF **+£0.1m**
- Education & training income **+£0.1m**
- Other income **+£0.2m**

Income is **£0.9m below prior year run-rate**, largely due to non-recurrent benefits in 2025/26 (including industrial action funding).

Pay (£1.6m adverse)
The adverse position is driven by:

- **£0.8m efficiency under-delivery** (including £0.4m unidentified)
- **£0.4m industrial action costs**
- Additional **£0.4m pressures** (WLI £0.2m; medical overspends £0.2m)

Key areas of underperformance include:

- Temporary staffing (£0.1m)
- Right Care UEC (£0.1m)

Pay costs are above prior year run-rate due to pay awards and medical accruals. Controls on temporary staffing and workforce reduction programmes are in place but not yet delivering at scale.

Non-pay (£0.2m favourable)

Favourable position reflects:

- **£0.3m lower depreciation** (offset in income)
- **£0.1m PFI accounting benefit**
- **£0.4m underspend** across supplies, drugs, and outsourcing

This is offset by:

- **£0.6m efficiency under-delivery**
- Scheme slippage in estates, procurement, and clinical divisions

Non-pay is **£0.5m above prior year run-rate**, driven by clinical supplies and passthrough drugs (income offset expected).

Efficiency Delivery

- **£0.5m delivered vs £2.4m plan → £1.9m shortfall in M01**
- Full year target: **£47.2m** (including £22.9m pay; c.217 WTE)
- **£30.0m schemes identified** → significant gap remains

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

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

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

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

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

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

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

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

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board/Committee/Group is requested to:

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

Accountable Lead Signature	Benny Goodman, Chief Operating Officer
Date	**21/05/2026**

Integrated Performance Report

May 2026

April 2026 & March 2026 data period

Improving together

Service Teamwork Ambition Respect

Content & introduction

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

Key Indicators

Measure Name	Target/Thres.	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Percentage of RTT patients treated within 18 weeks		59.6%	60.8%	61.2%	60.5%	60.7%	60.6%	59.8%	59.0%	58.0%	57.3%	58.0%	56.7%
Percentage of RTT patients waiting over one year		2.0%	1.8%	1.8%	1.6%	1.4%	1.3%	1.4%	1.5%	1.7%	1.8%	1.9%	2.3%
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	75% (Nat)	76.8%	79.2%	74.5%	65.6%	61.4%	63.9%	61.6%	71.6%	64.9%	80.4%	80.7%	Reported one month
Percentage of patients treated for cancer within 62 days of referral	85% (Nat)	69.7%	78.2%	69.3%	65.6%	65.8%	66.7%	65.6%	71.0%	61.6%	60.6%	0.0%	Reported one month
Percentage of Emergency Attendances within Four Hours	95% (Nat)	70.1%	69.1%	69.1%	67.8%	68.1%	69.9%	71.0%	71.3%	66.5%	69.3%	69.3%	67.6%
Percentage of Emergency Attendances over Twelve Hours	2% (Nat)	8.5%	5.6%	5.6%	5.8%	7.4%	7.4%	7.5%	7.2%	10.7%	10.5%	10.5%	7.8%
Planned surplus/deficit		-3476	-1173	-801	-1411	-1105	-480	-1484	-929	-2734	-2145	-3195	-3463
Rate of productivity		-13.0%	-13.0%	-8.1%	-10.0%	-14.0%	-12.0%	-15.0%	-13.0%	-10.0%	-13.0%	-13.0%	Reported one month
Readmission rate		16.0%	15.3%	17.0%	17.4%	15.5%	15.1%	16.3%	15.2%	14.8%	17.2%	15.8%	16.1%
Summary Hospital Level Mortality Indicator		2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	2 - as expected	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months	Reported five months
Average number of days between planned and actual discharge date		2.4	2.2	2.3	2.7	2.7	2.9	2.9	2.7	2.8	2.4	2.7	2.7
Percentage of inpatients referred to stop smoking services		11.9%	12.0%	12.1%	11.3%	11.4%	11.3%	11.2%	11.5%	10.5%	9.2%	11.2%	11.6%
Percentage of people waiting over six weeks for a diagnostic procedure or test	99% (Nat)	85%	84%	86%	89%	90%	93%	92%	90%	91%	94%	92%	Reported one month
Rates of MRSA		0.0	0.0	5.8	0.0	0.0	0.0	0.0	0.0	5.9	0.0	17.0	One month behind
Rates of C-Difficile		48.9	33.7	23.0	11.9	11.9	23.0	6.1	17.7	41.2	31.4	56.7	One month behind
Rates of E-Coli		43.4	39.3	51.8	50.7	41.7	63.4	42.6	58.9	58.9	52.9	62.3	One month behind
Percentage of NHS Trust staff to leave in the last 12 months	14.8% (Int)	11.7%	11.6%	11.9%	13.1%	12.8%	11.4%	11.2%	11.1%	9.9%	10.1%	10.4%	One month behind
Sickness absence rate	3.5% (Int)	4.1%	4.2%	4.4%	4.3%	4.1%	4.3%	4.2%	4.5%	4.3%	4.1%	4.0%	One month behind
Rate of annual growth in under 18s elective activity		11.8%	9.6%	4.9%	4.2%	4.5%	4.1%	0.0%	0.0%	0.4%	4.9%	10.6%	20.8%

Key Indicators

Metrics	2019	2020	2021	2022	2023	2024	2025
NHS staff survey engagement theme score	6.96	6.96	6.67	6.70	6.80	6.82	6.81
NHS Staff Survey – raising concerns sub-score	-	-	6.40	6.42	6.49	6.48	6.39

Metrics	2023	2024
CQC inpatient survey satisfaction rate	8.0	7.9
CQC National maternity survey score	8.6	8.2

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

Metrics	2020
CQC safe inspection score	Requires improvement

Executive Summary

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

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

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

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

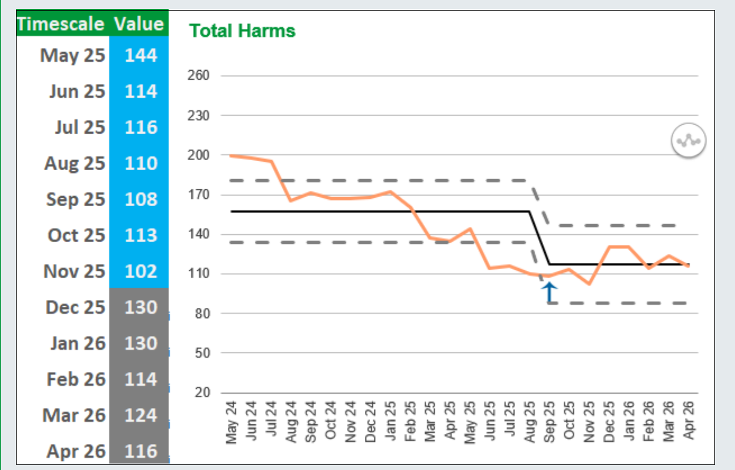
Trust Overall Complaint Response Rate
For 2025/26 this is a new pillar metric replacing the Friends and Family Test for the Patient Experience metric.

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

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

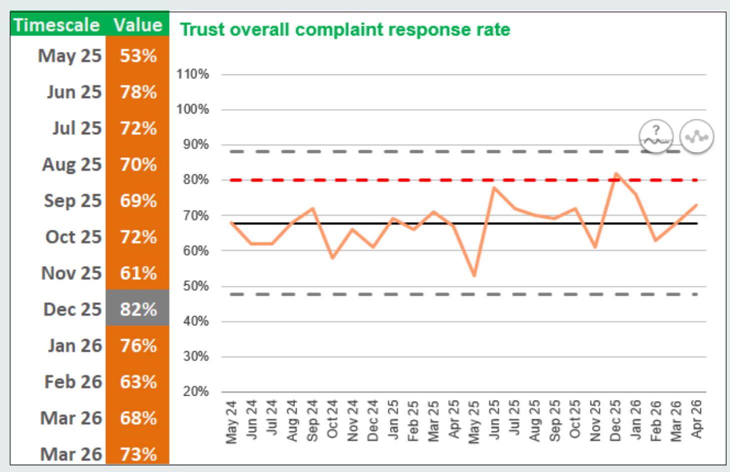
The monthly performance figure is based on the percentage of complaints responded to within the agreed timeframe. This is set at 35 working days and may be extended to up to 60 days where this is mutually agreed with the patient or their family.

Complaints response rate is tracked each month against timescale.



Total Harms
To achieve and sustain zero avoidable harm.

Timescale	Value
May 25	144
Jun 25	114
Jul 25	116
Aug 25	110
Sep 25	108
Oct 25	113
Nov 25	102
Dec 25	130
Jan 26	130
Feb 26	114
Mar 26	124
Apr 26	116



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

Timescale	Value
May 25	53%
Jun 25	78%
Jul 25	72%
Aug 25	70%
Sep 25	69%
Oct 25	72%
Nov 25	61%
Dec 25	82%
Jan 26	76%
Feb 26	63%
Mar 26	68%
Mar 26	73%

Counter Measures

The total number of harms in April was 116 a decrease from 125 in March.

Harm from Falls and Pressure Ulcers has reduced this month, with a notable decrease in Pressure Ulcers. Overall infection related harms have also declined; the main areas contributing to increased harm are infections associated with Methicillin-Sensitive Staphylococcus Aureus (MSSA) and Pseudomonas.

Medication incidents related to moderate harm or above have further increased in month.

In April, the complaint response rate showed improvement from 68% to 73%.

The divisional focus is on reducing older overdue cases that were carried over following policy changes introduced in February.

Improvement work includes Patient Experience “Go and See” initiatives to support divisional complaint meetings, alongside enhancements to Datix to ensure reporting is clear, accessible, and supports effective complaint management across divisions.

Executive Summary

Great Western Hospitals
NHS Foundation Trust

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

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

Countermeasures for the deteriorations seen here are listed below.

Cancer 62 Day – Combined Performance

In March, 63 pathways breached the standard with 49.5 being allocated to GWH resulting in performance of 72.0%. Of these, 28% are attributed to the Urology pathways & 26% to Beast pathways. These pathways are seeing issues with capacity for appointments and diagnostics. A number of pathways are also impacted by the need for multiple and repeat diagnostics.

RTT: Number of patients waiting over 52 weeks

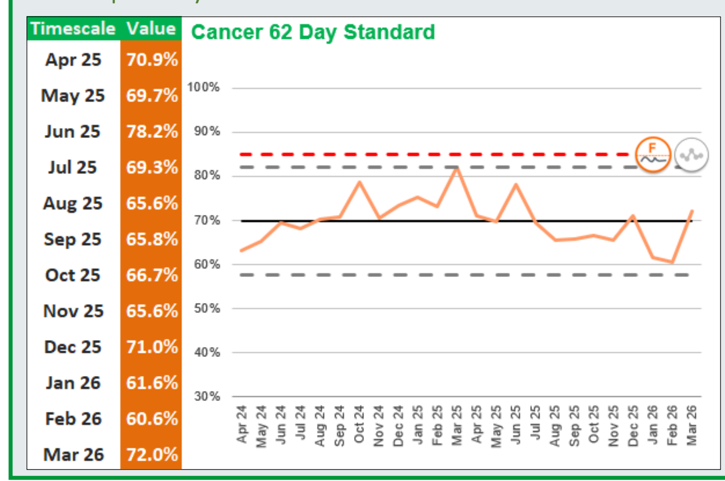
RTT performance decreased in April to 56.72%, a deterioration of nearly 1% when compared to the previous month. This was driven by a larger than expected volume of clock stops in the under 18-week waiters, and a 4% increase in clock stops in comparison to the previous month.

The total number of patients waiting over 52 weeks was reported as 1002, an increase of 214 from last month. These breaches were primarily seen across the Surgical and Planned Care Division in the following specialties: Urology, General Surgery and Trauma and Orthopaedics .

There were 19 patients reported at 65 weeks, an increase of 9 from last month.

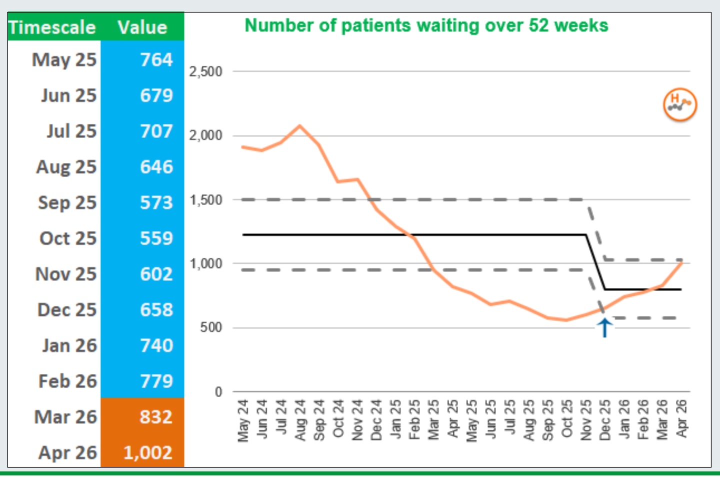
Benny Goodman | Chief Operating Officer

Cancer 62 Day
To achieve and sustain 85% performance for patients on a Cancer pathway.



Timescale	Value
Apr 25	70.9%
May 25	69.7%
Jun 25	78.2%
Jul 25	69.3%
Aug 25	65.6%
Sep 25	65.8%
Oct 25	66.7%
Nov 25	65.6%
Dec 25	71.0%
Jan 26	61.6%
Feb 26	60.6%
Mar 26	72.0%

RTT: Number of patients waiting over 52 weeks
To eliminate over 52-week waiters as soon as possible and to reduce to <1% of PTL by end March 2026



Timescale	Value
May 25	764
Jun 25	679
Jul 25	707
Aug 25	646
Sep 25	573
Oct 25	559
Nov 25	602
Dec 25	658
Jan 26	740
Feb 26	779
Mar 26	832
Apr 26	1,002

Counter Measures

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

Risk: Capacity issues for **Breast** first and follow up appointments
Mitigation: Additional WLI activity has been requested from the cancer alliance and south west region.

Risk: Capacity in **Dermatology** for first appointment and treatments
Mitigation: Additional activity being provided by external provider to help meet demand. Referral triage model changed to manage number of consultant appointments needed.

Risk: Insufficient capacity to eliminate waits over 65 weeks in Plastics
Mitigation:

- Mutual aid fully utilised as it becomes available
- Unfit patients/patient choice being managed in line with Trust Access Policy.
- Improved clinical review processes introduced with emphasis placed on the use of PIFU if a patient cannot be discharged.
- Validation of waiting lists
- Access team led intensive validation to work through cohort and increase clock stop run rate.
- Top 10 clinical specialty targeted recovery plans

Pillar Metrics

Executive Summary

ED Attendance as a Percentage of Population by Deprivation Quintile

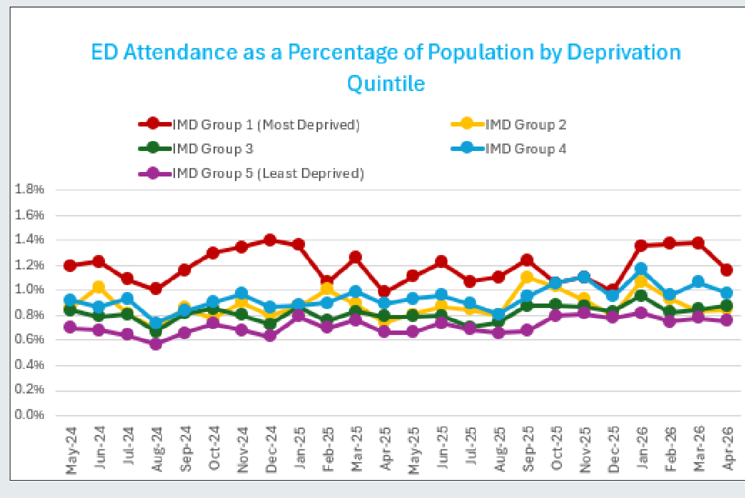
We want to understand whether our population's level of deprivation effects the use of emergency services. The metric shows that there is a difference in the percentage of the population who utilise ED/UTC that correlates with deprivation quintile. The populations in the most deprived quintile nationally (group 1) access ED/UTC slightly more frequently than less deprived populations (groups 2-5) although this gap has varied over time.

RTT wait top versus bottom quintile of social deprivation

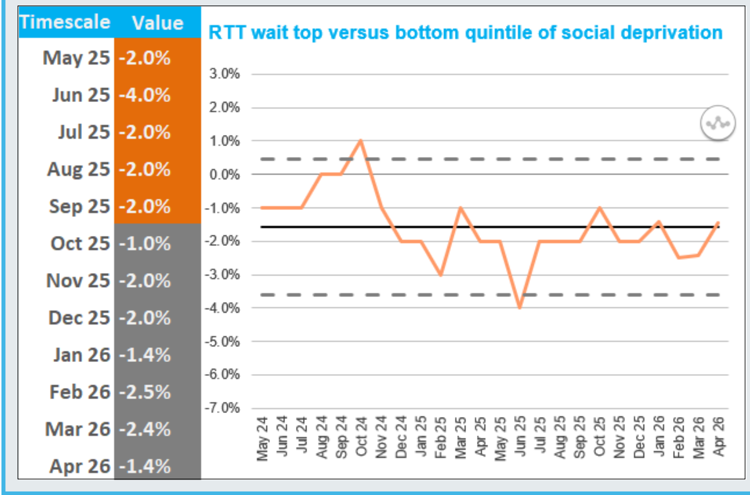
A value of 0% indicates that RTT performance was the same for the top and bottom quintiles of social deprivation. A negative value means that RTT performance was poorer for patients in the highest quintile of social deprivation, i.e. the most deprived areas.

Benny Goodman | Chief Operating Officer

Service | Teamwork | Ambition | Respect



RTT wait top versus bottom quintile of social deprivation



Timescale	Value
May 25	-2.0%
Jun 25	-4.0%
Jul 25	-2.0%
Aug 25	-2.0%
Sep 25	-2.0%
Oct 25	-1.0%
Nov 25	-2.0%
Dec 25	-2.0%
Jan 26	-1.4%
Feb 26	-2.5%
Mar 26	-2.4%
Apr 26	-1.4%

Counter Measures

We are seeking to understand the impact deprivation may have on our population's access to emergency services in order that we can work with people to provide alternative and earlier access to care where appropriate. The difference in access between people from the most deprived quintile and the rest of the population has narrowed in April and is inconsistent over time,

We have invested in an Associate Chief Medical Officer with a focus on partnership and health inequality who will take up post shortly. Gaining greater insight into the health inequalities within urgent care will be an important aspect of this role complimenting the ongoing work to review our approach to young people who access ED frequently to review whether similar support would support alternative pathways and earlier intervention.

This is a new measure for 2026/27 and aligns with information we see within the BSW Hospitals Group Integrated Performance Report. The data shows a consistently negative value with a mean of -1.6%; this means that patients from the most deprived areas wait (patients who live in the most deprived quintile nationally), on average, longer than the rest of the waiting list.

We are developing countermeasures as part of our RTT performance recovery programme. We need to further understand what is contributing to longer waits for this group of patients and want to review factors including: booking processes, digital access and literacy, patient information and accessibility & relevant adjustments. We aim to look at increasing equity and support to patients in accessing information about waiting and the next steps of their pathway.

Executive Summary

Emergency Care – Emergency Department - Mean Stay

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

The total meantime (ED & CEU) in April 2026 was 369 minutes (comparable to March 2026) against the national standard of 240 minutes, and the lowest time since December 2025. Mean length of stay has been affected by continued flow across the organisation, leading to ED outward flow and capacity to manage incoming patients.

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

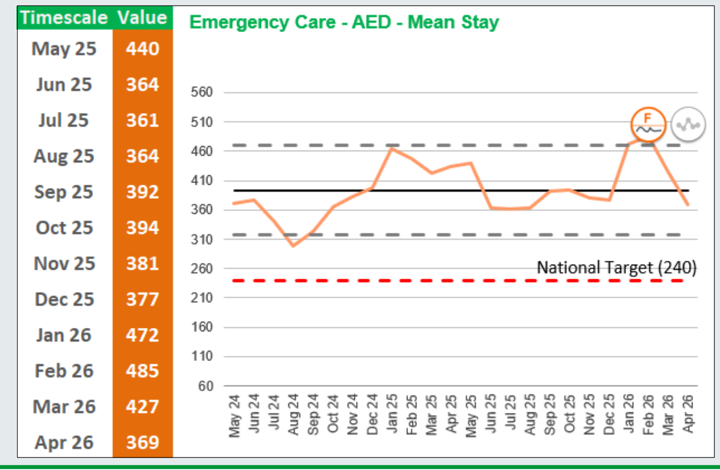
Emergency Care – Urgent Treatment Centre - Mean Stay

The total attendance mean time wait for a patient in April 2026 was 170 minutes against the national standard of 240 minutes, lowest performance since September 2025. Staffing has continued to be challenging with March having continuing staff sickness, leading to periods with longer length of stay, sometimes with 4hrs wait to be seen although discharge has then been prompt.

Benny Goodman | Chief Operating Officer

Emergency Care – Emergency Department - Mean Stay

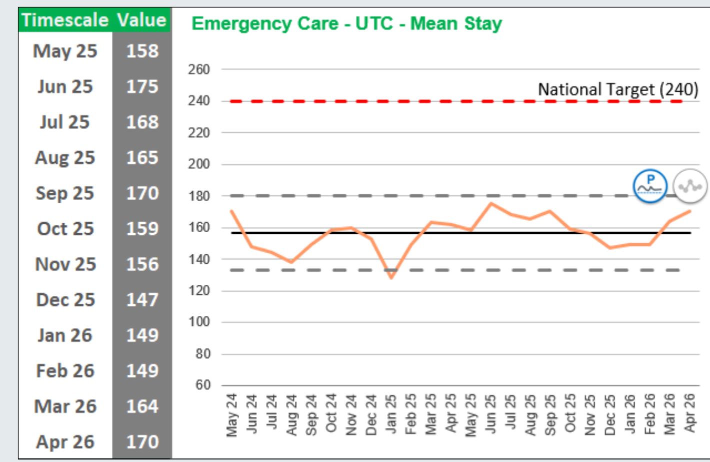
To achieve and sustain a mean time in department for all patients attending the Emergency Department.



Timescale	Value
May 25	440
Jun 25	364
Jul 25	361
Aug 25	364
Sep 25	392
Oct 25	394
Nov 25	381
Dec 25	377
Jan 26	472
Feb 26	485
Mar 26	427
Apr 26	369

Emergency Care – Urgent Treatment Centre - Mean Stay

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



Timescale	Value
May 25	158
Jun 25	175
Jul 25	168
Aug 25	165
Sep 25	170
Oct 25	159
Nov 25	156
Dec 25	147
Jan 26	149
Feb 26	149
Mar 26	164
Apr 26	170

Counter Measures

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

- ICB support to reduce attendances to UTC - increased community clinic places - Pharmacy 1st, Paediatric Acute Respiratory Hubs.
- Full utilisation of MAU/SDEC pathways
- Review of patient management SOPS to all IFD areas
- Reviewing criteria for UTC and SDEC

Executive Summary

Sickness Absence March 2026

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

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

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

Our target for sickness absence is 3.5%, and performance in March 2026 was 3.97%, a further improvement compared to the previous month.

Staff Recommendation as a Place to Work

The Trust recommend a place to work target is 63%. In 2025 the Trust achieved 59.1% performance in this area.

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

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

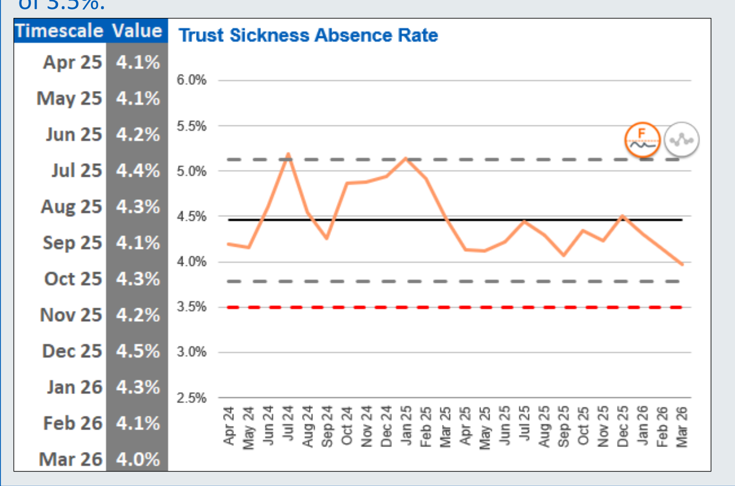
The number of staff who would recommend the organisation as a place to work increased from 53.3% in 2022 to 59.6% in the 2023 Annual Staff Survey.

The 2025 Staff Survey shows a small decline in this question, decreasing from 59.6% in 2024 to 59.1% in 2025.

Jude Gray
Director of Human Resources (HR)

Trust sickness absence rate

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



Timescale	Value
Apr 25	4.1%
May 25	4.1%
Jun 25	4.2%
Jul 25	4.4%
Aug 25	4.3%
Sep 25	4.1%
Oct 25	4.3%
Nov 25	4.2%
Dec 25	4.5%
Jan 26	4.3%
Feb 26	4.1%
Mar 26	4.0%

Staff % recommend the organisation as a place to work

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

Counter Measures

- Sickness absence further improved in March, decreasing from 4.1% to 3.97%. Long-term absence remains below target for the third month at 1.93%, whilst short-term absence is above KPI at 2.03% however has reduced compared to February.
- The Improving Attendance working group extends focus on new Trust improvement initiatives:
  - Exploring the use of scenario-based training and podcasts to support absence management;
  - Support managers to conduct 'rota health check reviews';
  - Working with HWB colleagues on monthly promotional campaign to support staff to 'stay well at work'
- Nominations for the Staff Excellence Awards have been open throughout April and shortlisted nominees will be announced in June ahead of the event on 17th July 2026.
- The Q1 Pulse Survey closed on 30 April with a 17.13% response rate (955 participants). Results, available on 15 May, will provide feedback on the 9 national questions and local themes including workplace discrimination, speaking up, patient safety, and embedding 'Our Behaviours'. Staff feedback has also been sought on awareness and impact of the emerging BSW Group model.
- During the month, the Health and Wellbeing programme prioritised delivery of TRiM (Trauma Risk Management) training for MAYBO trainers to strengthen staff support awareness, wellbeing sessions within the Expectations of Line Managers programme for Clinical Leads, psychological wellbeing training based on ACT principles, and on-site physiotherapy support for staff experiencing neck pain.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

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

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

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

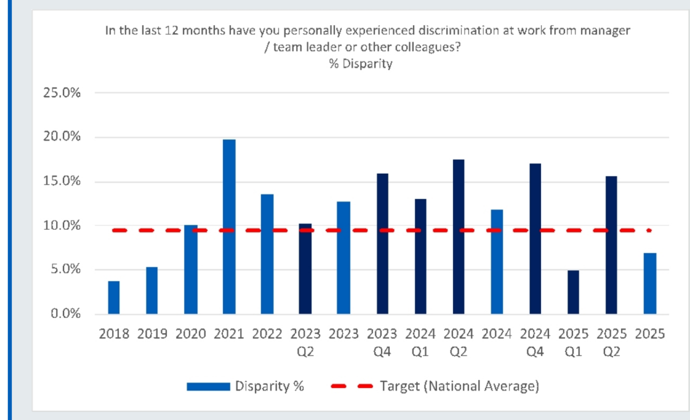
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

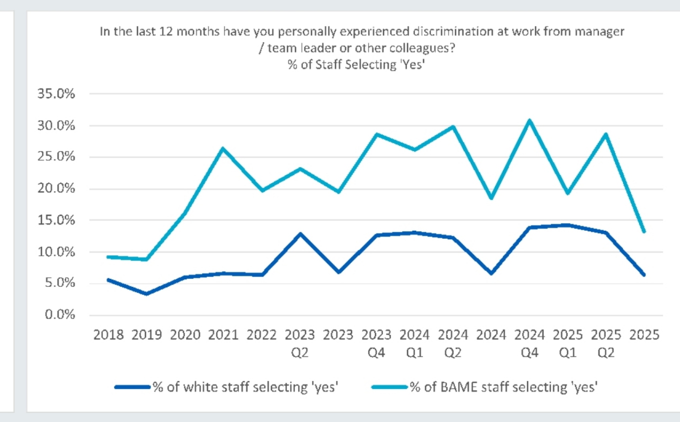
The Trust ambition in 2023 was to reduce the disparity in the q16b (personally experienced discrimination at work from manager/team leader or other colleague) between white staff and BAME staff from 13.5% to 9.4% in line with the national average and be below the national average for all staff.

Disparity has further improved in the 2025 staff survey results, reducing from 11.9% in 2024 to 6.9% in 2025.

Jude Gray
Director of Human Resources (HR)

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





Counter Measures

The Trust launched the 'Let's Talk Inclusion' initiative on 20 April – a joint campaign with RUH Bath and Salisbury NHS Foundation Trusts, designed to encourage staff to contribute to the development of the EDII agenda across the BSW Hospitals Group. Engagement across May and June will include site visits and virtual sessions and a survey has been published to gather further intelligence.

Staff continue to have access to training to improve inclusion awareness and to support them to embed inclusion into their working practices. An inclusive language workshop delivered on the 5th May providing practical guidance on communicating inclusively and developing confident approach to challenging non-inclusive behaviour. Bevan Brittan, Trust legal advisors delivered a 'Navigating Gender Identity' webinar for employers on the 12th May, outlining legal developments, statutory and policy implications.

The Trust's staff networks celebrated National Day for Staff Networks on the 13th May, with a drop-in session for staff to join and find out more about network opportunities. BSW Group EDI leads are working closely together and have produced self-help resources, aimed at equipping staff to develop local initiatives to improve equity and inclusion in their work areas. The resources include an eight-minute training module that will be launched at the EDI and Health Inequalities Conference in June 2026.

Executive Summary

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

The Trust reported a **£3.5m deficit in M01**, representing a **£1.8m adverse variance to plan**, driven primarily by under-delivery of efficiencies and workforce pressures. The deficit is **recoverable**, but only with **rapid traction on efficiency delivery and tighter workforce discipline from M02 onward**. Current run-rate is unsustainable against plan without corrective action. External support (Hunter Healthcare) has been mobilised to accelerate delivery.

Income (£0.4m adverse)

The variance reflects:

- **£0.5m shortfall in efficiency delivery** (outpatients £0.2m, specialty schemes £0.2m, coding £0.1m)
- **£0.3m depreciation funding shortfall** (offset in costs)

This was partially offset by:

- ERF **+£0.1m**
- Education & training income **+£0.1m**
- Other income **+£0.2m**

Income is **£0.9m below prior year run-rate**, largely due to non-recurrent benefits in 2025/26 (including industrial action funding).

Pay (£1.6m adverse)

The adverse position is driven by:

- **£0.8m efficiency under-delivery** (including £0.4m unidentified)
- **£0.4m industrial action costs**
- Additional **£0.4m pressures** (WLI £0.2m; medical overspends £0.2m)

Key areas of underperformance include:

- Temporary staffing (£0.1m)
- Right Care UEC (£0.1m)

Pay costs are above prior year run-rate due to pay awards and medical accruals. Controls on temporary staffing and workforce reduction programmes are in place but not yet delivering at scale.

Non-pay (£0.2m favourable)

Favourable position reflects:

- **£0.3m lower depreciation** (offset in income)
- **£0.1m PFI accounting benefit**
- **£0.4m underspend** across supplies, drugs, and outsourcing

This is offset by:

- **£0.6m efficiency under-delivery**
- Scheme slippage in estates, procurement, and clinical divisions

Non-pay is **£0.5m above prior year run-rate**, driven by clinical supplies and passthrough drugs (income offset expected).

Efficiency Delivery

- **£0.5m delivered vs £2.4m plan → £1.9m shortfall in M01**
- Full year target: **£47.2m** (including £22.9m pay; c.217 WTE)
- **£30.0m schemes identified** → significant gap remains

Simon Wade | Chief Financial Officer

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

To achieve and sustain a break-even financial position.

Timescale	Value
May 25	-3476
Jun 25	-1173
Jul 25	-801
Aug 25	-1411
Sep 25	-1105
Oct 25	-480
Nov 25	-1484
Dec 25	-929
Jan 26	-2734
Feb 26	-2145
Mar 26	-3195
Apr 26	-3463

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

5,000 · 3,000 · 1,000 · -1,000 · -3,000 · -5,000 · -7,000

May 24 · Jun 24 · Jul 24 · Aug 24 · Sep 24 · Oct 24 · Nov 24 · Dec 24 · Jan 25 · Feb 25 · Mar 25 · Apr 25 · May 25 · Jun 25 · Jul 25 · Aug 25 · Sep 25 · Oct 25 · Nov 25 · Dec 25 · Jan 26 · Feb 26 · Mar 26 · Apr 26

Counter Measures

Cash releasing efficiency savings were £1.9m below target in month. Actual savings delivered were £0.5m against a plan of £2.4m. Pay was £0.8m under plan and non-pay £0.6m, with income £0.5m under plan. Recurrent delivery was 34% in month. The total efficiency target for the year is £47.2m, and at current trajectory delivery is expected to fall significantly short. Reducing spend on a monthly basis is a key priority, and the Trust is working at pace with Hunter Healthcare to help divisions and services deliver recurrent savings.

Executive Summary

Carbon Footprint / Sustainability

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

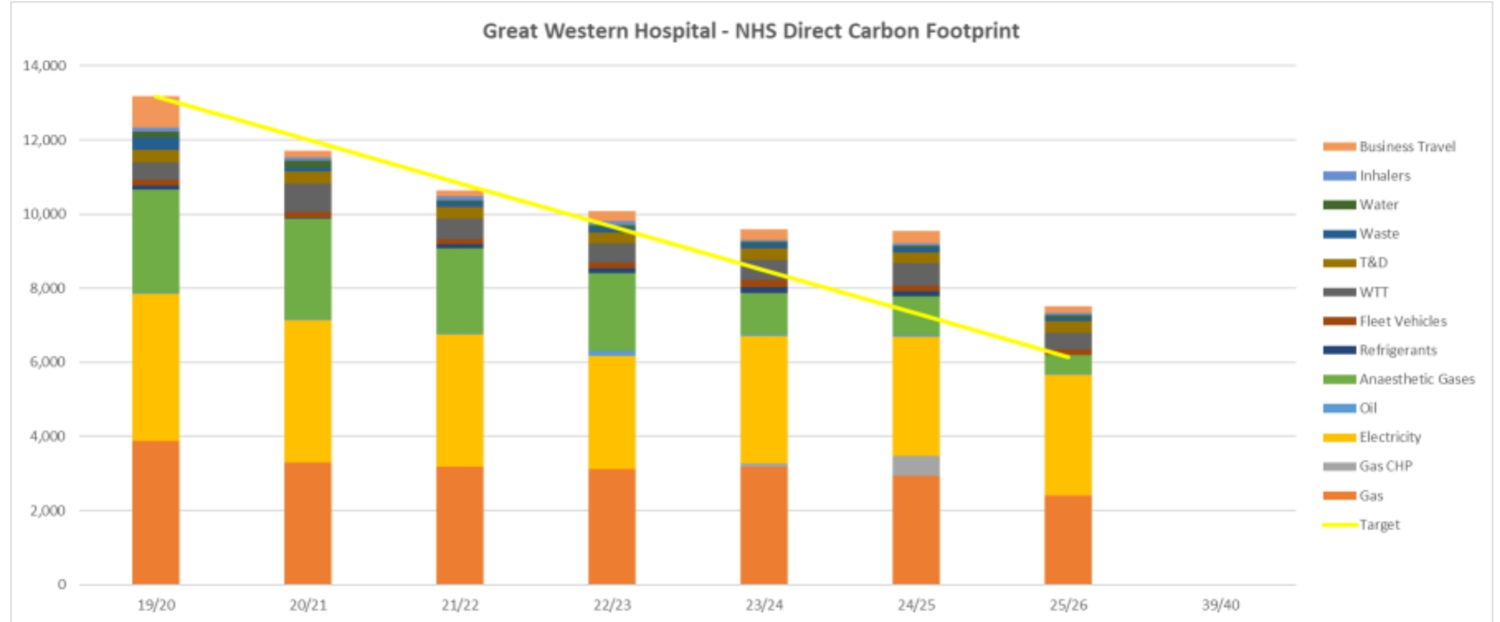
In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032 as shown with the target line on the graph from our 19/20 baseline year.

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

The graph to the right of the screen shows the draft carbon footprint for 2025-2026. The team are still waiting for the last items of utility data from THC and anaesthetic gas data from NHS England and then they will be able to confirm the carbon footprint for 2025-2026.

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

Simon Wade
Chief Financial Officer



Counter Measures

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

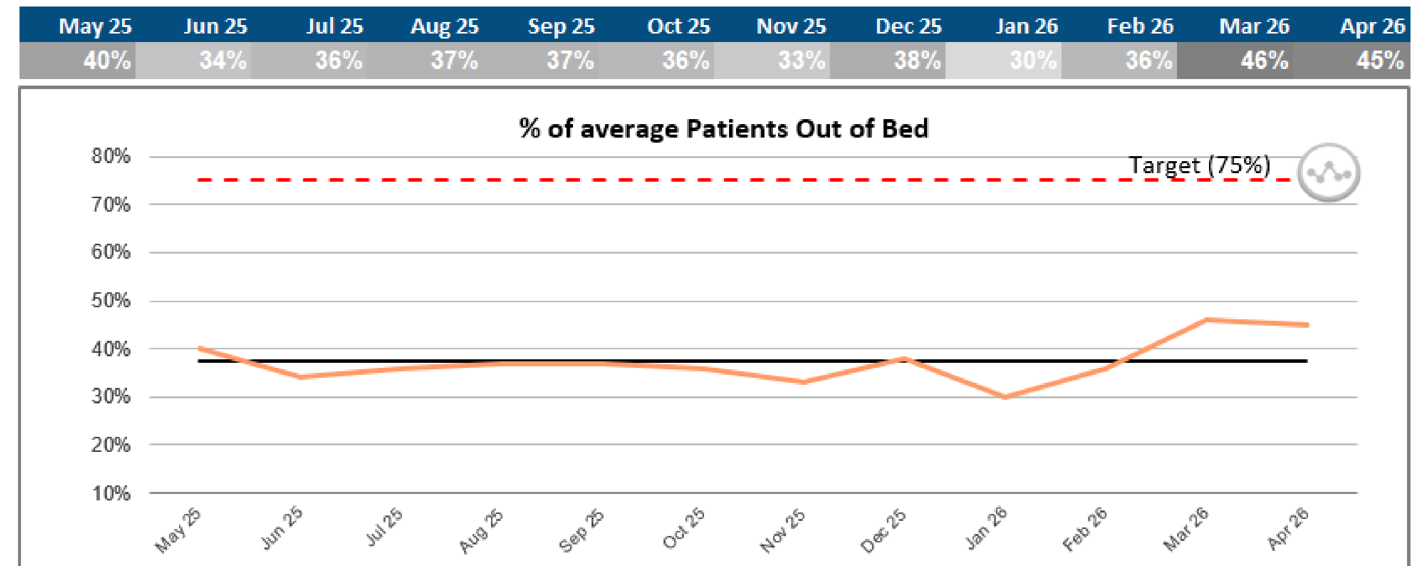
Please see the Green Plan for the full list of actions proposed for the next year. There is also ongoing projects within clinical departments such as Theatres, Critical Care and Endoscopy.

2026/27 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Reducing deconditioning in acute care

May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
40%	34%	36%	37%	37%	36%	33%	38%	30%	36%	46%	45%



Common cause - no significant change

Understanding the Data

Deconditioning is a significant and preventable harm, associated with increased risks of falls, pressure ulcers, hospital-acquired infections, delirium, prolonged length of stay, and higher care needs on discharge.

In May 2025, a Trust target was set for 75% of patients to be mobilised out of bed, appropriately dressed, and seated in a chair for lunch. Current performance averages 40%, highlighting a substantial gap and the need for focused, system-wide action. This underpins the prioritisation of deconditioning reduction as a Trust breakthrough objective.

We are driving this measure because...

National evidence indicates that **60–70% of patients** experience deconditioning following acute hospital admission. Limited routine mobilisation and reliance on bed-based care expose patients to hidden harm.

Patients who experience deconditioning are more likely to:

- Fall
- Increased risk of pressure damage
- Are more susceptible to upper respiratory and other hospital acquired infections
- Develop delirium and cognitive decline
- Have an increased length of stay
- Have increased care needs on discharge from hospital.

Performance

Overall, performance in 2025/26 shows that, on average, around 40% of patients are sitting out of bed for lunch. There has been slight improvements over the past two months, reflecting the impact of targeted deconditioning projects on two wards.

As this is the first month of focused project work, variation in performance across wards is expected while implementation is in its early stages. April performance shows an overall achievement of 45%. While some areas are already showing improvement, others remain at an earlier stage of implementation, reflected in lower rates of patients sitting out of bed for lunch. This variation provides a clear opportunity to share learning and accelerate improvement across all wards. New countermeasures are currently being explored to support consistent delivery. Over the past year, Aldbourne Ward was the only area to achieve the 75% target, doing so in May and December 2025.

Improvement Actions:
Targeted microculture “Improving Together” projects have been launched on Teal Ward and the Trauma Unit, with a further ward planned to commence shortly.

Monthly ward-based audits are ongoing and will be strengthened to provide more robust insight into the reasons why patients are not consistently sitting out of bed.

Key themes identified at ward level will be shared across divisions to support learning, with the Improving Together methodology used to develop and implement targeted improvement actions.

Reducing hospital acquired deconditioning will help reduce harm, financial burden, length of stay and improve patient experience and quality of care provision.

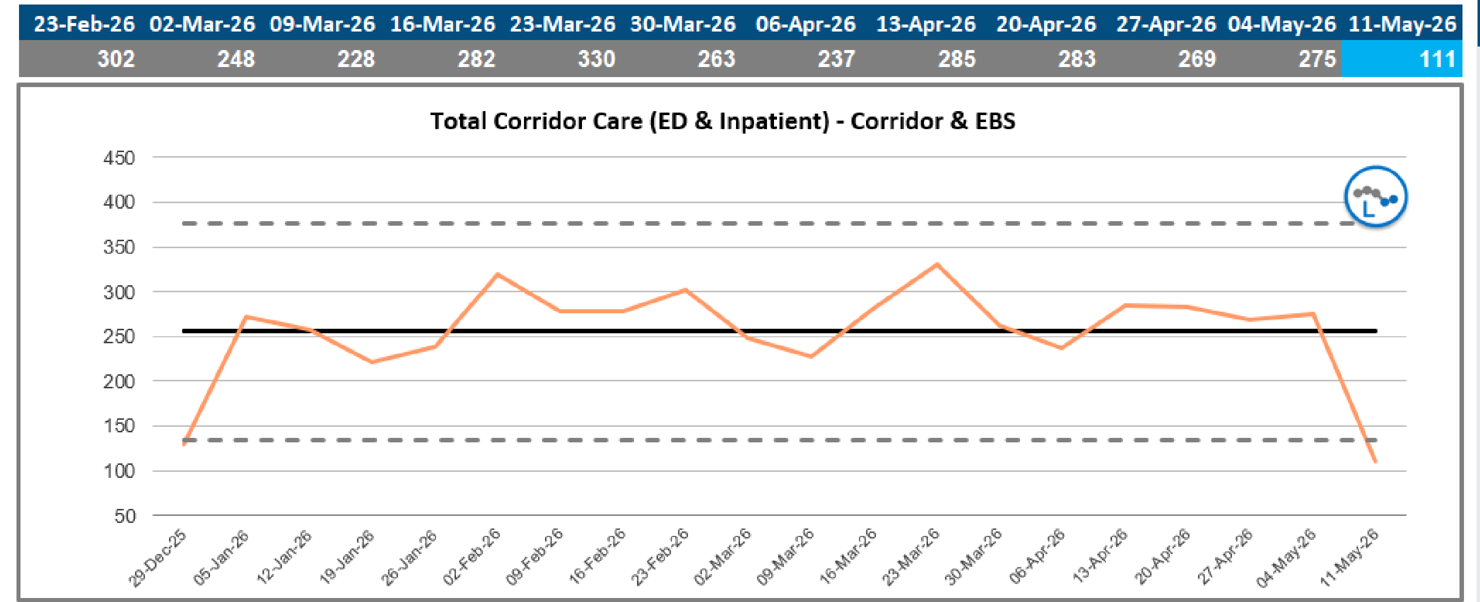
Aim for 2026/27: For the trust average of patients dressed appropriately and sat out of bed to eat lunch will consistently reach **75%**.

2026/27 Breakthrough Objectives

Great Western Hospitals
NHS Foundation Trust

Total Corridor Care (ED & Inpatient) - Corridor & EBS

23-Feb-26	02-Mar-26	09-Mar-26	16-Mar-26	23-Mar-26	30-Mar-26	06-Apr-26	13-Apr-26	20-Apr-26	27-Apr-26	04-May-26	11-May-26
302	248	228	282	330	263	237	285	283	269	275	111



Special Cause Improving Variation

Understanding the Data

This metric shows the weekly average of daily patients receiving corridor care in the Emergency Department and inpatient ward areas. It is based on daily counts of patients who spent over 45 minutes in a setting that did not meet safety, privacy, dignity, or infection-control criteria. Figures are reported midnight to midnight and exclude ambulance handover delays, providing a consistent view of sustained pressure rather than single-day variation.

We are driving this measure because…

Corridor care poses significant risks to patient safety, dignity, and experience and reflects severe pressure on flow and capacity.

Tracking this weekly average helps identify persistent system strain, supports escalation and improvement actions, and enables monitoring of progress over time. The measure strengthens accountability and aligns with the NHS commitment to reduce and eliminate corridor care in hospital settings.

Performance

In the most recently available reporting week there were 111 patients who experienced corridor care for over 45 minutes as part of their attendance or stay in the hospital. This was the first period of special cause improvement in the 20 week period. Counter-measures remain in development for this new breakthrough objective but include:

- Mobilisation of the Right Care programme focusing on two workstreams: specialty bed realignment to develop the bed base and medical workforce to match demand and the every minute matters workstream targeting various hospital flow improvement initiatives to improve alternatives to ED, reduce length of stay and reduce discharges at the point in which patients are clinically ready to be discharged
- Implementation of the NHS England and Getting it Right First Time (GIRFT) Clinical Operational Standards monitoring tool with a focus on improving clinical communication protocols and technology
- Review of discharge planning processes to inform best practice for Board rounds and redesign of the function of the complex discharge support team to improve support for Ward areas that have the top contributors towards no criteria to reside
- Ongoing improvements to the Acute medicine model with support from the GIRFT national team
- Implementation of the Trust wide corridor care improvement plan to improve patient safety and experience
- Mobilisation of the short stay medical assessment unit expansion plan by October to increase capacity and reduce corridor care in the medical assessment unit which is one of the top contributors towards current challenges

The Trust wide Urgent and Emergency care transformation programme continues to focus on sustaining the improvements made in non-elective length of stay and embedding further progress into 2026/27.

Risks

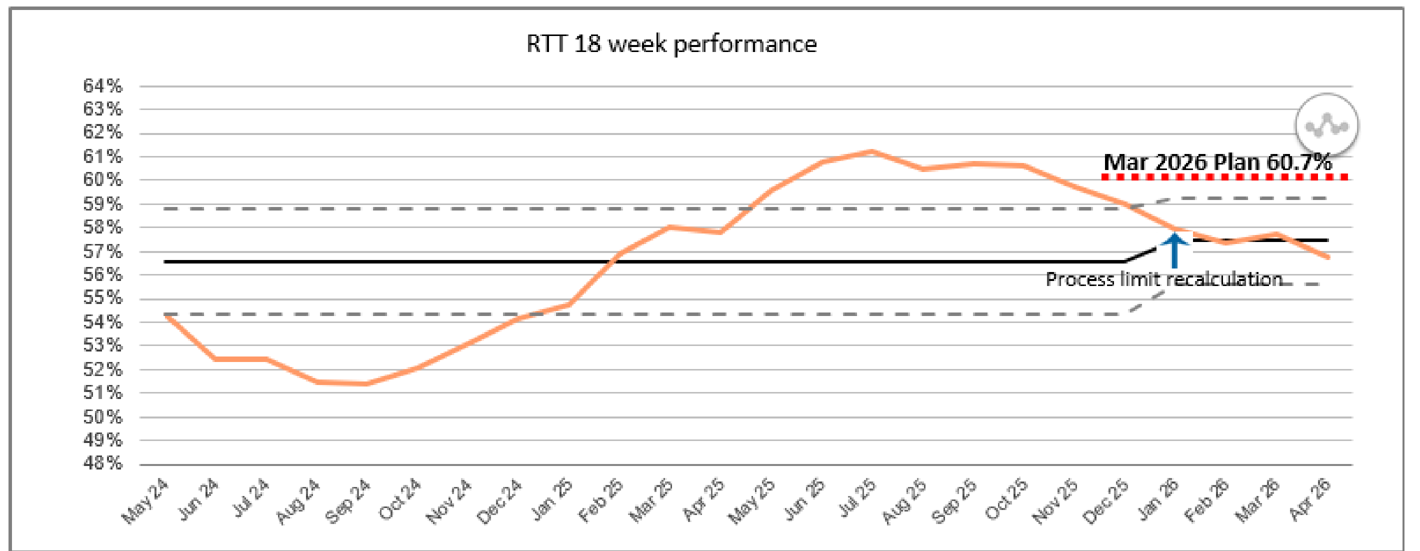
There is a risk that sustained high hospital occupancy and poor patient flow increase the use of corridor care within the Emergency Department. This can result in delays to assessment and treatment, overcrowding, and reliance on temporary escalation spaces that do not meet required safety, dignity, or privacy standards. Prolonged corridor care is associated with higher patient safety incidents, increased mortality risk, and poorer patient experience, particularly when general and acute bed occupancy regularly exceeds safe operating levels.

2026/27 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

RTT 18-week performance

May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
59.6%	60.8%	61.2%	60.5%	60.7%	60.6%	59.8%	59.0%	58.0%	57.3%	57.7%	56.7%



Understanding the Data

This metric shows performance against the planned trajectory for the Referral to Treatment (RTT) 18-week standard, which measures the proportion of patients starting consultant-led treatment within 18 weeks of referral. Performance is compared to the agreed recovery plan, highlighting variance between actual delivery and expected progress. This provides a clear view of whether elective recovery activity is on track and where backlogs or capacity constraints are impacting delivery.

We are driving this measure because…

Meeting the RTT 18-week standard is a key indicator of timely access to planned care and patient experience. Tracking performance against plan supports oversight of elective recovery, helps identify gaps in capacity or productivity, and enables targeted action where delivery is off trajectory. Sustained improvement in this measure reduces waiting times, clinical risk from long waits, and supports national NHS elective recovery priorities.

Performance

RTT performance decreased in April to 56.7%, a deterioration of nearly 1% when compared to the previous month. The overall waiting list size increased month on month by 3.6% and currently stands at 44,196 patients. However, this is 589 better than planned and the monthly trend of waiting list growth experienced since July 2025 has continued to stabilise in the last two months. In April, the combined impact of the Easter bank holidays and a 1 week period of industrial action impacted on treatment plans, especially for outpatients, whilst the month on month reduction in clock stop activity reflects the end of the enhanced waiting list validation effort initiated in March.

Current RTT performance is 3.5% below plan for April and the work taking place in May will provide the required assurance on the timescales to recover to plan, with May's operating plan requirement set at 61%. Counter-measures include:

- Executive led recovery plans informed by demand and capacity plans for top 10 contributing specialties requiring 10% improvement in year
- Backlog clearance for outpatient bookings over 40 weeks
- Review of waiting list management standard operating procedures, escalation management and governance

Risks

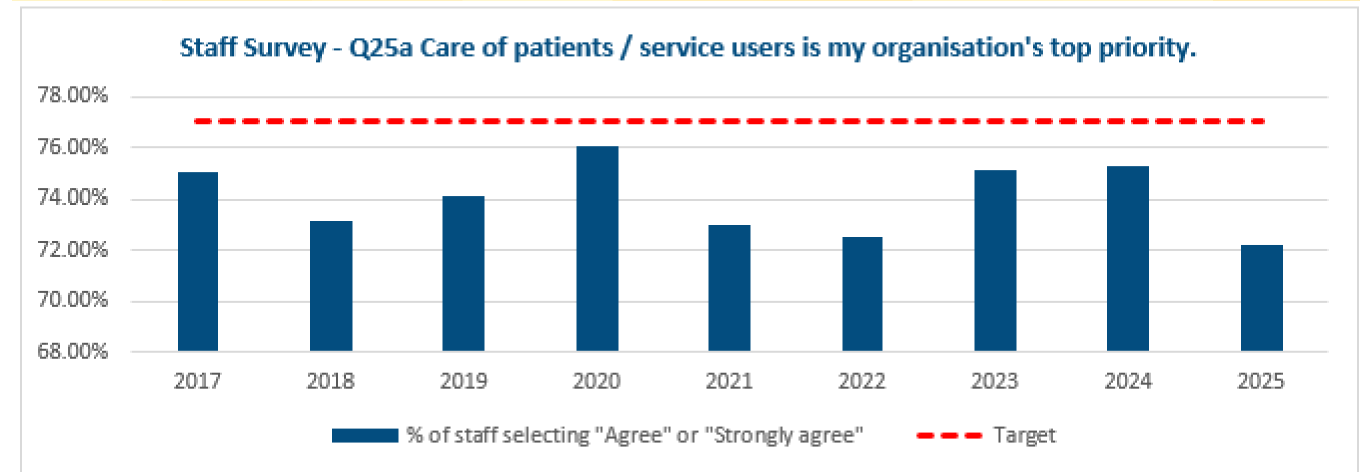
- Administrative capacity to build, validate and support new pathways may result in delays to implementation or pausing of this sub workstream.
- Capacity Constraints: If there is insufficient capacity to handle the increased demand for early appointments, it could delay the overall process and hinder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

2026/27 Breakthrough Objectives

Staff Survey – Q25a Care of patients / service users is my organisation's top priority.

Great Western Hospitals NHS Foundation Trust

2017	2018	2019	2020	2021	2022	2023	2024	2025
75.00%	73.12%	74.06%	76.04%	73.00%	72.53%	75.08%	75.29%	72.20%



Understanding the Data

The data shows the percentage of staff positively responding that they feel care of our patients and service users is the organisation's top priority.

These results reflect staff perceptions of whether patient care is truly prioritised within the organisation. This is a key indicator of culture and leadership credibility, and is closely linked to staff advocacy, morale, and overall confidence in the organisation.

We are driving this measure because...

This staff survey feedback is an important measure of staff's levels of engagement and advocacy with the organisation.

When staff feel confident that delivering high-quality care is the organisation's true focus, it strengthens engagement and trust in leadership. This, in turn, supports staff recommending the organisation as a place to work, as well as positively influencing morale, teamwork, and retention.

Performance

At the TMC away day in April, the group reviewed the Staff Survey breakthrough question, "Care of patients/service users is my organisation's top priority" and agreed a number of focused improvement areas to strengthen staff experience and confidence in the organisation's patient-centred approach. Work is now progressing to define detailed countermeasures and delivery plans across the agreed themes of staffing, safety culture, and communication:

- Staffing levels: improving staff understanding of how daily roles contribute to patient outcomes, strengthening communication when staff redeployment is required, and addressing perceptions around staffing pressures through targeted myth-busting and engagement activity.
- Safety culture: reinforcing a culture of speaking up through 'Our Behaviours', improving feedback and shared learning following complaints and incidents, ensuring consistent use of Datix learning processes, and strengthening feedback mechanisms for teams experiencing predominantly negative interactions.
- Communication: increasing visibility of patient and Friends & Family feedback within Trust communications, reducing reliance on WhatsApp through alternative communication channels, and developing digital solutions to better direct staff queries to the appropriate departments.

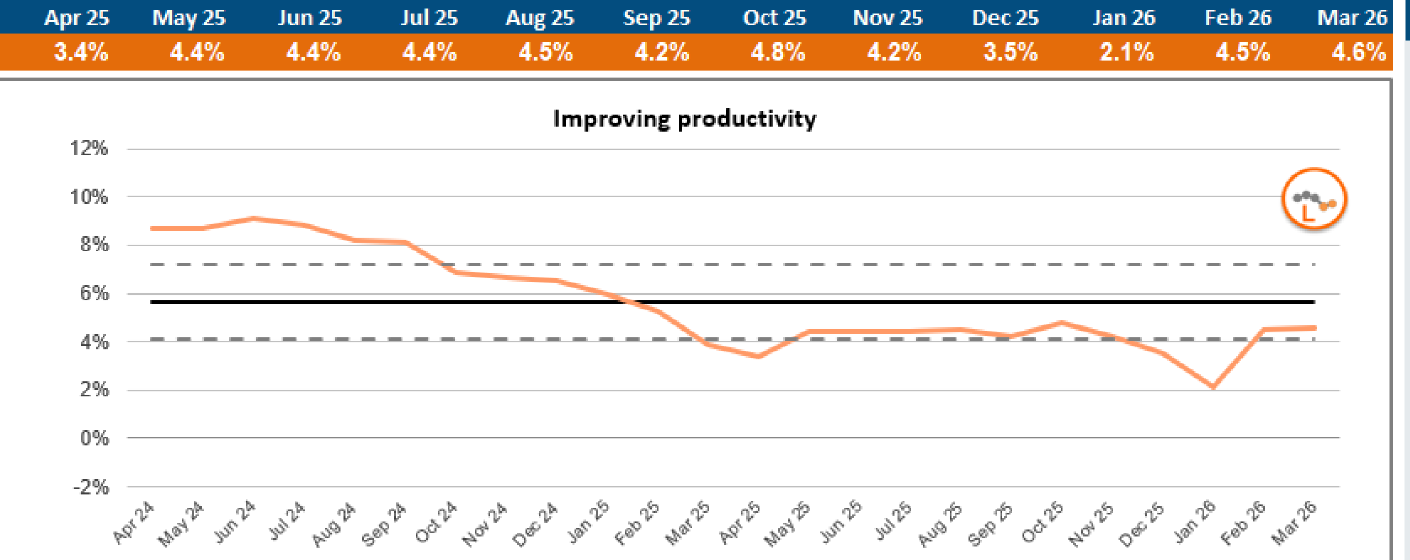
Risks

- There is a risk to advocacy and engagement levels due to our current financial challenges, where the requirement to reduce run-rate spend and identify high levels of efficiency may be seen as prioritisation over patient care.
- In addition, there is a risk that high levels of pressure to site and the utilisation of escalation spaces may be seen by staff as a compromise to care.

2026/27 Breakthrough Objectives

Improving productivity

Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
3.4%	4.4%	4.4%	4.4%	4.5%	4.2%	4.8%	4.2%	3.5%	2.1%	4.5%	4.6%



Special cause - concern

Understanding the Data

Firstly, total activity is looked at by POD level – outpatients, elective etc. These are weighted by the inputs required and adjusted for any calendar/working days. Activity growth is applied and it is costed to give a weighted activity growth %.

Relevant pay and non-pay expenditure is then included. This is adjusted for any inflation to show real term growth %.

Both of these weighted activity and real terms cost %s can be positive or negative. They are then derived into an implied productivity calculation.

We are driving this measure because...

Real term cost growth and weighted activity are the true measures of productivity as a positive result means that productivity has improved.

With limited resources for new investment in activity and income generation it is critical that productivity from current resources is the focus.

Performance

Latest implied productivity is March 2026 and is estimated at 4.5% vs the previous year 2024/25. The latest validated model hospital is the 3.5% shown for December as there is a lag in this being on model hospital due to flex and freeze processes.

The trend shows that productivity is a positive % throughout the trend period but has declined with 2024-25 vs 2023-24 being a higher level than the last year of 2025-26 vs 2024-25.

In the 2025-26 trend we have seen a dip in December and January where activity was notably lower in these months. Some of this was due to industrial action.

For the plan for 2026-27 we are forecasting a 6.3% implied productivity for the end of the year. This would be a further improvement.

26/27 plan	%
Expenditure - real term growth	-3.70%
Activity - real term growth	2.40%
Implied Productivity	6.30%

Month 1 (April 2026) will soon be reported on performance vs this plan and the aim is for divisional analysis to form part of the recovery work alongside specialty opportunities for cost and activity improvement

Risks

Our Care

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26	Trend
Concerns and Complaints	No. of concerns received	SPC		522	475	544	495	
IP&C	C.Diff	4.50 (Int)		7	6	10	6	
	MSSA	1.92 (Int)		2	3	3	5	
	E.coli	7.50 (Int)		10	9	11	9	
FFT	Positive response (%)	90.0% (Int)		86.2%	84.5%	85.7%	84.7%	

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

Performance & Counter Measure

The PALS service received fewer concerns in April compared to March, with levels remaining consistent with February. Waiting time concerns continue to represent the largest proportion of contacts. Work is underway to explore additional ways to support patients in accessing updates, including the use of resources such as the My Planned Care website.

The initial pilot of the *What Matters to You?* campaign was successful, with positive feedback from both staff and patients. Planning is now underway to deliver a full-day rollout across the Trust in June. The initiative has also helped to address concerns early, reducing the likelihood of issues escalating further.

In April, Escherichia coli (E. coli) blood stream infections showed a slight reduction, remaining in line with expected levels, with most incidents linked to urinary tract infections. Klebsiella cases are currently under review to identify any contributing factors, while Methicillin-Sensitive Staphylococcus Aureus (MSSA) cases have increased and are also being reviewed to support learning and improvement. Clostridioides Difficile (C.Diff) cases have reduced in April to 6, the cases from February and March were reviewed and found learning on prescribing of antibiotics, Proton Pump inhibitors (PPI) and laxatives. There were no links identified between the C.Diff cases.

Focus for improvement continues with catheter management and hand hygiene, supported by the rollout of a new hand sanitiser to encourage good practice across the Trust. Screening processes for wounds and broken skin are being reviewed following recent learning.

The overall Trust positive response rate saw a slight decrease. Improvement work continues across inpatient and outpatient areas, with a focus on strengthening communication so patients have a clearer understanding of the next steps in their care.

Risks

A temporary delay in FFT data capture using the feedback cards, as the trust embeds into the new supplier. Text message feedback is already live with the new supplier.

Our Care

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26
Harm	Patient safety incident investigation	SPC		0	2	0	1
	Falls rate per 1000 bed days	SPC		4.69	4.72	4.11	4.32
	No. of Falls in month	SPC		89	79	77	76
	No. falls with moderate harm or above	SPC		0	3	5	1
	Medication incidents with moderate harm	SPC		1	1	3	8
	Pressure Ulcer (Hospital Acquired)	SPC		16	13	12	8
Concerns and Complaints	No. of complaints received	SPC		81	84	81	94
	Number of reopened complaints	SPC		3	4	5	5
IP&C	MRSA	0 (Int)		1	0	3	0
	Klebsiella	2.17 (Int)		2	0	4	3
	Pseudomonas	1.75 (Int)		2	3	0	1

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

Performance & Counter Measure

In April, 1 Patient Safety Incident Investigation (PSII) was declared. There are currently 11 investigations in progress, with 7 overdue against agreed timelines. This reflects a slight improvement from March, with continued focus on reducing delays across May. Patient safety incident training was delivered in April, with further sessions planned throughout the year to support improvement.

The number of falls reported in the month is 76, remaining stable since March, with 1 fall resulting in harm. Work continues to reduce falls, with a focus on increasing meaningful activity for enhanced care patients and improving handover processes to ensure staff are clear on individual patients' mobility needs.

The number of Hospital-acquired pressure ulcers has decreased to 8 in month. The overall cumulative rate remains below the Trust's planned reduction trajectory with a rate of 0.64 per 1000 bed days for total pressure ulcer harms. Improvement activity has focused on strengthening the fundamentals of care, including enhanced skin assessment. This has been supported through targeted ward-based training and a continued emphasis on consistent application of best practice across teams.

There has been an increase in medication incidents reported at moderate harm or above. No early themes have been identified, and each case is currently under review to ensure that learning is captured and appropriate actions are taken.

There were 94 complaints received in April, representing an increase compared to previous months. The number of cases reopened, where the Trust's initial response did not fully meet expectations, remained stable. Work continues to address key themes within outpatient pathways, with a focus on improving how patients are communicated with throughout their journey, including providing clearer information on next steps and expected waiting times.

In April, cases of C. difficile decreased, with the Trust remaining below the regional average. There were no bloodstream infections caused by meticillin-resistant Staphylococcus aureus (MRSA). Pseudomonas cases showed a small increase. Ongoing work includes antimicrobial stewardship, and a continued focus on early identification. This includes strengthening processes in front door areas, with clear expectations for skin assessment and swabbing where appropriate, to support timely detection and prevention of infection.

Risks

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

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26
Safer Staffing	Safer Staffing – average fill rate RN (%)	85.0% (Nat)	P	93.6%	91.6%	92.5%	92.9%
	Safer Staffing – average fill rate HCA (%)	85.0% (Nat)	P	118.8%	116.8%	101.9%	106.2%
FFT	ED & UTC Positive Responses	78.3% (Int)	?	76.0%	77.4%	79.2%	78.2%
	Inpatients Positive Responses	90% (Int)	?	91.6%	85.8%	87.0%	88.2%
	Daycases Positive Responses	95.1% (Int)	?	95.7%	94.2%	93.4%	95.2%
	Outpatients Positive Responses	91.6% (Int)	?	100.0%	83.3%	83.3%	92.3%
	Maternity Positive Responses	94.2% (Int)	?	95.3%	96.7%	97.4%	95.0%

Performance & Counter Measures

Additional escalation spaces remain in place in response to sustained increases in patient demand. Staffing fill rates have remained stable and consistently above national expectations.

FFT top themes remain unchanged and continue to be a focus for improvement, particularly in relation to waiting times and communication. The *What Matters to You?* campaign was successfully piloted in April, with plans for a Trust-wide rollout in June. The initiative focuses on promoting conversations to support personalised care and enable early identification and resolution of concerns.

A new FFT supplier is now in place, with the SMS feedback process already underway. New feedback cards, QR codes, and online options are planned to go live next month.

The new Cherwell information hub opened in March is now working well with patients and carers being referred and the support offer increasing. We are also working closely with partner organisations to share information.

Common cause - no significant change.

Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.

Special cause of improving nature or lower pressure due to (H)igher or (L)ower values.

Variation indicates inconsistently hitting passing and falling short of the target.

Variation indicates consistently (P)assing the target.

Variation indicates consistently (F)alling the target.

Our Performance

Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target /SPC Target	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26	Trend
RTT	No. of >=18 weeks waiters		L	18469	18906	18530	19127	
	No. of >=52 weeks waiters		H	740	779	832	1002	
DM01	No. of patients on DM01 waitlist		L	6638	7100	7850	One month behind	
	DM01 performance %	99% (Nat)	F	91.1%	93.9%	92.3%	One month behind	
	DM01 6 week wait breaches		L	593	430	605	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	F	61.6%	60.6%	72.0%	One month behind	
	% Cancer 31 day performance	96% (Nat)	?	85.5%	85.3%	89.7%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	62.3%	66.7%	67.4%	One month behind	

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

Performance & Counter Measure

DM01

March's validated DM01 performance closed at 92.3%, a reduction from February (93.9%) but in line with the year-end target of 92.3%. This slight deterioration has been driven by an increase in patients waiting over six weeks, rising from 430 to 605. The total diagnostic waiting list also increased from 7,100 to 7,850, indicating growing demand and pressure across pathways.

Imaging modalities continue to underpin the Trust's performance, with MRI, CT and DEXA delivering 100% compliance, and Neurophysiology at 98.4%, providing resilience across high-volume services. Ultrasound performance remains stable at 93.8%, though it continues to represent the largest waiting list.

However, endoscopy remains the principal area of pressure, with flexi-sigmoidoscopy (73.7%) and colonoscopy (83.0%) continuing to impact overall DM01 compliance. Cardiology (85.0%) and Audiology (91.3%) also remain below the 95% standard. Cystoscopy continues to remain the worst performing modality (48.7%),

Countermeasures

Ultrasound remains the largest waiting list at 3,006 patients, with 187 patients waiting over six weeks. Additional clinics and expanded capacity at Cherwell continue to support backlog management and mitigate further ageing.

Audiology performance remains below the 95% standard at 91.3% but continues recover from the change in included waitlists.

Endoscopy performance is expected to remain variable in the short term as services continue to embed within the new CDC endoscopy unit in West Swindon. Ongoing operational stabilisation, alongside targeted recovery plans will be critical to improving compliance across colonoscopy and flexi-sigmoidoscopy pathways. Cystoscopy will require an action plan by the Surgery division to recover during 2026/7

Cancer

62 Day performance remains heavily impacted by pathway issues in Urology, where diagnostic reporting delays and all options nature of prostate patients means a large number of breaches continue. 28% of the 49.5 breaches allocated to GWH were on a Urology pathway

31D performance fell short in March due to capacity issues in outpatients. Of the 25 pathways that breaches, 12 were in Skin.

Cancer waiting times for first appointment remain below standard. Breast is the largest contributors with 45% of all breaches and an average time to first appointment of 19 days, with Colorectal next with 31%. Capacity for Appointments /Diagnostics in an Outpatient setting accounted for 66% of breaches.

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	66.5%	69.3%	68.6%	67.6%	
	A&E (ED & UTC) Emergency Care 12 Hour Performance %	2% (Nat)	F	10.7%	10.5%	8.5%	7.8%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	44.0%	47.6%	47.9%	54.6%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	19.6%	20.2%	16.1%	13.2%	
	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	93.6%	93.5%	90.8%	87.0%	
	Total ED Type 1 Attendances (all arrival methods)	SPC	H	6337	5608	6241	7093	
	Emergency Care - AED - Median Stay	240 (Int)	F	326	290	296	238	

Performance & Counter Measure

Performance reviewed in weekly Emergency Flow meeting

4-hour performance (type 1 and 3) decreased to 67.6%. This is below the 25/26 national target. The decrease in overall performance relates to type 3 performance decreasing due to volume of patients with April attendances remaining high.
Total % over 12 hours (Type 1) in April 13.2% decreased by 2.9% from last month at 16.1%.
Any prolonged length of stay in ED leads to overcrowding and subsequent delays in ambulance offload.

Management of 'Timely Handover Process' with ambulance patients off-loaded as per 'WAIT 45' into ED temporary escalation spaces, predominantly maintained as nine trolley spaces: THP continues to be used consistently to support THP protocols with the ambulance services . Counter measures remain in place within the Breakthrough objective slides and are now being refreshed as part of the Trust UEC and Flow programme reset around reducing non-elective length of stay.

Risks

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

Our Performance

NHS Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26
RTT	No. of >=78 weeks waiters	SPC		2	2	2	1
Cancer	% 28 day faster diagnosis	75% (Nat)		64.9%	80.4%	80.7%	One month behind
	No. of referrals received	SPC		1965	2079	2119	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.0%	0.0%	0.2%	0.2%
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC		86.9%	87.7%	87.8%	88.8%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		57.8%	59.0%	56.5%	56.6%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		60.7%	61.4%	38.1%	51.8%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	200	190	204	202
	Emergency Care - UTC - Median Stay	240 (Int)	P	141	139	157	160

Performance & Counter Measure

ED, CEU & UTC

ED – 4,817, CEU – 2,101, UTC – 4,931

Triage performance for ED for 15-minute remained similar 56.5% to 56.6%

For Type 3 (UTC only) triage performance within 15 minutes performance has increased from 31.1% to 51.8%
They continue to have sickness issues, resulting in numerous shifts down a triage nurse.

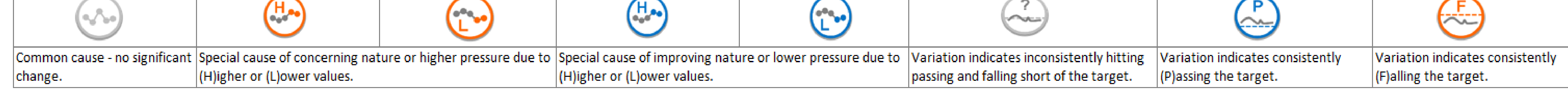
CEU attendances have increased 997 from March to April. As of 13th April a joint stream was implemented booking all children in to CEU, no filter of UTC or CEU.

Cancer

Cancer Faster Diagnosis achieved the national standard in March

Risks

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



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Our Performance

Great Western Hospitals NHS Foundation Trust

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26
ED	Total Number of Ambulance Handovers	SPC		2107	2081	2278	2202
	Total Hours Ambulance Handover Waits (over 15mins)	SPC		1063.15	1468.90	1302.72	907.48
	Number of Ambulance Handover Over 15 Minute Waits	SPC		1682	1788	1848	1680
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC		79.8%	85.9%	81.1%	76.3%
	Number of Ambulance Handover 30 Minute Waits	SPC		904	1010	1104	965
	Percentage of Ambulance Handover Over 30 Minutes	SPC		42.9%	48.5%	48.5%	43.8%
	Number of Ambulance Handover Over 60 Minutes Waits	SPC		772	770	896	847
	Percentage of Ambulance Handovers Over 60 Minutes	SPC		37%	37%	39%	38%
	Average hours lost to ambulance handover delays per day	SPC		38	52	42	30

Performance & Counter Measure

ED, CEU & UTC

Number of ambulance conveyances decreased slightly in April to 2202 a decrease of 76 on March. Average daily hours lost however reduced to 30, a decrease of 12 from March.

Ambulance arrivals averaging 73 per day in April 2026 equalling the average of 74 March 2026

W45 Ambulance Offload protocol went live 6th October 2025 (offload in under 45 minutes) and has been challenging to maintain, with hroughout November, December, January and February with an organisational response required.

Risks

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Our Performance

Non-Alerting Watch Metrics

Great Western Hospitals NHS Foundation Trust

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		708	791	653	590
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		343	323	309	277
	Elective Patients Average Length of Stay (Days)	SPC		3.2	3.2	3.6	3.8
	Non-Elective Patients Average Length of Stay (Days)	SPC		6.1	6.6	6.5	6.8
	GWH Discharges by Noon (%)	SPC		18.5%	17.8%	16.4%	18.8%
	Number of Stranded Patients (over 14 days)	SPC		141	145	140	150
	Number of Super Stranded Patients (over 21 days)	SPC		76	88	79	86
	Adult general and acute type 1 bed occupancy	SPC		98.5%	98.1%	98.4%	98.0%
	GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	SPC	H	21.4%	20.3%	19.9%	20.7%
	Proportion of patients discharged from hospital to their usual place of residence	SPC		95.29%	95.49%	96.29%	96.03%
	Non-elective average length of stay	SPC		6.1	6.6	6.5	6.8

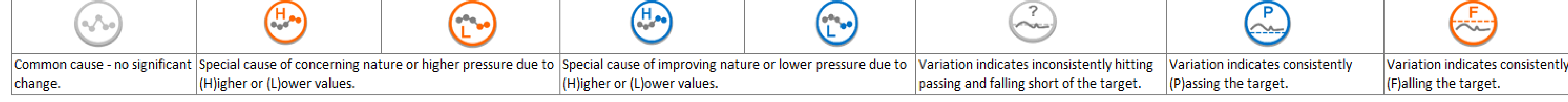
Performance & Counter Measure

Patient Flow

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

Risks

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



Use of Resources

Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26
Use of Resources	Capital Expenditure (£'000)	SPC	H	1835	7197	16759	Waiting for data
	Pay (£'000)	SPC	H	27668	28190	50108	28716
	Non Pay (£'000)	SPC	H	17777	16448	27327	17957

	H	L	H	L	?	P	F
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Performance & Counter Measure

Capital spend at M12 is £32.9m against a plan of £40.6m, giving an underspend against plan of £7.7m. The £32.9m spend includes £2.6m of disposal proceeds from community property. Other key underspend drivers are £5m relating to a CDC project carry forward to 2026/27, £2.5m underspend on PFI capital and £0.25m re-categorisation of expenditure to revenue.

M01 pay costs are £1.2m higher than the M1-11 average for 2025/26 (M12 excluded due to number of exceptional items). C£0.9m is the 3.3% AfC pay award paid in M01 plus further accruals for the 3.5% medical pay award. The remainder relates to higher escalation and enhanced care costs still being incurred in M01; these costs increased from a low base in the first half of 2025/26.

Non-Pay costs are £0.3m higher than the M1-M11 average for 2025/26. While there are fluctuations across all account lines, a key driver is the one-off benefits from prior year gains achieved in 2025/26 run rate, particularly the closure of aged POs.

Risks

The £1.9m shortfall on the Trust's cash releasing efficiency savings programme already incurred at M01 represents a significant risk. The Trust's overall savings target for 2026/27 is £47.2m, and the Trust is working with Hunter Healthcare at pace to find recurrent savings schemes and reduce monthly spend.

Our People

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Jan-26	Feb-26	Mar-26	Apr-26
Workforce	% of leavers within 1st year of employment	14.8% (Int)	?	9.9%	10.1%	10.4%	One month behind

Performance & Counter Measure

- Marginal increase to leavers within the first year (10.4%) although remaining within target.
- Response rate for the Q1 Pulse Survey was 17%, a decrease compared to the Q4 survey.

Plan Area	Metric	Target /SPC Target Icon	2017	2018	2019	2020	2021	2022	2023	2024	2025
Workforce	Staff Survey response rates	44% (Nat)	46.5%	43.6%	40.0%	53.4%	39.5%	58.7%	69.0%	71.0%	66.0%
Workforce	My immediate manager takes a positive interest in my health and well-being	67.4% (Nat)	68.8%	67.5%	74.8%	69.2%	64.4%	67.6%	70.4%	70.9%	71.7%
Workforce	Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	57.5% (Avg)	59.6%	54.1%	60.4%	57.1%	56.1%	56.4%	56.5%	55.5%	55.6%

Risks

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

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Service | Teamwork | Ambition | Respect

Our People

Workforce Scorecard

Type	Metric	Unit/Measure	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Trend Vs	
																	Last Month	Apr-25
	Vacancy																	
W	Vacancy against Funded WTE (excl. unidentified CIP)	WTE	-	215.93	215.09	210.64	214.60	357.16	313.92	279.60	248.92	236.60	240.66	209.19	188.04	248.01		
W	Vacancy against Funded %	%	7.00%	4.28%	4.26%	4.18%	4.25%	7.08%	6.22%	5.54%	4.94%	4.69%	4.77%	4.15%	3.73%	4.77%	↑	↑
W	Trust Vacancy against Planned WTE	WTE	-	215.93	215.09	210.64	214.60	185.13	153.23	120.97	91.70	70.16	69.06	37.36	19.11	123.74		
W	Trust Vacancy against Planned %	%	7.00%	4.28%	4.26%	4.18%	4.25%	3.67%	3.04%	2.40%	1.82%	1.39%	1.37%	0.74%	0.38%	2.44%		
W	All Nursing Vacancy WTE against Funded WTE	WTE	-	3.52	1.47	1.23	-1.17	106.44	89.57	77.15	55.26	57.74	53.59	41.26	31.36	51.90		
W	All Nursing Vacancy against Funded %	%	7.00%	0.1%	0.1%	0.1%	0.0%	4.3%	3.6%	3.1%	2.2%	2.3%	2.1%	1.6%	1.2%	2.1%	↑	↑
W	*All Nursing Vacancy (Reg & Unreg) Excl Maternity Leave*	*WTE*	-	*109.95*	*102.44*	*104.99*	*99.78*	*212.20*	*186.93*	*180.08*	*151.01*	*153.79*	*147.91*	*134.89*	*126.12*	*145.14*		
W	*All Registered Nursing Vacancy*	WTE	-	*-10.86*	*-7.52*	*-9.24*	*-10.35*	*48.99*	*28.96*	*9.25*	*-0.13*	*4.73*	*3.49*	*-2.64*	*-10.03*	*21.85*		
W	*B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)*	WTE	-	*-41.18*	*-38.96*	*-38.48*	*-40.30*	*-2.99*	*-19.44*	*-33.19*	*-36.70*	*-38.12*	*-28.15*	*-30.88*	*-33.97*	*-18.98*		
W	*B2-4 Nursing Vacancy (exc. Pre-Reg)*	WTE	-	*14.38*	*8.99*	*10.47*	*9.18*	*11.68*	*14.84*	*0.90*	*-11.61*	*-15.68*	*-20.02*	*-26.22*	*-28.73*	*30.05*		
W	Medical Vacancy against Funded %	%	7.00%	8.31%	8.05%	8.10%	8.00%	15.65%	13.70%	11.55%	11.54%	11.56%	10.98%	10.06%	8.72%	11.31%	↑	↑
W	Medical Vacancy against Funded WTE	WTE	-	61.95	59.95	60.35	59.64	131.92	115.28	97.23	97.10	97.29	92.38	84.65	73.02	97.63		
W	STT/AHP Vacancy against Funded %	%	7.00%	8.3%	7.7%	7.1%	7.4%	5.2%	4.1%	3.4%	2.4%	0.5%	1.3%	0.5%	0.9%	3.7%	↑	↓
W	STT/AHP Vacancy against Funded WTE	WTE	-	66.18	61.87	56.78	59.15	59.90	51.32	44.34	37.17	21.65	23.85	16.78	20.44	30.35		
W	SMA Vacancy against Funded %	%	7.00%	7.5%	8.2%	8.3%	8.7%	7.2%	7.1%	7.3%	7.2%	7.2%	7.9%	7.4%	7.1%	6.8%	↓	↓
W	SMA Vacancy against Funded WTE	WTE	-	84.28	91.80	92.28	96.98	78.16	77.01	78.84	77.96	77.79	84.46	79.52	76.24	68.13		
W	Recruitment Time to Hire - AFC	Days	46.00	34.80	36.40	39.70	37.70	41.30	40.30	39.10	36.20	37.80	38.90	37.50	38.70	37.30	↓	↑
W	Recruitment Time to Hire - Bank	Days	46.00	40.00	18.00	40.20	61.10	51.70	28.50	26.50	18.80	21.80	30.60	18.50	13.70	19.20	↑	↓
W	Recruitment Time to Hire - Medical	Days	46.00	38.00	37.40	40.20	49.00	40.10	39.50	35.50	39.10	39.20	42.40	45.50	36.50	37.50	↑	↓

Our People

Workforce Scorecard

Type	Metric	Unit/Measure	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Trend Vs Last Month	Trend Vs Apr-25
	Workforce Utilisation																	
W	Substantive WTE	WTE	-	4,827.81	4,828.65	4,833.10	4,829.14	4,858.61	4,890.51	4,922.77	4,952.04	4,973.58	4,974.68	5,006.38	5,024.63	4,954.62		
W	Additional Substantive WTE	WTE	-	11.97	11.84	9.79	9.54	10.88	11.32	11.83	11.15	10.34	10.54	12.97	17.87	9.66		
W	Bank WTE	WTE	-	54.68	306.31	270.91	287.37	304.15	241.73	274.78	298.19	287.23	333.51	317.94	354.67	308.90		
W	Agency WTE	WTE	-	22.35	54.27	45.68	44.12	29.32	27.72	26.43	26.99	24.18	31.36	22.75	25.29	16.28		
W	Total WTE Utilised	WTE	-	**4,916.81**	**5,201.07**	**5,159.48**	**5,170.17**	**5,202.96**	**5,171.28**	**5,235.82**	**5,288.37**	**5,295.33**	**5,350.09**	**5,360.05**	**5,422.46**	**5,289.46**		
W	Planned Establishment WTE	WTE	-	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,043.74	5,045.14	5,043.74	5,043.74	5,043.74		
W	Variance to planned est	WTE	-	-126.93	157.33	115.74	126.43	159.22	127.54	192.08	244.63	251.59	304.95	316.31	378.72	245.72		
W	GL Funded Establishment WTE	WTE	-	5,043.74	5,043.74	5,043.74	5,043.74	5,215.77	5,204.43	5,202.37	5,200.96	5,210.18	5,215.34	5,215.57	5,212.67	5,202.63		
W	Variance to GL funded	WTE	-	-126.93	157.33	115.74	126.43	-12.81	-33.15	33.45	87.4	85.1	134.7	144.5	209.8	86.83		
W	Planned Est, vs GL Funded	WTE	-	0.0	0.0	0.0	0.0	-172.0	-160.7	-158.6	-157.2	-166.4	-170.2	-171.8	-168.9	-158.89		
W	Actual Worked vs Planned Establishment	%	-	97.48%	103.12%	102.29%	102.51%	103.16%	102.53%	103.81%	104.85%	104.99%	106.04%	106.27%	107.51%	104.87%		
W	Total Workforce Cost £	£	-	£26.55M	£26.60M	£26.34M	£25.70M	£30.78M	£27.60M	£27.27M	£27.86M	£28.11M	£27.86M	£28.15M	£28.30M	£28.70M		
W	Agency Spend as % of Total Spend	%	4.50%	2.26%	2.40%	2.75%	1.82%	1.70%	1.78%	0.97%	1.05%	0.59%	1.17%	1.09%	1.13%	0.52%	↓	↓
W	Agency Spend £	£	-	£0.60M	£0.64M	£0.72M	£0.47M	£0.52M	£0.49M	£0.26M	£0.29M	£0.17M	£0.33M	£0.31M	£0.32M	£0.15M		
W	Agency Target £	£		£0.20M	£0.19M	£0.18M	£0.17M	£0.16M	£0.16M	£0.15M	£0.14M	£0.13M	£0.12M	£0.11M	£0.11M	-		
W	Agency Spend vs Target £	£ Diff	£0.00M	£0.40M	£0.45M	£0.55M	£0.30M	£0.36M	£0.33M	£0.12M	£0.15M	£0.04M	£0.20M	£0.19M	£0.21M	-		
W	Bank Spend £	£	-	£2.21M	£2.18M	£2.05M	£1.92M	£2.36M	£1.97M	£1.94M	£2.50M	£2.67M	£2.11M	£2.29M	£2.46M	£2.50M		
W	Bank Target £	£		£2.90M	£2.56M	£2.22M	£1.88M	£1.53M	£1.19M	£1.31M	£1.38M	£1.45M	£1.47M	£1.48M	£1.50M	-		
W	Bank Spend vs Target £	£ Diff	£0.00M	-£0.69M	-£0.38M	-£0.17M	£0.05M	£0.83M	£0.78M	£0.63M	£1.13M	£1.22M	£0.64M	£0.80M	£0.96M	-		
	Retention																	
W	All Turnover %	%	13.00%	11.31%	11.16%	10.85%	10.74%	10.38%	10.20%	9.94%	9.65%	9.62%	9.50%	9.70%	9.37%	-	↓	↓
W	Voluntary Turnover %	%	11.00%	8.41%	8.29%	8.13%	7.94%	7.68%	7.49%	7.19%	7.00%	6.90%	6.88%	7.04%	6.79%	-	↓	↓
W	Number of Leavers	Headcount	-	38	32	43	41	43	50	43	30	41	32	33	54	-		
W	Number of RN Leavers	Headcount	-	8	8	11	9	9	13	11	6	13	7	6	14	-		
W	Registered Nursing Vol Turnover	%	-	6.51%	6.16%	6.01%	5.80%	5.46%	5.69%	5.50%	5.44%	5.33%	5.14%	4.98%	5.01%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	6	10	9	8	8	8	8	9	10	4	8	5	-		
W	Unregistered Nursing Vol Turnover	%	-	9.45%	9.81%	9.21%	9.38%	9.49%	9.13%	8.94%	8.97%	8.79%	8.88%	9.01%	8.40%	-		
W	Leavers within 1st Year - Rolling 12 Month	%	-	10.30%	11.68%	11.62%	11.93%	13.09%	12.84%	11.35%	11.24%	11.09%	9.94%	10.06%	10.42%	-		
W	Number of starters	Headcount	-	43	29	50	40	50	93	58	67	36	55	49	64	-		

Our People

Workforce Scorecard

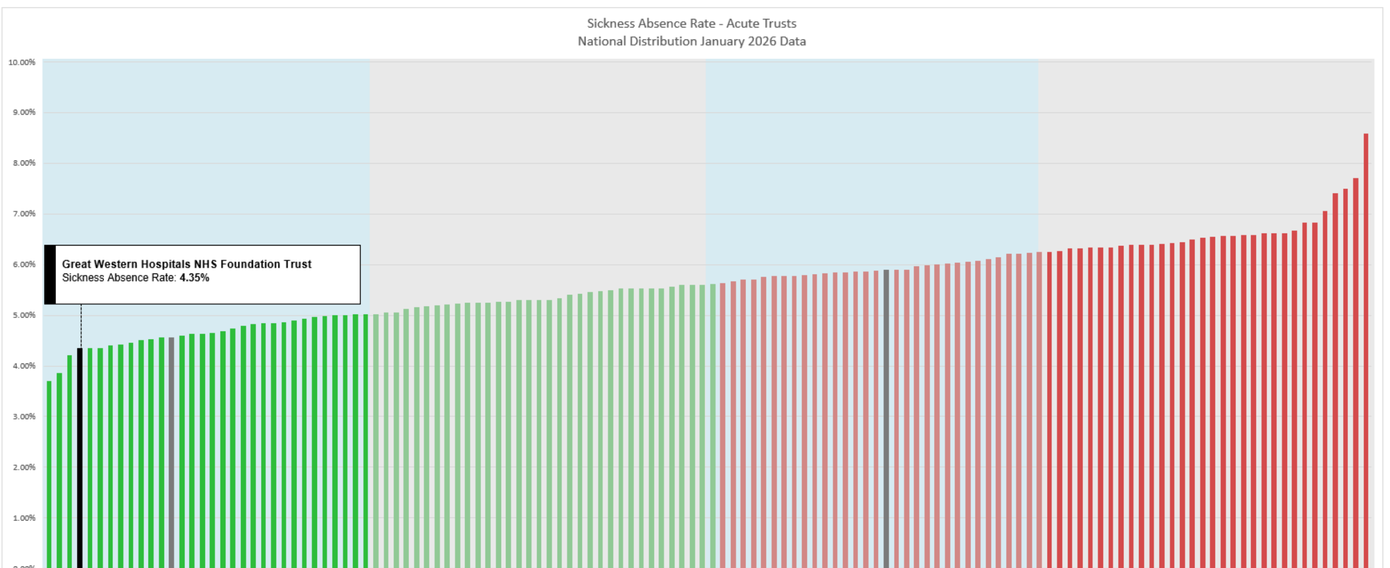
Type	Metric	Unit/Measure	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	Trend Vs	
																	Last Month	Apr-25
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	4.68%	4.68%	4.65%	4.59%	4.57%	4.55%	4.51%	4.46%	4.42%	4.34%	4.28%	4.23%	-	↓	↓
D	Sickness Absence %	%	3.50%	4.13%	4.11%	4.22%	4.44%	4.29%	4.08%	4.35%	4.24%	4.50%	4.31%	4.15%	3.97%	-	↓	↓
W	Long Term Sickness %	%	2.00%	2.12%	2.09%	2.24%	2.30%	2.40%	2.05%	2.02%	2.01%	2.28%	1.85%	1.77%	1.93%	-	↑	↓
W	Short Term Sickness %	%	1.50%	2.01%	2.02%	1.98%	2.14%	1.88%	2.03%	2.33%	2.23%	2.22%	2.46%	2.38%	2.03%	-	↓	↑
W	Sickness Absence Cost £	£	-	£681.0k	£702.2k	£685.5k	£769.3k	£760.1k	£742.3k	£791.4k	£748.6k	£806.7k	£803.7k	£709.2k	£743.6k	-		
W	WTE Days Lost	WTE	-	5,979.0	6,159.6	6,117.3	6,674.6	6,456.8	5,979.9	6,638.5	6,303.8	6,943.7	6,650.8	5,806.2	6,177.3	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	90.46%	90.94%	91.66%	91.60%	91.10%	91.38%	91.23%	91.55%	91.47%	91.31%	91.08%	90.94%	91.46%	↑	↑
W	Role Essential MT %	%	85.00%	90.57%	90.95%	91.77%	91.95%	91.33%	91.70%	91.68%	92.05%	91.98%	91.95%	91.81%	91.77%	92.04%	↑	↑
W	CQC Safe MT %	%	85.00%	90.33%	90.92%	91.52%	91.15%	90.79%	90.99%	90.67%	90.91%	90.83%	90.49%	90.16%	89.86%	90.76%	↑	↑
W	Bank-Only Mandatory Training Compliance %	%	85.00%	65.69%	64.67%	64.11%	73.77%	79.71%	77.67%	76.14%	78.59%	78.32%	78.63%	54.55%	78.11%	75.90%	↓	↑
W	Appraisal Compliance %	%	85.00%	83.88%	81.56%	80.36%	80.08%	80.91%	80.81%	79.02%	78.86%	78.39%	76.91%	79.60%	79.81%	78.31%	↓	↓
W	Non Medical Appraisal Compliance %	%	85.00%	84.15%	82.14%	81.04%	80.45%	80.90%	80.30%	78.65%	78.80%	78.51%	77.75%	78.88%	79.38%	78.11%	↓	↓
W	Medical Appraisal Compliance %	%	85.00%	82.08%	77.82%	76.02%	77.75%	80.99%	83.98%	81.21%	79.20%	77.67%	72.12%	83.73%	82.21%	79.39%	↓	↓
	Demographics																	
W	Staff in Leadership Roles % (B8a+)	%	-	4.30%	4.36%	4.30%	4.20%	4.15%	4.14%	4.20%	4.27%	4.30%	4.31%	4.26%	4.25%	4.31%		
W	Staff in Leadership Roles WTE (B8a+)	WTE	-	255.00	259.00	256.00	252.00	248.00	249.00	254.00	260.00	263.00	264.00	263.00	263.00	262.00		
W	% of Leadership Roles who are Female (B8a+	%	-	68.24%	68.34%	67.58%	67.86%	68.15%	68.67%	69.29%	69.23%	68.82%	68.94%	68.82%	68.82%	68.70%		
W	% of Leadership Roles who from BME (B8a+)	%	-	5.88%	6.18%	5.47%	5.56%	5.65%	6.02%	6.30%	6.15%	6.84%	6.82%	6.46%	6.84%	6.87%		
W	Staff in Leadership Roles % (B8c+)	%	-	1.01%	1.03%	1.01%	1.00%	1.00%	1.00%	1.01%	0.98%	0.98%	1.03%	1.02%	1.02%	1.05%		
W	Staff in Leadership Roles WTE (B8c+)	WTE	-	60.00	61.00	60.00	60.00	60.00	60.00	61.00	60.00	60.00	63.00	63.00	63.00	64.00		
W	% of Leadership Roles who are Female (B8c+	%	-	53.33%	52.46%	51.67%	53.33%	53.33%	55.00%	57.38%	56.67%	56.67%	58.73%	58.73%	58.73%	59.38%		
W	% of Leadership Roles who from BME (B8c+)	%	-	5.00%	4.92%	5.00%	5.00%	5.00%	5.00%	6.56%	5.00%	5.00%	6.35%	6.35%	6.35%	6.25%		
W	% of Leadership Roles who are disabled (B8c	%	-	3.33%	3.28%	3.33%	3.33%	3.33%	3.33%	3.28%	3.33%	3.33%	4.76%	4.76%	4.76%	4.69%		
W	Male % of Workforce	%	-	19.33%	19.44%	19.51%	19.67%	19.87%	20.00%	19.98%	20.06%	20.08%	20.05%	20.23%	20.38%	20.39%		
W	Female % of Workforce	%	-	80.67%	80.56%	80.49%	80.33%	80.13%	80.00%	80.02%	79.94%	79.92%	79.95%	79.77%	79.62%	79.61%		
W	BME % of Workforce	%	-	30.08%	30.30%	30.65%	30.66%	30.71%	31.50%	31.63%	31.75%	32.19%	32.11%	32.55%	32.84%	33.60%		
W	White % of Workforce	%	-	62.05%	61.76%	61.35%	61.27%	60.43%	59.79%	60.38%	60.20%	59.90%	60.05%	59.83%	59.65%	59.01%		
W	ER Cases Closed	Number	-	56	47	50	50	49	56	67	61	54	53	42	33	31		

WS

Workforce Scorecard

Our People

Sickness absence



Performance & Counter Measure

The Improving Attendance working group extends focus on new Trust improvement initiatives:

- Exploring the use of scenario-based training and podcasts to support absence management
- Support managers to conduct 'rota health check reviews'
- Working with HWB colleagues on monthly promotional campaign to support staff to stay well at work

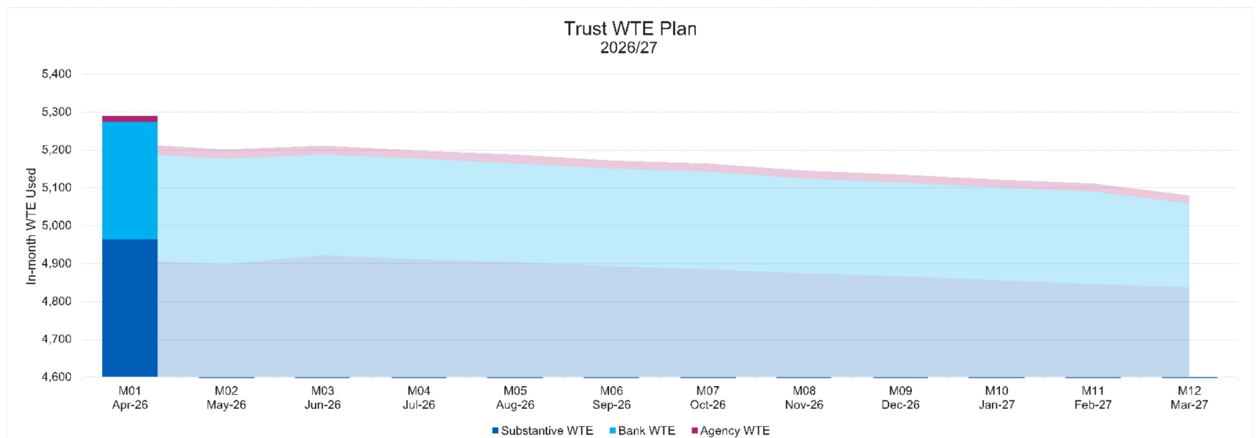
The existing Trust-wide initiatives led by the group are showing initial successful results, with formal evaluation underway through the improving attendance working group;

- **Burnout toolkits:** Introduction of the burnout toolkit across hotspot areas, supported by video-based resources, has shown promising reductions to short-term absence notably in ED, Neptune, and Saturn. It is anticipated that full benefits from this initiative will emerge over a longer period as residual absence cases resolve and the number of new episodes linked to stress/anxiety/depression decreases.
- **Medical sickness QR codes:** All clinical divisions are now introducing QR-code reporting for Medical staff sickness absence, following an increase in reporting compliance within Medicine.
- **"In-the-moment" support through EAP:** Strong continued socialisation of EAP resources has continued with consistent positive feedback coming through the working group. In addition to this the Health & Wellbeing team continue to promote training through the organisation empowering staff to stay well at work.

Our People

Workforce Delivery Plan

Great Western Hospitals NHS Foundation 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
Total workforce	Actual	5,289											
	Plan	5,215	5,199	5,210	5,199	5,187	5,172	5,164	5,146	5,135	5,122	5,110	5,078
	Variance	75	-5,199	-5,210	-5,199	-5,187	-5,172	-5,164	-5,146	-5,135	-5,122	-5,110	-5,078
Substantive	Actual	4,964	0	0	0	0	0	0	0	0	0	0	0
	Plan	4,908	4,898	4,922	4,912	4,902	4,892	4,885	4,875	4,865	4,856	4,846	4,836
	Variance	57	-4,898	-4,922	-4,912	-4,902	-4,892	-4,885	-4,875	-4,865	-4,856	-4,846	-4,836
Bank	Actual	309											
	Plan	283	278	266	264	262	257	257	249	248	246	244	223
	Variance	26	-278	-266	-264	-262	-257	-257	-249	-248	-246	-244	-223
Agency	Actual	16											
	Plan	24	24	23	23	22	22	22	21	21	21	21	19
	Variance	-8	-24	-23	-23	-22	-22	-22	-21	-21	-21	-21	-19

Performance & Counter Measure

The 2026/27 workforce plan sets out a reduction trajectory from a March 2026 closing position of 5,422 WTE to a planned March 2027 position of 5,078 WTE. Delivery of this trajectory will be supported through the Outpatients, Right Care, and Theatres transformation programmes alongside the Group Corporate Services Redesign programme, with a continued internal focus on reducing temporary staffing usage and improving workforce productivity through substantive workforce optimisation.

At month 1 the Trust workforce position was 5,289 WTE against a planned position of 5,215 WTE, an adverse variance of +75 WTE to plan. Following the transfer of Soft FM services in March, our substantive position was 4,908 WTE (+57 WTE to plan). This variance is attributable to workforce growth following submission of the 2026/27 plan, alongside non-delivery of planned CIP in month 1.

Bank usage was +26 WTE to plan, whilst agency usage was a more favourable position at -8 WTE. Our adverse position for bank relates wholly to continued high levels of enhanced care, and additional staffing deployed to mitigate ongoing site pressures.

The month 1 position demonstrates that whilst agency usage remains controlled and below planned levels, substantive and bank workforce levels are above plan at the start of the financial year. Delivery against the workforce reduction trajectory will therefore require sustained focus through the agreed transformation programmes and corporate services review to achieve the planned reduction to 5,078 WTE by March 2027.

Risks & Mitigations

- Whilst opportunities for reduction have been identified, there are not material plans at present to deliver these reductions to pay/workforce. This means that there is a risk that workforce CIP will not be delivered during the first quarter of the year where transformation programmes are still in the process of identifying reductions, adding an additional non-recurrent reduction requirement later in the year.

26/27 Strategic Planning Framework

Improving Together – Great Western Hospitals NHS Foundation Trust

Improving together

Service Teamwork Ambition Respect

Explaining the IPR

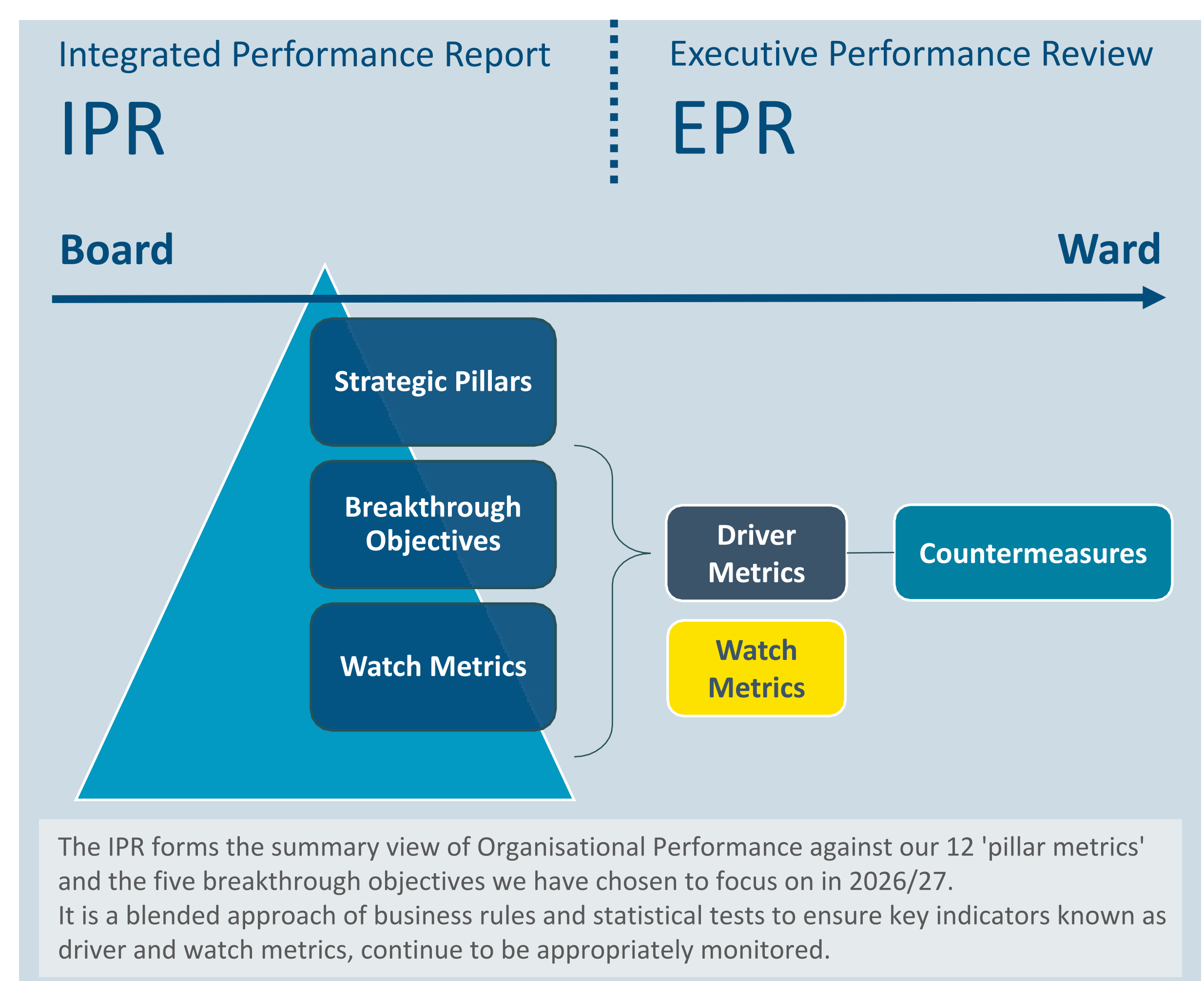
To turn our strategic themes (pillars) into real improvements, we're focusing on five key objectives that contribute to these themes for the next year.

- Reducing deconditioning
- Improving elective waiting times (RTT)
- Reducing corridor/escalation care
- Care as our top priority
- Increasing Productivity

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

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

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



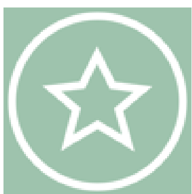
The IPR forms the summary view of Organisational Performance against our 12 'pillar metrics' and the five breakthrough objectives we have chosen to focus on in 2026/27.
It is a blended approach of business rules and statistical tests to ensure key indicators known as driver and watch metrics, continue to be appropriately monitored.

Our vision & strategic focus

Vision

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

Our four strategic pillars



Outstanding care

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

Valued teams

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

Better together

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

Sustainable future

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

26/27 Strategic Planning Framework

Our four strategic pillars

Outstanding Care

Valued Teams

Better Together

Sustainable Future

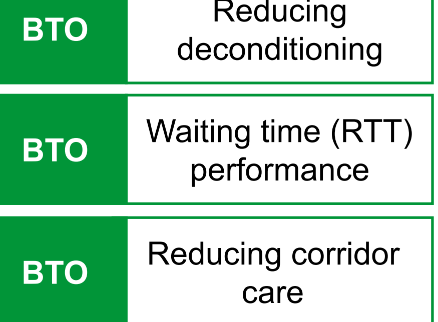
To know if we are winning or losing we have metrics assigned to each domain that we will continuously measure to gauge improvement

Pillar metrics

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

Focused improvement action over the next 12-18 months to deliver 30% improvement in top contributing areas

Breakthrough Objectives



Outstanding Care	Valued Teams	Sustainable Future
BTO Reducing deconditioning	BTO Staff Survey = Care as our top priority	BTO Increasing productivity
BTO Waiting time (RTT) performance		
BTO Reducing corridor care		

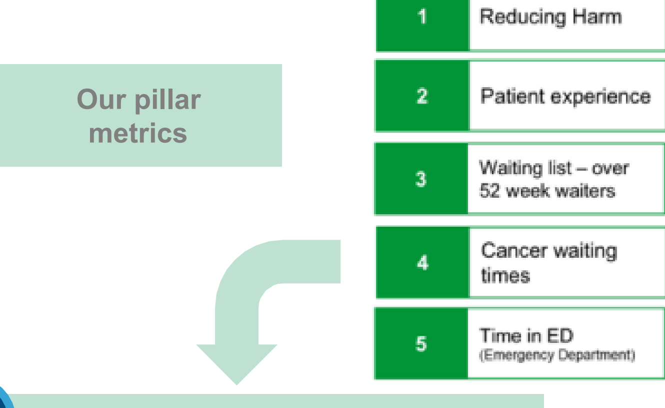
26/27 Strategic Planning Framework

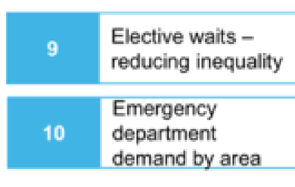
Great services for local people at home, in the community and in hospital, enabling independent and healthier lives.

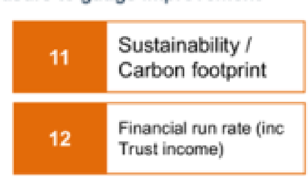
1 Our four strategic pillars

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

Our pillar metrics







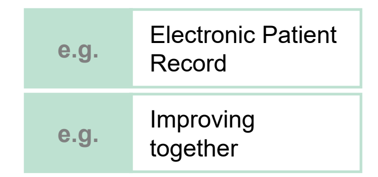
To know if we are winning or losing we have metrics assigned to each domain that we will continuously measure to gauge improvement

3 Strategic Initiatives

Must do can't fail

4 Overlap

Corporate Projects



2 12-Month Breakthrough Objectives

Operational in nature and where we will focus our improvement

BTO	Reducing deconditioning
BTO	Waiting time (RTT) performance
BTO	Reducing corridor care
BTO	Staff Survey = Care as our top priority
BTO	Increasing productivity

Delivery mechanism – running the organisation

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

Ward to Board Meeting Blueprint

Continuous Improvement on Drivers

Performance Management on Driver & Watch Metrics

Level

Daily

Weekly

Monthly

Exec

Exec Performance Meeting

Division

Divisional Weekly Driver

Divisional Performance Meeting

Information Flow

Speciality

Speciality Weekly Driver

Speciality Performance Meeting

Frontline

Improvement Huddles

Information Flow

Frontline Performance Meeting

Building a culture of continuous improvement

Communications and engagement

Providing an environment that values staff and engages them with the organisation.

Wards
Primary Care
Theatres
Therapies
Women's & Children's Services
Estates
IT
Community Services
Specialties
Diagnostics
Urgent & Emergency Care
HR
Finance

Transformational projects

Using improvement methodology to create step-change improvement.

Operational Management System

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

Transformation & Improvement Hub

Develop an internal capability to develop and sustain improvement journey.

Transformation & Improvement Hub

Clinical Divisions
Corporate Teams

Leadership behaviours

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

Executive Team

Strategy deployment

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

Trust Vision & Strategy

SPC supporting business rules

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

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

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

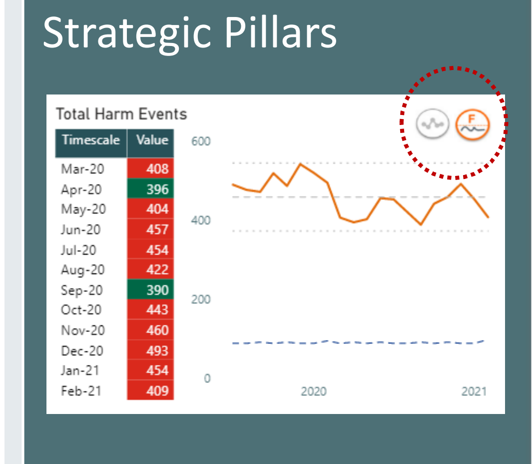
- E.g. ED 4 hour Performance % - Nationally the target is 95%, while the Planning target for 23/24 is 76%. So the planning target may be met, yet still show as alerting for that metric.

NHS Improvement SPC icons:

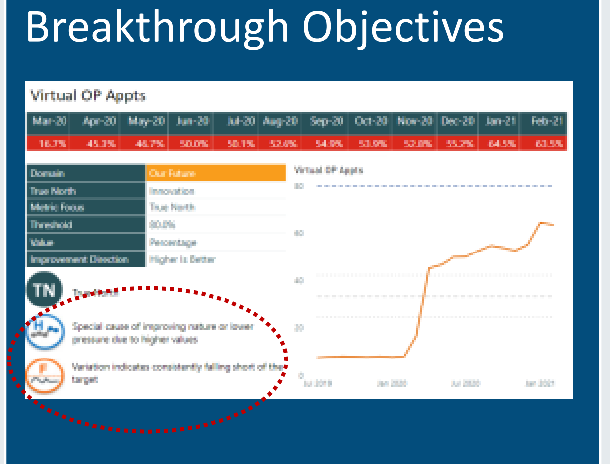
Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short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

Where to find them:

Strategic Pillars



Breakthrough Objectives



Performance business rules

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

Agreed Terms

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

Agreed Terms

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

Agreed Terms

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

Agreed Terms

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

Agreed Terms

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

Board Committee Assurance Report

Committee	Charitable Funds Committee
Meeting Date	6 May 2026
Committee Chair	Julian Duxfield, Non-Executive Director

Items received by the Committee	Level of Assurance Ratings focus on overall assurance over effectiveness of controls	Board Action Required? Yes ✓ or No x
1. Finance & Fundraising Report	Partial	x
2. Case of Need Schedule	Good	x
3. Divisional Charitable Funds Spending Plans	Good	x
4. Brighter Futures team staffing update	N/A	x
5. Presentation about RUH's charity (RUHX)	N/A	x
6. Foundation Trust & Charity Relationship	N/A	Possible
7. Staff Lottery governance	N/A	x

POINTS OF ESCALATION	This meeting was the final meeting with current participants, two of the three NEDs involved will step down at the end of June. The committee discussed some possible options for future governance but a final decision will be needed on the structure of the governance relationship between the Trust and the charity.
KEY AREAS TO NOTE	The total value of the Trust's overall charitable funds on 31st March 2026 were £859k of which £556k is restricted and £303k is unrestricted. Prior to the meeting the general fund's uncommitted balance stood at £125k above our agreed minimum threshold of £57k. The core run-rate of income generation remains well below the last two years, although the Q4 performance has exceeded the previous year which is encouraging. Expenditure is less than budgeted as a result of staff vacancies and absences. There were no new cases of need presented to the Committee. The Committee received assurance from Surgery and Planned Care about their use of the first formal meetings of the Divisional Charitable Funds Panels following the Trust-wide rationalisation of charitable funds and the establishment of devolved, divisional-level governance arrangements. The committee received a presentation from RUH on their charity, RUHX, and its progress since 2020. The key lessons are: • Clear strategy and rebrand: The 2022 charity strategy and rebrand provided a single, coherent purpose and identity, establishing a strong foundation for sustainable growth, donor confidence and ethical fundraising. • Stronger governance and impact: Fund rationalisation and the new internal grants programme have improved oversight, reduced inactive funds and enabled greater focus on high-impact, transformational projects. • Investment in specialist capability: Treating fundraising as a specialist profession, supported by role redesign and external recruitment, has strengthened expertise, resilience and ethical practice. • Effective Trust partnership: Trust in specialist leadership, enabling finance support and a clear pipeline of clinically led priorities has underpinned confident, aligned fundraising. • Demonstrable success and future ambition: Significant fundraising achievements have been delivered, with a clear plan to use donor insight to inform a new 2027 strategy and grow RUHX into a sustainable £4m-per-year charity.

	The staff lottery which is run by volunteers will need to secure new volunteers to run it and be signatories for the bank account. The Trust's relationship with the lottery will be overseen by the site director of finance who will provide annual assurance to the Charity Funds Committee on its governance.
BOARD ASSURANCE FRAMEWORK & RISKS	As summarised above.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	
REFERRALS TO OTHER BOARD COMMITTEES	None

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

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

Report Title	2025 Trust Staff Survey Results			
Meeting	Trust Board			
Date	11/06/2026	Part 1 - Public ☐		Part 2 - Private ☐
Accountable Lead	Claire Warner, Site HR Director			
Report Author	Angela Morris, Senior People Partner			
Appendices	Staff Survey Benchmark and Trend Data			

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:

A monthly Trust Wide Staff Survey working group provides a forum to divisional survey leads for oversight and assurance of actions, progress, and learning, to support the Trust breakthrough objective. Progress highlights are shared with the Trust Management Committee on a monthly basis and leadership guidance and support agreed.

Report

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

The Trust achieved a response rate 66% (3,638 colleagues), against a national response average of 49%.

Scores are broadly in line with 2024 results and are significantly better than the sector scores for similar organisations surveyed by IQVIA. People Promise scores for the themes of 'We are recognised and rewarded', 'We each have a voice that counts', 'We are safe and healthy', and 'We work flexibly' are significantly better than similar organisations.

Themes of Morale and Staff Engagement remain key performance indicators for the organisation. Both theme scores are significantly better than the sector scores and are in line with 2024 scores.

At question level, 10 scores are in the top-20% range of similar organisations. There are 99 scores that are in the intermediate-60% and 2 in the bottom-20%.

Where comparable to 2024, 6 question-level scores have declined and there have been 6 significant improvements. The declines include experience of physical violence from patients/service users or members of the public, organisational handling of reports of errors, near misses or incidents or concerns raised by patients/service users, career development opportunities and care of patients/service users being the organisation's top priority (Q25a).

The majority of the People Promise scores for the 2025 National NHS Bank Staff Survey are in line with the substantive Trust scores. A similar picture when looking at the People Promise scores in more detail, with the scores for the theme of 'We are safe and healthy' and subtheme of team working are significantly better than the substantive scores. The subthemes of 'Compassionate leadership', 'Development' and 'Line management' are significantly worse.

The Trust worked within a challenging financial operating environment during 2025 with additional recruitment controls and governance applied across the workforce, and divisions working towards headcount reduction targets. Schemes included a mutually agreed resignation scheme (MARS), and enhanced restrictions applied to recruitment of administrative positions, as well as use of bank and agency staffing, which are likely to have restricted progress in the pillar metric.

Progress of Trust countermeasures have had a positive impact on staff reporting respect from colleagues at work which improved by 0.5%.

Analysis of the survey data highlighted 'Care of Patients as a Top Priority' (question 25a) as an area that will further drive improvement in staff recommending the organisation as a place to work. This question forms one of the 3 advocacy indicator questions (alongside recommending as a place to work; and being happy with standard of care for friends or relatives) and has been adopted as the breakthrough metric for 2026/7. An A3 for question 25a is included at slide 29.

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

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

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

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

A subset of questions in the staff survey are directly related to staff experience of diversity and inclusion and provide indicators use din the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). The EDI Driver Metric Q16a and Q16b, Discrimination from patients/public and from staff:-

- **By Patients/relatives/public:** Improved for global majority staff by 1.5% - 23.1% experienced discrimination in 2025, compared to 24.6% last year. Slightly worsened for disabled staff by 0.8% - 9.4% compared to 8.6% last year.
- **By Staff:** Significantly improved for global majority staff by 5.3% - 13.3% experienced discrimination from a colleague in 2025, compared to 18.6% last year. Improved for disabled staff by 1.9% - 12.2% compared to 14.1% last year.

Recommendation / Action Required

The Board/Committee/Group is requested to:

TMC is requested to:-

- Agree that all divisions align to the Trust breakthrough question for 2026/76, being Q25a 'Care of Patients and service users is the organisations top priority.'
- Leads within TMC to influence identification and delivery of local and Trust level countermeasures within their reporting line functions.
- Champion the staff survey as an indicator of staff engagement.

Accountable Lead Signature	Claire Warner
Date	**04/06/2026**

2025 Staff Survey Results

Great Western Hospitals NHS Foundation Trust

Headline Findings

Great Western Hospitals
NHS Foundation Trust

GWH 2025

Participation

3,638 staff responded

66% response rate

(71% 2024)

National 2025: 49% (51% 2024)

Questions

(significance vs 2024)

54% improve

41% decline

5% unchanged

Successes

Top 5 scores vs Sector Average	Org	IQVIA Avg
My organisation takes positive action on health and well-being. Agree (Q11a)	61.3%	54.5%
The opportunities for flexible working patterns. Satisfied 9Q4d)	61.2%	56.4%
I look forward to going to work. Often (Q2a)	55.3%	51.7%
As soon as I can find another job, I will leave this organisation. Disagree (Q26c)	60.3%	56.8%
I can approach my immediate manager to talk openly about flexible working. Agree (Q6d)	73.0%	70.3%

Most improved scores	2024	2025
Can eat nutritious and affordable food while working. Agree (Q22)	52.3%	55.3%
Last time you experienced physical violence at work, did you or a colleague report it. Yes (Q13d)	65.2%	68.1%
On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours. 0 hours (Q10c)	50.6%	53.2%
My immediate manager asks for my opinion before making decisions that affect my work. Yes (Q9c)	58.0%	60.4%
I am able to make suggestions to improve the work of my team / department. Agree (Q3d)	69.0%	71.4%

Challenges

Bottom 5 scores vs Sector Average	Org	IQVIA Avg
If a friend or relative needed treatment would be happy with the standard of care by organisation. Agree (Q25d)	59.3%	62.2%
In the last month have you seen any errors, near misses/incidents that could have hurt staff/patients/service users. No (Q18)	61.9%	64.7%
I have unrealistic time pressures. Rarely (Q5a)	22.9%	25.5%
The last time you experienced physical violence at work, did you or a colleague report it. Yes (Q13d)	68.1%	70.7%
On average, how many additional PAID hours do you work per week over and above contracted hours. 0 hours (Q10b)	64.1%	66.6%

Most declined scores	2024	2025
There are opportunities for me to develop my career in this organisation. Agree (Q24b)	55.7%	52.3%
Have you felt pressure from your manager to come to work? No (Q11e)	79.8%	77.7%
I am confident that my organisation would address my concern. Agree (Q20b)	57.3%	55.4%
My organisation takes positive action on health and well-being. Agree (Q11a)	62.3%	61.3%

Headline Findings

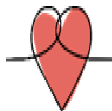
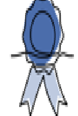
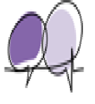
Promise and Themes

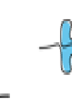
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.29	5.96	6.68	6.17	5.69	6.49	6.79	6.81	5.96
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	3628	3629	3592	3604	3470	3605	3625	3629	3632

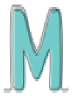
- All people promise and themes in line with 2024 and above sector average.
- Morale and Staff Engagement remain key performance indicators for the organisation. Both theme scores are significantly better than sector scores.

Southwest Ranking

2025 Survey





Rank	Acute and Acute & Community Trusts South West Region inc. OUH	Response Rate	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale	Total Score
1	University Hospitals Bristol and Weston NHS Foundation Trust	61%	7.61	6.18	6.91	6.30	5.92	6.57	7.07	7.07	6.15	59.8
2	North Bristol NHS Trust	56%	7.55	6.14	6.87	6.28	5.95	6.47	6.89	7.09	6.17	59.4
3	Somerset NHS Foundation Trust	46%	7.50	6.21	6.81	6.29	5.78	6.54	6.96	6.94	6.13	59.2
4	Dorset County Hospital NHS Foundation Trust	43%	7.40	6.05	6.76	6.09	5.70	6.49	6.87	6.92	5.91	58.2
5	Royal Devon University Healthcare NHS Foundation Trust	33%	7.52	6.13	6.71	6.17	5.34	6.40	6.91	6.85	6.01	58.1
6	**Great Western Hospitals NHS Foundation Trust**	66%	7.29	5.96	6.68	6.17	5.69	6.49	6.79	6.81	5.96	57.8
7	University Hospitals Dorset NHS Foundation Trust	55%	7.39	5.95	6.72	6.14	5.56	6.29	6.80	6.83	5.93	57.6
8	**Salisbury NHS Foundation Trust**	53%	7.31	5.93	6.69	6.14	5.55	6.29	6.74	6.87	5.87	57.4
9	**Royal United Hospitals Bath NHS Foundation Trust**	52%	7.39	5.96	6.63	6.01	5.50	6.29	6.86	6.83	5.84	57.3
10	Torbay and South Devon NHS Foundation Trust	36%	7.31	5.96	6.57	6.01	5.37	6.33	6.73	6.72	5.82	56.8
11	University Hospitals Plymouth NHS Trust	48%	7.20	5.82	6.53	6.02	5.53	6.36	6.70	6.60	5.83	56.6
12	Gloucestershire Hospitals NHS Foundation Trust	50%	7.08	5.72	6.30	6.00	5.45	5.99	6.61	6.43	5.73	55.3
13	Royal Cornwall Hospitals NHS Trust	50%	7.05	5.64	6.27	5.79	5.04	5.89	6.62	6.27	5.57	54.1

- Ranked 6th across Southwest Acute and Acute & Community Trusts (9th in 2024)
- Highest response rate across southwest benchmarking group

Results by People Promise & Theme

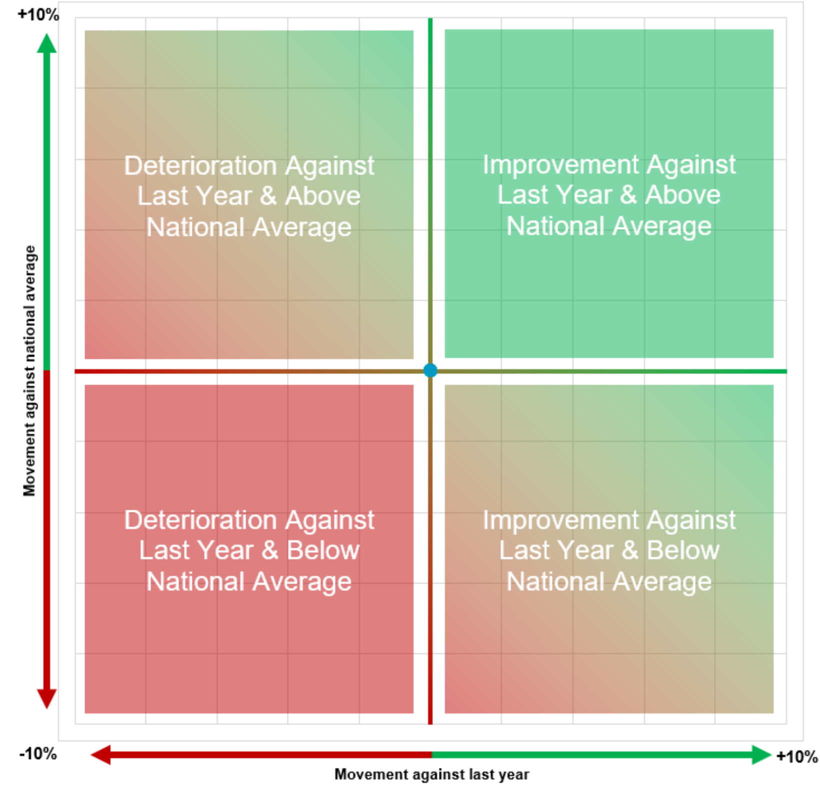
2025 Staff Survey

Using This Report

2025 Staff Survey

From the 2021 survey onwards, questions in the NHS Staff Survey have been aligned to the People Promise which is comprised of seven elements:

- This report breaks down performance against these People Promise elements as well as two historic 'themes' reported in previous years (Engagement and Morale).
- A quadrant graph has been created for each promise/theme, showing the relevant group of questions and their performance against last year and the national average.
- For 2025 reporting, all methodology (positive or negative scoring) continues to be aligned with the national methodology.
- Positively scored questions are denoted with a (+) and a higher result than last year/national average is good.
- Negatively scored questions are denoted with a (-) and a higher result than last year/national average is bad.



Positive/negative reporting

Variance to last year's results for GWH

Variance to national average

	Theme	Question Number	Question	2023 Result	Variance to 2022	National Average	Variance to National Average
+	Sub-Theme	ex1	Example Question 1 (Strongly Agree/Agree) Positive Reporting: Higher than LY/Average is good	67.5%	1.3%	65.0%	2.5%
-	Sub-Theme	ex2	Example Question 2 (Disagree/Strongly Disagree) Negative Reporting: Higher than LY/Average is bad	9.3%	-9.3%	9.0%	-0.3%

We are compassionate and inclusive

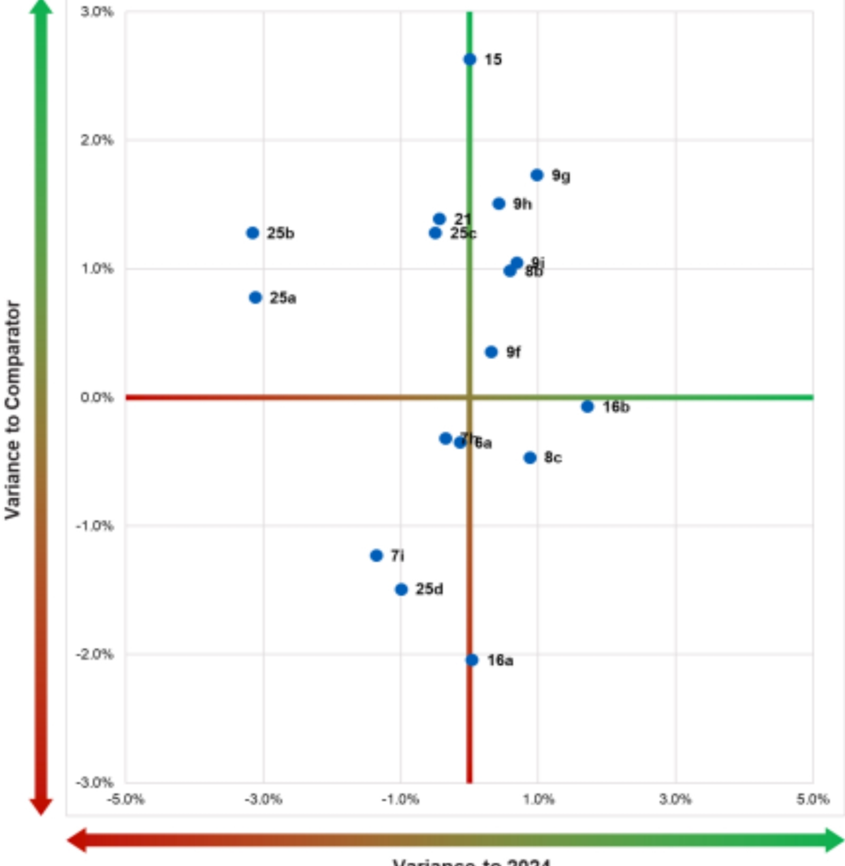
2025 Staff Survey

Compassionate Leadership

- Redesigned leadership programmes are streamlined for shorter delivery and broader MDT participation, offering increased capacity and improved attendance. Initial cohorts are fully booked with positive early feedback.
- Participation in the Active Bystander and Radical Candour programmes continues to grow, helping to extend impact across the organisation.
- The leadership conference in June 25 centred on anti-racism and system leadership and incorporated discussion on development of the behaviours.

Compassionate Culture

- Scores indicate that staff have an understanding of the Trust's values, though these are not yet consistently reflected in everyday behaviours. This is in line with the early stage of the 2025 behaviours soft launch. New and planned initiatives to embed behaviours further in 2026/7 include:- themed e-cards; self and peer assessment tool; meeting role cards; visible displays; STAR champion engagement group; civility handbook; behaviour resource toolkits.
- Never OK campaign: This collaboration with Wilts Police included national press and local radio coverage with representatives from the police force and Swindon Town football club sharing experiences with staff. A focussed task group created an action plan to raise awareness and improve response to incidents.
- EDI: Sustainable strategies based on education, support, and challenge of behaviours that do not align with STAR values shaped initiatives in 2025/6 with a holistic approach to addressing unprofessional behaviours through virtual reality based training; equipping individuals and 65 EDI champions with tools and techniques in emotional resilience and self-advocacy; and promotion of a mentorship programme. Network leads meet with the board annually, and lived experience used to shape programmes.
- Care of patients (Q25a) is the breakthrough focus in 2026.

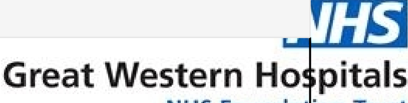


We are compassionate and inclusive

2025 Staff Survey

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We are compassionate and inclusi	Compassionate culture	6a	I feel that my role makes a difference to patients / service users (Agree/Strongly agree).	Higher = better	87.9%	88.0%	-0.1%	88.2%	-0.3%
We are compassionate and inclusi	Compassionate culture	25a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	Higher = better	72.4%	75.5%	-3.1%	71.6%	0.8%
We are compassionate and inclusi	Compassionate culture	25b	My organisation acts on concerns raised by patients / service users (Agree/Strongly agree).	Higher = better	69.4%	72.6%	-3.2%	68.1%	1.3%
We are compassionate and inclusi	Compassionate culture	25c	I would recommend my organisation as a place to work (Agree/Strongly agree).	Higher = better	59.1%	59.6%	-0.5%	57.8%	1.3%
We are compassionate and inclusi	Compassionate culture	25d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	Higher = better	59.3%	60.3%	-1.0%	60.8%	-1.5%
We are compassionate and inclusi	Compassionate leadership	9f	My immediate manager works together with me to come to an understanding of problems (Agree/Strongly agree).	Higher = better	69.2%	68.9%	0.3%	68.9%	0.4%
We are compassionate and inclusi	Compassionate leadership	9g	My immediate manager is interested in listening to me when I describe challenges I face (Agree/Strongly agree).	Higher = better	72.8%	71.8%	1.0%	71.1%	1.7%
We are compassionate and inclusi	Compassionate leadership	9h	My immediate manager cares about my concerns (Agree/Strongly agree).	Higher = better	71.2%	70.8%	0.4%	69.7%	1.5%
We are compassionate and inclusi	Compassionate leadership	9i	My immediate manager takes effective action to help me with any problems I face (Agree/Strongly agree).	Higher = better	67.8%	67.2%	0.7%	66.8%	1.0%
We are compassionate and inclusi	Diversity and equality	21	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc) (Agree/Strongly agree).	Higher = better	70.3%	70.7%	-0.4%	68.9%	1.4%
We are compassionate and inclusi	Diversity and equality	15	Does your organisation act fairly with regard to career progression / promotion, regardless of e.g. age, disability, ethnic background, gender reassignment, religion, sex or sexual orientation (Yes).	Higher = better	55.7%	0.0%	0.0%	53.1%	2.6%
We are compassionate and inclusi	Diversity and equality	16a	In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public (Yes).	Lower = better	10.6%	10.6%	0.0%	8.6%	-2.0%
We are compassionate and inclusi	Diversity and equality	16b	In the last 12 months have you personally experienced discrimination at work from a manager / team leader or other colleagues (Yes).	Lower = better	8.8%	10.5%	1.7%	8.7%	-0.1%
We are compassionate and inclusi	Inclusion	7h	I feel valued by my team (Agree/Strongly agree).	Higher = better	68.5%	68.9%	-0.4%	68.9%	-0.3%
We are compassionate and inclusi	Inclusion	7i	I feel a strong personal attachment to my team (Agree/Strongly agree).	Higher = better	61.7%	63.0%	-1.4%	62.9%	-1.2%
We are compassionate and inclusi	Inclusion	8b	The people I work with are understanding and kind to one another (Agree/Strongly agree).	Higher = better	69.5%	68.9%	0.6%	68.5%	1.0%
We are compassionate and inclusi	Inclusion	8c	The people I work with are polite and treat each other with respect (Agree/Strongly agree).	Higher = better	69.2%	68.4%	0.9%	69.7%	-0.5%

We are recognised and rewarded



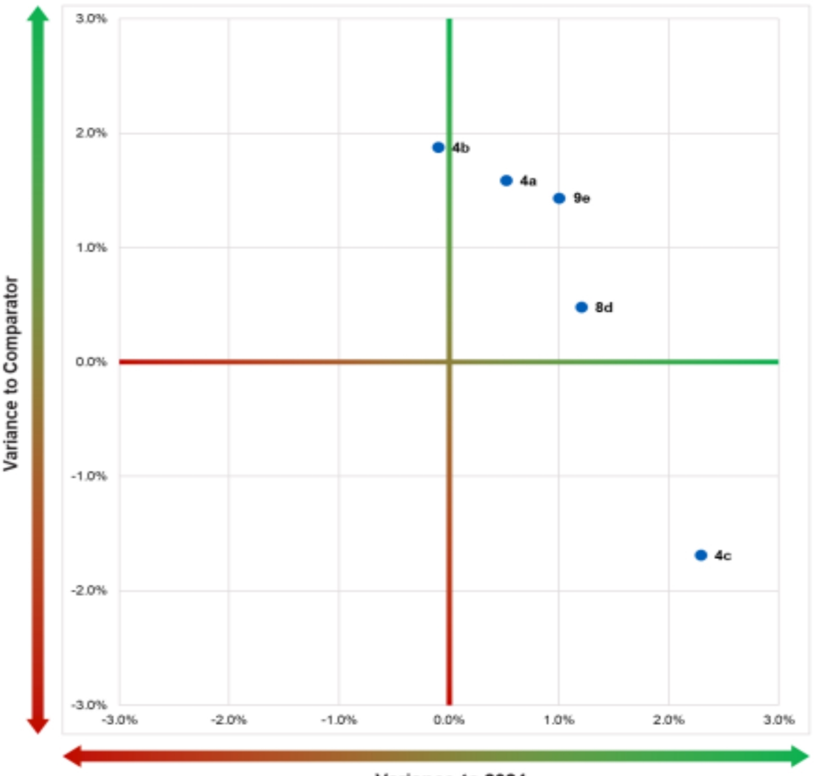
2025 Staff Survey

Reward

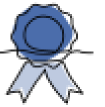
- There were 3 major strike periods by medical colleagues in July, Oct, and Dec 2025. Satisfaction with level of pay increases from 46% to 52% in the medical and dental staff group.
- A Gender Pay Gap workshop with the Women's Network invited members to share ideas about what the care organisation can do to reduce the gap, which is mainly driven by the medical and dental staff group. Feedback will inform the Medical Workforce Strategy in the spring of 2026.

Recognition

- Quarterly in-person long service awards ceremonies continue to thrive with 15+ staff receiving awards each time. New in 2025: being accompanied by family members/colleagues.
- 340 nominations received for the Staff Excellence awards, the event welcoming up to 500 staff members. Awards will be aligned to Behaviours in July 26.
- A monthly social media campaign was introduced in autumn 2025 celebrating good news stories and staff achievements. Introduced in response to Pulse feedback and as a positive reinforcement of peer-to-peer recognition. Further opportunities are provided through Hidden Hero (there were 158 presentations in 2025), star of the month, long-service (82 awards in 2025) and e-cards.
- The Trust's fifth annual 'Great West Fest' took place in September, offering an opportunity for 4,500 staff and families to attend.



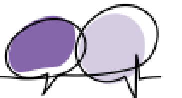
We are recognised and rewarded



2025 Staff Survey

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We are recognised and rewarded	-	4a	The recognition I get for good work (Satisfied/Very satisfied).	Higher = better	53.3%	52.8%	0.5%	51.7%	1.6%
We are recognised and rewarded	-	4b	The extent to which my organisation values my work (Satisfied/Very satisfied).	Higher = better	43.8%	43.9%	-0.1%	41.9%	1.9%
We are recognised and rewarded	-	4c	My level of pay (Satisfied/Very satisfied).	Higher = better	29.8%	27.5%	2.3%	31.5%	-1.7%
We are recognised and rewarded	-	8d	The people I work with show appreciation to one another (Agree/Strongly agree).	Higher = better	66.1%	64.9%	1.2%	65.6%	0.5%
We are recognised and rewarded	-	9e	My immediate manager values my work (Agree/Strongly agree).	Higher = better	73.1%	72.1%	1.0%	71.6%	1.4%

We each have a voice that counts



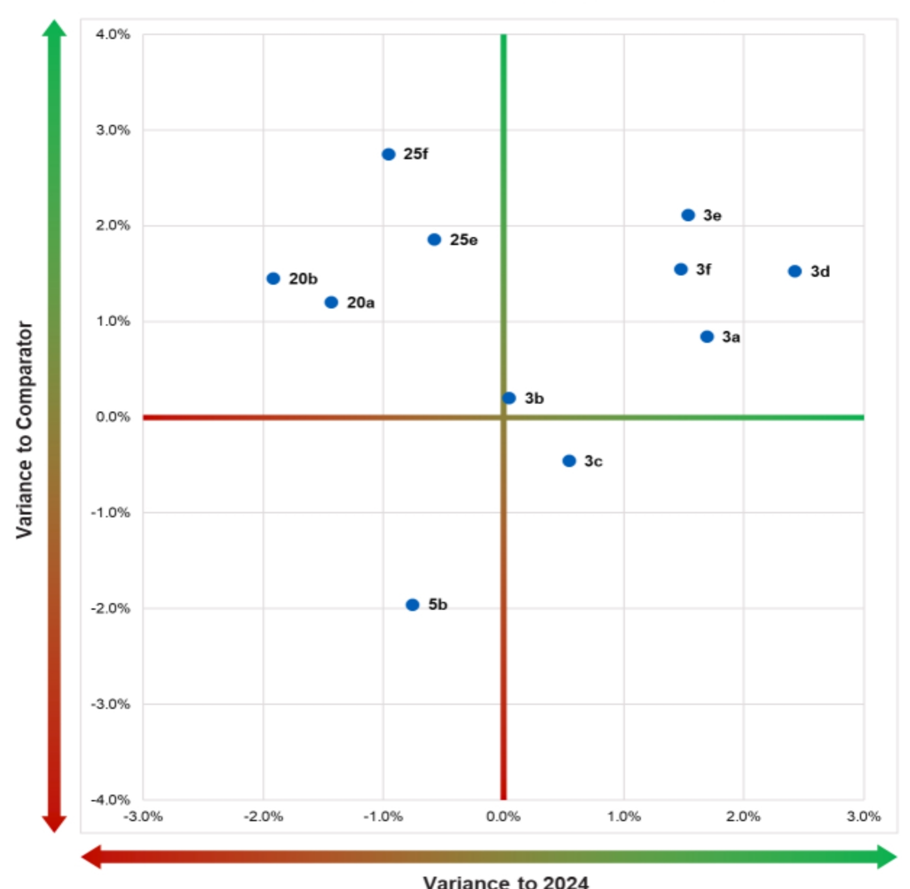
2024 Staff Survey

Highlight

- 635 staff shared 5,200 contributions to the 'Lets Talk Behaviours' big conversation on-line platform, helping to shape the Trust behaviours aligned to STAR values.

Raising Concerns

- GWH scores above sector average for all FTSU-related questions.
- New FTSU operating model embedded, strengthening governance, consistency, Guardian independence, and alignment with BSW-wide practice for improved system-level approach.
- Improved FTSU Guardian visibility and proactive engagement with staff and leaders, including strengthened Senior Leadership involvement and clearer accountability.
- Analysis of FTSU-related questions highlights specific teams low scoring themes: organisational responsiveness, awareness of routes for raising concerns, feeling listened to (feedback loop), local leadership behaviours (accepting poor behaviours as norm).
- Active bystander provides a framework for people to speak up and address poor behaviours.
- Improvement evidenced in staff feeling able to raise concerns and confidence that they will be addressed



We each have a voice that counts

2025 Staff Survey

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We each have a voice that counts	Autonomy and control	3a	I always know what my work responsibilities are (Agree/Strongly agree).	Higher = better	87.6%	85.9%	1.7%	86.8%	0.8%
We each have a voice that counts	Autonomy and control	3b	I am trusted to do my job (Agree/Strongly agree).	Higher = better	90.1%	90.0%	0.0%	89.9%	0.2%
We each have a voice that counts	Autonomy and control	3c	There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree).	Higher = better	72.1%	71.5%	0.5%	72.5%	-0.5%
We each have a voice that counts	Autonomy and control	3d	I am able to make suggestions to improve the work of my team / department (Agree/Strongly agree).	Higher = better	71.4%	69.0%	2.4%	69.9%	1.5%
We each have a voice that counts	Autonomy and control	3e	I am involved in deciding on changes introduced that affect my work area / team / department (Agree/Strongly agree).	Higher = better	51.7%	50.2%	1.5%	49.6%	2.1%
We each have a voice that counts	Autonomy and control	3f	I am able to make improvements happen in my area of work (Agree/Strongly agree).	Higher = better	56.1%	54.6%	1.5%	54.5%	1.5%
We each have a voice that counts	Autonomy and control	5b	I have a choice in deciding how to do my work (Often/Always).	Higher = better	49.4%	50.2%	-0.8%	51.4%	-2.0%
We each have a voice that counts	Raising concerns	20a	I would feel secure raising concerns about unsafe clinical practice (Agree/Strongly agree).	Higher = better	71.0%	72.5%	-1.4%	69.8%	1.2%
We each have a voice that counts	Raising concerns	20b	I am confident that my organisation would address my concern (Agree/Strongly agree).	Higher = better	55.4%	57.3%	-1.9%	53.9%	1.5%
We each have a voice that counts	Raising concerns	25e	I feel safe to speak up about anything that concerns me in this organisation (Agree/Strongly agree).	Higher = better	60.7%	61.3%	-0.6%	58.9%	1.9%
We each have a voice that counts	Raising concerns	25f	If I spoke up about something that concerned me I am confident my organisation would address my concern (Agree/Strongly agree).	Higher = better	48.9%	49.9%	-1.0%	46.2%	2.8%

We are safe and healthy

2024 Staff Survey

Burnout

- GWH scores positively in the top 20% against the sector for staff reporting burnout as a result of work.
- Sickness absence and associated temporary cover has a high impact on staff morale and engagement. The Trust has achieved a 0.4% reduction in rolling 12 month average since April 25, reflecting the work of a Trust-led Attendance programme.

Health & Safety Climate

OHWB team work collaboratively on key topics and as part of the Trust Attendance and Never OK campaign working groups supporting areas of high need. This has included:-

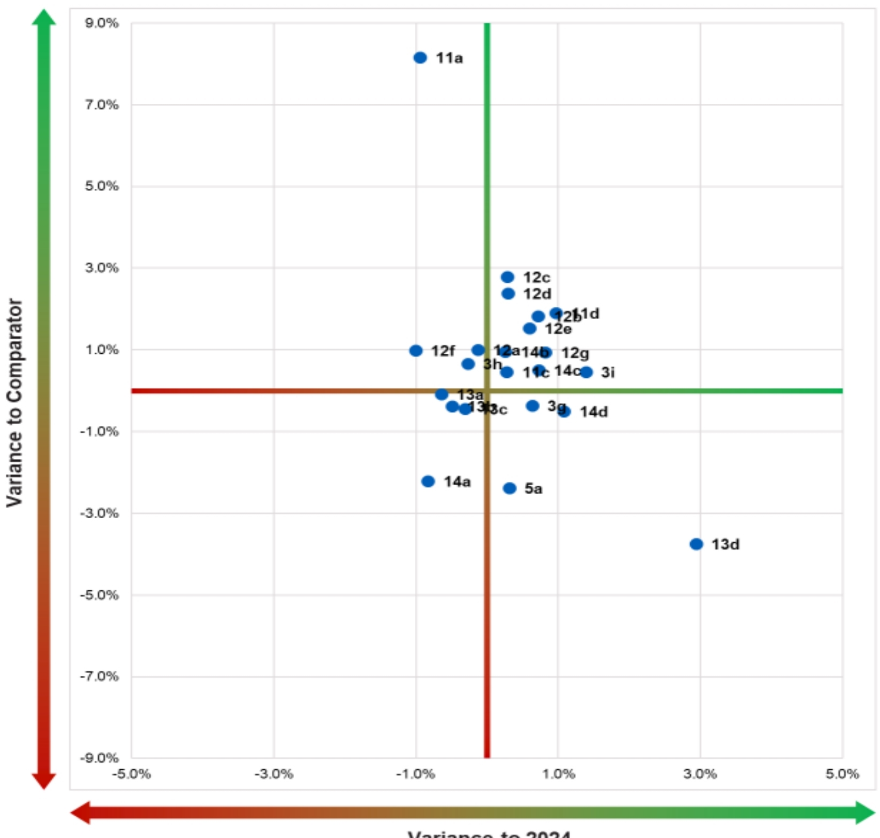
- Promotion and growth of H&WB local champions;
- Proactive physiotherapy approach to support staff with MSK conditions, with bespoke in-reach departmental groups, joint training sessions, and trust wide preventative workshops.

Continued embedding of preventative psychological support mechanisms for all staff, including compassion skills teaching, as well as responsive interventions as needed, such as TRiM (trauma risk management).

Enhanced training for managers to support their team's wellbeing proactively and compassionately via Mental Health Skills for Managers training course and Expectations of Line Managers programme.

2025 saw an increase in numbers of staff accessing Vivup and another great year in numbers of staff accessing the flu campaign.

- Improved scores in all divisions for staff reporting violence, a positive reflection of the Never OK awareness campaign.



We are safe and healthy

Great Western Hospitals NHS Foundation Trust

2025 Staff Survey

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We are safe and healthy	Health and safety climate	3g	I am able to meet all the conflicting demands on my time at work (Agree/Strongly agree).	Higher = better	45.8%	45.1%	0.6%	46.1%	-0.4%
We are safe and healthy	Health and safety climate	3h	I have adequate materials, supplies and equipment to do my work (Agree/Strongly agree).	Higher = better	54.5%	54.8%	-0.3%	53.8%	0.7%
We are safe and healthy	Health and safety climate	3i	There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	Higher = better	31.8%	30.4%	1.4%	31.3%	0.5%
We are safe and healthy	Health and safety climate	5a	I have unrealistic time pressures (Never/Rarely).	Higher = better	22.9%	22.6%	0.3%	25.3%	-2.4%
We are safe and healthy	Health and safety climate	11a	My organisation takes positive action on health and well-being (Agree/Strongly agree).	Higher = better	61.3%	62.3%	-0.9%	53.2%	8.2%
We are safe and healthy	Health and safety climate	13d	The last time you experienced physical violence at work, did you or a colleague report it (Yes).	Higher = better	68.1%	65.2%	2.9%	71.9%	-3.7%
We are safe and healthy	Health and safety climate	14d	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it (Yes).	Higher = better	52.4%	51.3%	1.1%	52.9%	-0.5%
We are safe and healthy	Burnout	12a	How often, if at all, do you find your work emotionally exhausting (Often/Always).	Lower = better	34.1%	33.9%	-0.1%	35.1%	1.0%
We are safe and healthy	Burnout	12b	How often, if at all, do you feel burnt out because of your work (Often/Always).	Lower = better	30.3%	31.0%	0.7%	32.1%	1.8%
We are safe and healthy	Burnout	12c	How often, if at all, does your work frustrate you (Often/Always).	Lower = better	34.3%	34.6%	0.3%	37.1%	2.8%
We are safe and healthy	Burnout	12d	How often, if at all, are you exhausted at the thought of another day/shift at work (Often/Always).	Lower = better	27.0%	27.3%	0.3%	29.4%	2.4%
We are safe and healthy	Burnout	12e	How often, if at all, do you feel worn out at the end of your working day/shift (Often/Always).	Lower = better	42.0%	42.6%	0.6%	43.5%	1.5%
We are safe and healthy	Burnout	12f	How often, if at all, do you feel that every working hour is tiring for you (Often/Always).	Lower = better	20.0%	19.0%	-1.0%	21.0%	1.0%
We are safe and healthy	Burnout	12g	How often, if at all, do you not have enough energy for family and friends during leisure time (Often/Always).	Lower = better	28.9%	29.7%	0.8%	29.9%	0.9%
We are safe and healthy	Negative experiences	13a	In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public (One or more times).	Lower = better	14.7%	14.1%	-0.6%	14.7%	-0.1%
We are safe and healthy	Negative experiences	13b	In the last 12 months how many times have you personally experienced physical violence at work from managers (One or more times).	Lower = better	1.1%	0.6%	-0.5%	0.8%	-0.4%
We are safe and healthy	Negative experiences	13c	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues (One or more times).	Lower = better	2.2%	1.9%	-0.3%	1.8%	-0.4%
We are safe and healthy	Negative experiences	14a	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public (One or more times).	Lower = better	26.8%	26.0%	-0.8%	24.6%	-2.2%
We are safe and healthy	Negative experiences	14b	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers (One or more times).	Lower = better	8.2%	8.5%	0.3%	9.2%	1.0%
We are safe and healthy	Negative experiences	14c	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues (One or more times).	Lower = better	17.4%	18.1%	0.7%	17.9%	0.5%
We are safe and healthy	Negative experiences	11b	In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities (Yes)?	Lower = better	40.8%	0.0%	-40.8%	40.7%	-0.1%
We are safe and healthy	Negative experiences	11c	During the last 12 months have you felt unwell as a result of work related stress (Yes).	Lower = better	41.8%	42.1%	0.3%	42.3%	0.5%
We are safe and healthy	Negative experiences	11d	In the last three months have you ever come to work despite not feeling well enough to perform your duties (Yes).	Lower = better	54.2%	55.1%	1.0%	56.1%	1.9%

We are always learning

2025 Staff Survey

Development

- OD prospectus launched in 2025.
- EOLM has been successful with 97% of target audience (current managers) attending. This is being extended to Clinical Leads April 26.
- Apprenticeships focus in 2025 to make best use of available funding and GWH has exceeded 200 learners on program for the first time.
- Scope for Growth uptake continues to increase and extended to include medical colleagues. Year 1 target of 110 met, stretch target of 220 now in place for 206/7.
- CPD funding sustained this year.
- Satisfaction with career development is impacted by Estates and Administrative staff groups, reflecting the organisation restrictions on recruitment and Corporate re-design work in these functions.

Appraisal

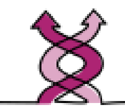
- Refreshed form now includes an individual evidenced based assessment against the Trust behaviours.
- A standardised process on ESR is helping to improve tracking and record keeping. The system transition to ESR has had an impact on KPI completion with support available via user guides and training.

We are always learning

2025 Staff Survey

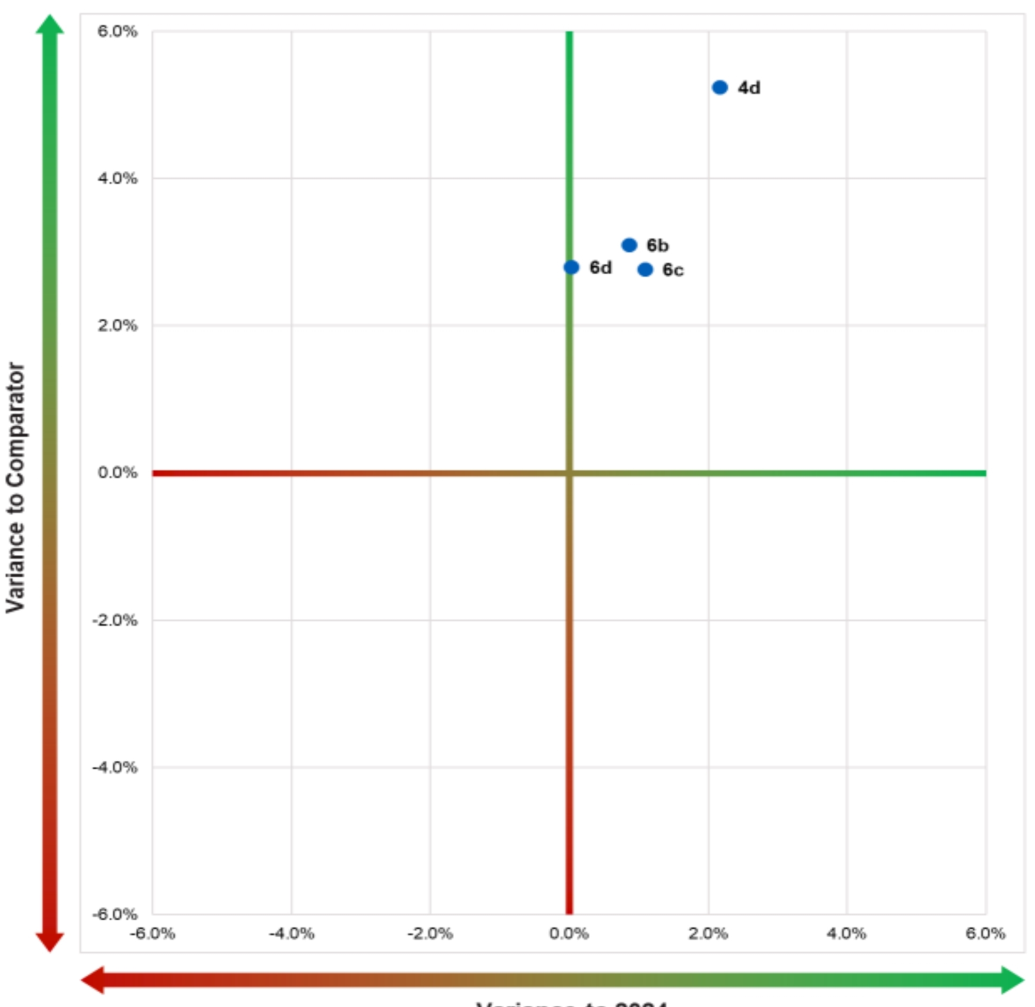
Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We are always learning	Development	24a	This organisation offers me challenging work (Agree/Strongly agree).	Higher = better	66.3%	66.5%	-0.2%	67.5%	-1.2%
We are always learning	Development	24b	There are opportunities for me to develop my career in this organisation (Agree/Strongly agree).	Higher = better	52.3%	55.7%	-3.4%	50.4%	1.9%
We are always learning	Development	24c	I have opportunities to improve my knowledge and skills (Agree/Strongly agree).	Higher = better	70.2%	71.5%	-1.3%	67.4%	2.8%
We are always learning	Development	24d	I feel supported to develop my potential (Agree/Strongly agree).	Higher = better	56.7%	56.7%	0.0%	54.1%	2.6%
We are always learning	Development	24e	I am able to access the right learning and development opportunities when I need to (Agree/Strongly agree).	Higher = better	60.0%	60.3%	-0.3%	57.4%	2.5%
We are always learning	Appraisals	23b	It helped me to improve how I do my job (Yes, definitely).	Higher = better	28.0%	28.1%	0.0%	25.2%	2.8%
We are always learning	Appraisals	23c	It helped me agree clear objectives for my work (Yes, definitely).	Higher = better	37.4%	36.4%	0.9%	34.8%	2.6%
We are always learning	Appraisals	23d	It left me feeling that my work is valued by my organisation (Yes, definitely).	Higher = better	35.4%	34.4%	0.9%	33.0%	2.3%

We work flexibly

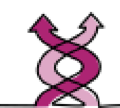


2025 Staff Survey

- National results show We Work Flexibly remaining static at 6.31 whereas GWH improves vs 2024 to 6.5.
- The application process for Agenda for Change flexible working requests was launched on ESR during the survey period.
- Expectations of the Line Manager promotes awareness and a standardised approach when staff submit a request. 1:1 and appraisal templates support continuous, open discussions between staff and managers, helping to balance individual working patterns with service requirements.



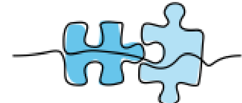
We work flexibly



2025 Staff Survey

Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We work flexibly	Flexible Working	4d	The opportunities for flexible working patterns (Satisfied/Very satisfied).	Higher = better	61.2%	59.0%	2.2%	55.9%	5.2%
We work flexibly	Support for work-life balance	6b	My organisation is committed to helping me balance my work and home life (Agree/Strongly agree).	Higher = better	51.3%	50.5%	0.9%	48.2%	3.1%
We work flexibly	Support for work-life balance	6c	I achieve a good balance between my work life and my home life (Agree/Strongly agree).	Higher = better	58.3%	57.2%	1.1%	55.5%	2.8%
We work flexibly	Support for work-life balance	6d	I can approach my immediate manager to talk openly about flexible working (Agree/Strongly agree).	Higher = better	73.0%	73.0%	0.0%	70.2%	2.8%

We are a team



2025 Staff Survey

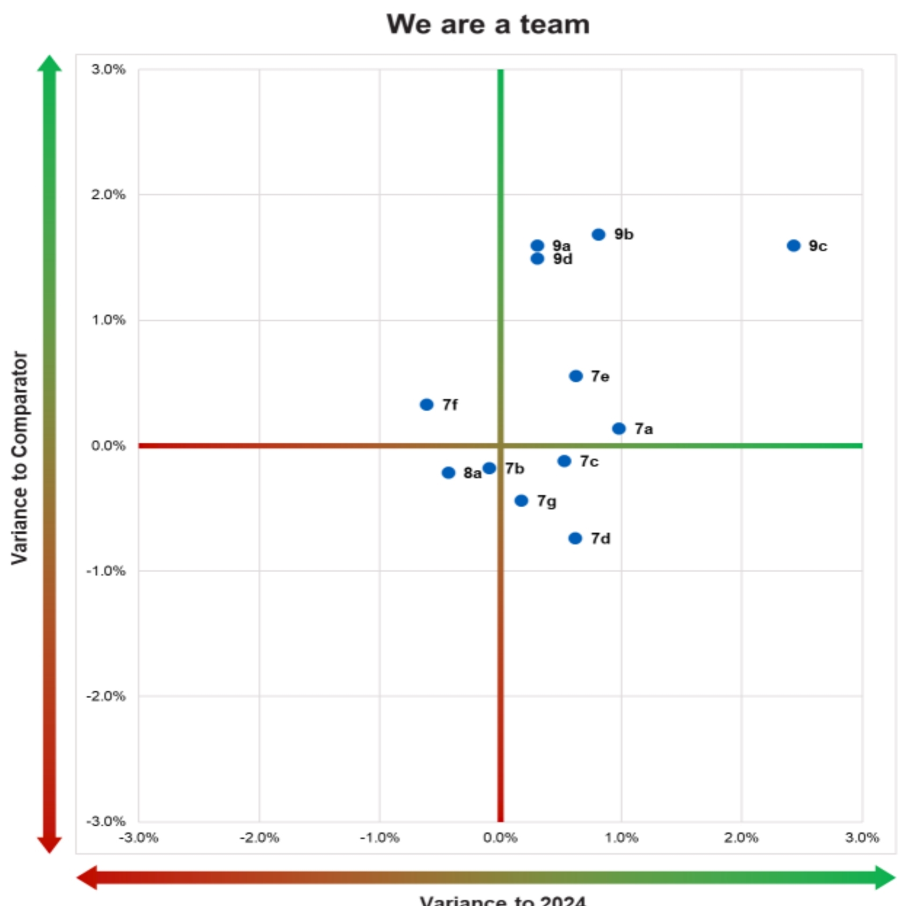
Team working
Encouraging to see results broadly consistent with the previous year, despite significant team moves during 2025 including TUPE transfer to HCRG; Pathology and Maternity services transferring to FaSS division; bed reconfiguration phase 2 transferring Gastro to S&PC, and Saturn moving to Medicine as a Respiratory speciality ward;

- There has been increased uptake of the TED tool with ownership and management of the process being embedded into the line manager role with OD support and guidance.

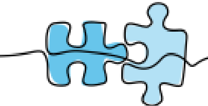
  642 responses through 122 surveys were completed in 2025 (28 previous year when introduced). Running a TED project is also now integrated into leadership programmes as part of the course. Positive teamworking outcomes are evidenced, for example in the newly-formed team Saturn.

- Trust countermeasures focussed on hotspot teams and themes to improve respect between colleagues under the improving together approach. This has resulted in a 0.5% improvement in Q7c vs 2024.

- Cara Charles-Barks (CEO) and Lisa Thomas (MD) introduced regular Group and Trust staff forums during 2025. These provide an opportunity for staff to come together and receive updates on projects, performance, and priorities, and questions from staff are invited. Face-to-face listening sessions were also introduced, hosted by members of the Exec team to hear and respond to matters affecting staff.



We are a team



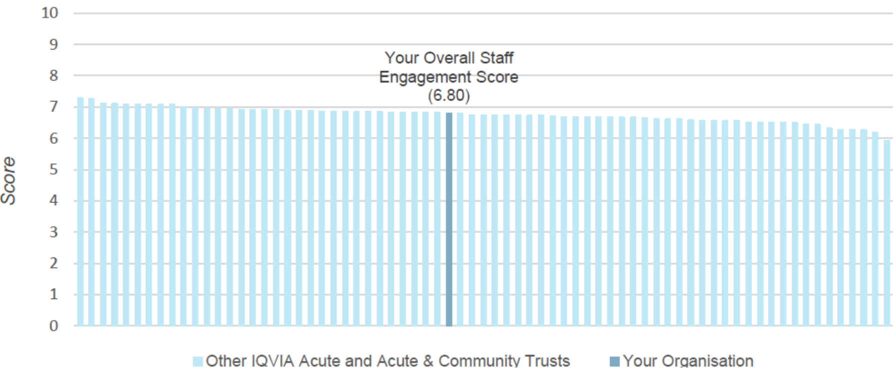
2025 Staff Survey

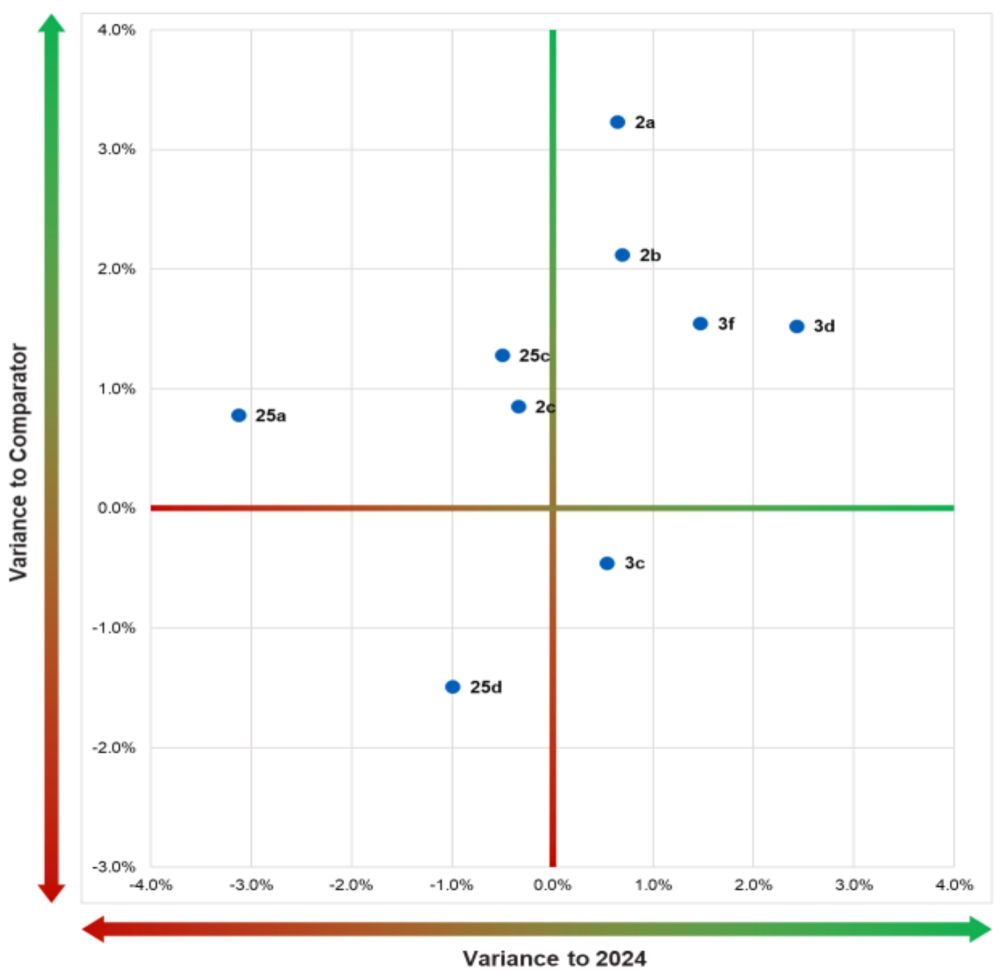
Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
We are a team	Team working	7a	The team I work in has a set of shared objectives (Agree/Strongly agree).	Higher = better	73.7%	72.7%	1.0%	73.5%	0.1%
We are a team	Team working	7b	The team I work in often meets to discuss the team's effectiveness (Agree/Strongly agree).	Higher = better	61.6%	61.7%	-0.1%	61.8%	-0.2%
We are a team	Team working	7c	I receive the respect I deserve from my colleagues at work (Agree/Strongly agree).	Higher = better	70.3%	69.8%	0.5%	70.4%	-0.1%
We are a team	Team working	7d	Team members understand each other's roles (Agree/Strongly agree).	Higher = better	70.4%	69.8%	0.6%	71.2%	-0.7%
We are a team	Team working	7e	I enjoy working with the colleagues in my team (Agree/Strongly agree).	Higher = better	80.1%	79.5%	0.6%	79.5%	0.6%
We are a team	Team working	7f	My team has enough freedom in how to do its work (Agree/Strongly agree).	Higher = better	58.8%	59.5%	-0.6%	58.5%	0.3%
We are a team	Team working	7g	In my team disagreements are dealt with constructively (Agree/Strongly agree).	Higher = better	55.6%	55.4%	0.2%	56.0%	-0.4%
We are a team	Team working	8a	Teams within this organisation work well together to achieve their objectives (Agree/Strongly agree).	Higher = better	53.1%	53.5%	-0.4%	53.3%	-0.2%
We are a team	Line management	9a	My immediate manager encourages me at work (Agree/Strongly agree).	Higher = better	73.3%	73.0%	0.3%	71.7%	1.6%
We are a team	Line management	9b	My immediate manager gives me clear feedback on my work (Agree/Strongly agree).	Higher = better	67.1%	66.3%	0.8%	65.4%	1.7%
We are a team	Line management	9c	My immediate manager asks for my opinion before making decisions that affect my work (Agree/Strongly agree).	Higher = better	60.4%	58.0%	2.4%	58.8%	1.6%
We are a team	Line management	9d	My immediate manager takes a positive interest in my health and well-being (Agree/Strongly agree).	Higher = better	71.2%	70.9%	0.3%	69.7%	1.5%

Staff engagement

2025 Staff Survey

- Nationally the Motivation sub theme is at it's lowest level for 5 years. Staff engagement at GWH is unchanged from 2024 and scores 7 vs 6.87 nationally.
- Decline in all 3 Advocacy questions, including the Trust pillar metric "I would recommend my organisation as a place to work." The breakthrough focus will therefore move to Q25a (Care of patients is top priority) in 2026/7 to drive greater progress towards the pillar matric goal. GWH is currently 59.1% with a goal of achieving 2% above national average which was 58.05% in 2025.
- GWH vs sector:





Staff engagement

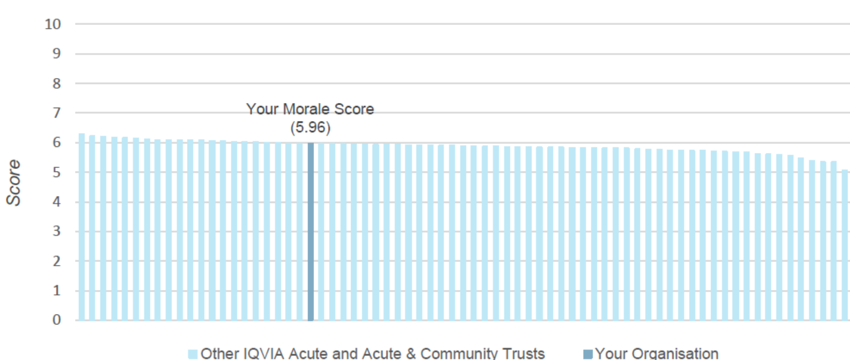
2025 Staff Survey

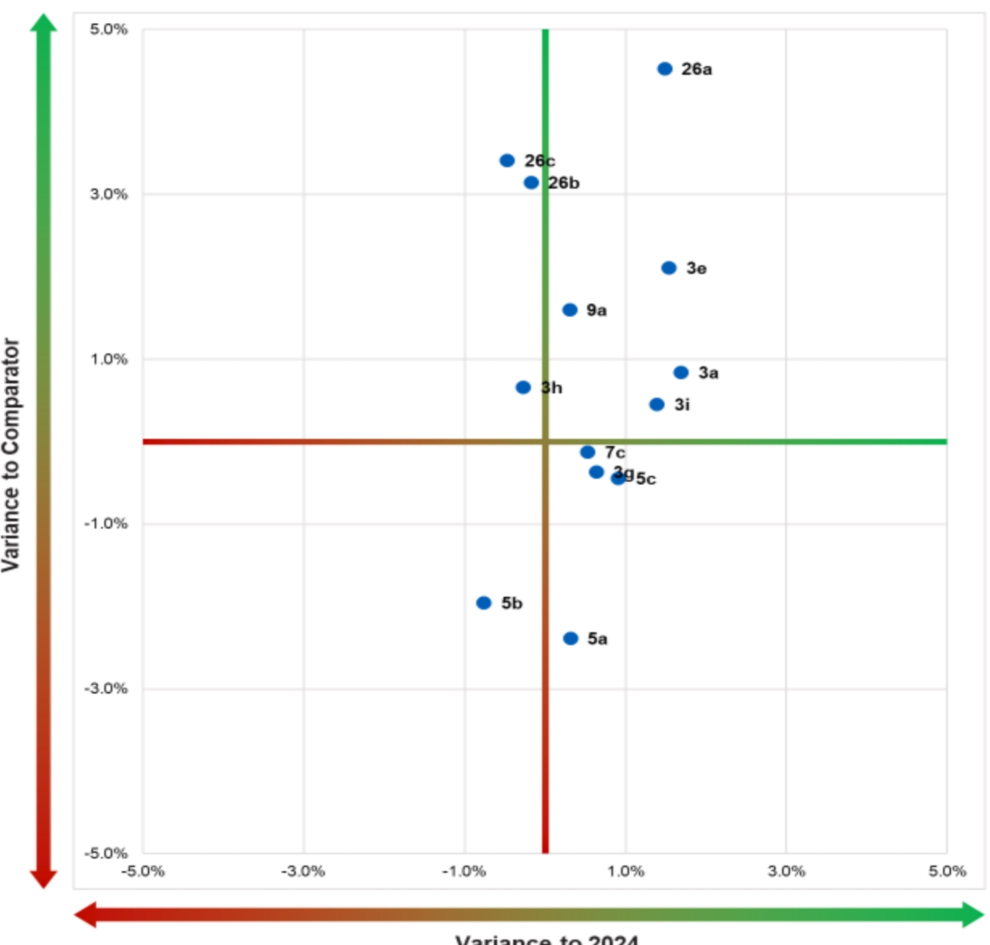
Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
Staff Engagement	Motivation	2a	I look forward to going to work (Often/Always).	Higher = better	55.3%	54.6%	0.6%	52.0%	3.2%
Staff Engagement	Motivation	2b	I am enthusiastic about my job (Often/Always).	Higher = better	68.2%	67.5%	0.7%	66.1%	2.1%
Staff Engagement	Motivation	2c	Time passes quickly when I am working (Often/Always).	Higher = better	70.9%	71.2%	-0.3%	70.0%	0.9%
Staff Engagement	Involvement	3c	There are frequent opportunities for me to show initiative in my role (Agree/Strongly agree).	Higher = better	72.1%	71.5%	0.5%	72.5%	-0.5%
Staff Engagement	Involvement	3d	I am able to make suggestions to improve the work of my team / department (Agree/Strongly agree).	Higher = better	71.4%	69.0%	2.4%	69.9%	1.5%
Staff Engagement	Involvement	3f	I am able to make improvements happen in my area of work (Agree/Strongly agree).	Higher = better	56.1%	54.6%	1.5%	54.5%	1.5%
Staff Engagement	Advocacy	25a	Care of patients / service users is my organisation's top priority (Agree/Strongly agree).	Higher = better	72.4%	75.5%	-3.1%	71.6%	0.8%
Staff Engagement	Advocacy	25c	I would recommend my organisation as a place to work (Agree/Strongly agree).	Higher = better	59.1%	59.6%	-0.5%	57.8%	1.3%
Staff Engagement	Advocacy	25d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly agree).	Higher = better	59.3%	60.3%	-1.0%	60.8%	-1.5%

Morale

2025 Staff Survey

- The Morale score is similar to last year and remains above 2022 and 2021.
- Nationally, the 'Work pressure' sub-score is at its lowest level since 2023 with less than half of staff say they are able to meet all of the conflicting demands on their time at work, which has been the case since 2021.
- GWH also has less than half (45.8%) of staff reporting being able to meet all conflicting demands, although this is a marginal (0.7%) improvement vs 2024.
- Stressors overall are in line with sector and again marginally improve vs 2024. Relationships and respect both improve and are linked to the Trust 2025/6 breakthrough objective.
- GWH position vs sector - Morale:





Morale

2025 Staff Survey

NHS Great Western Hospitals NHS Foundation Trust

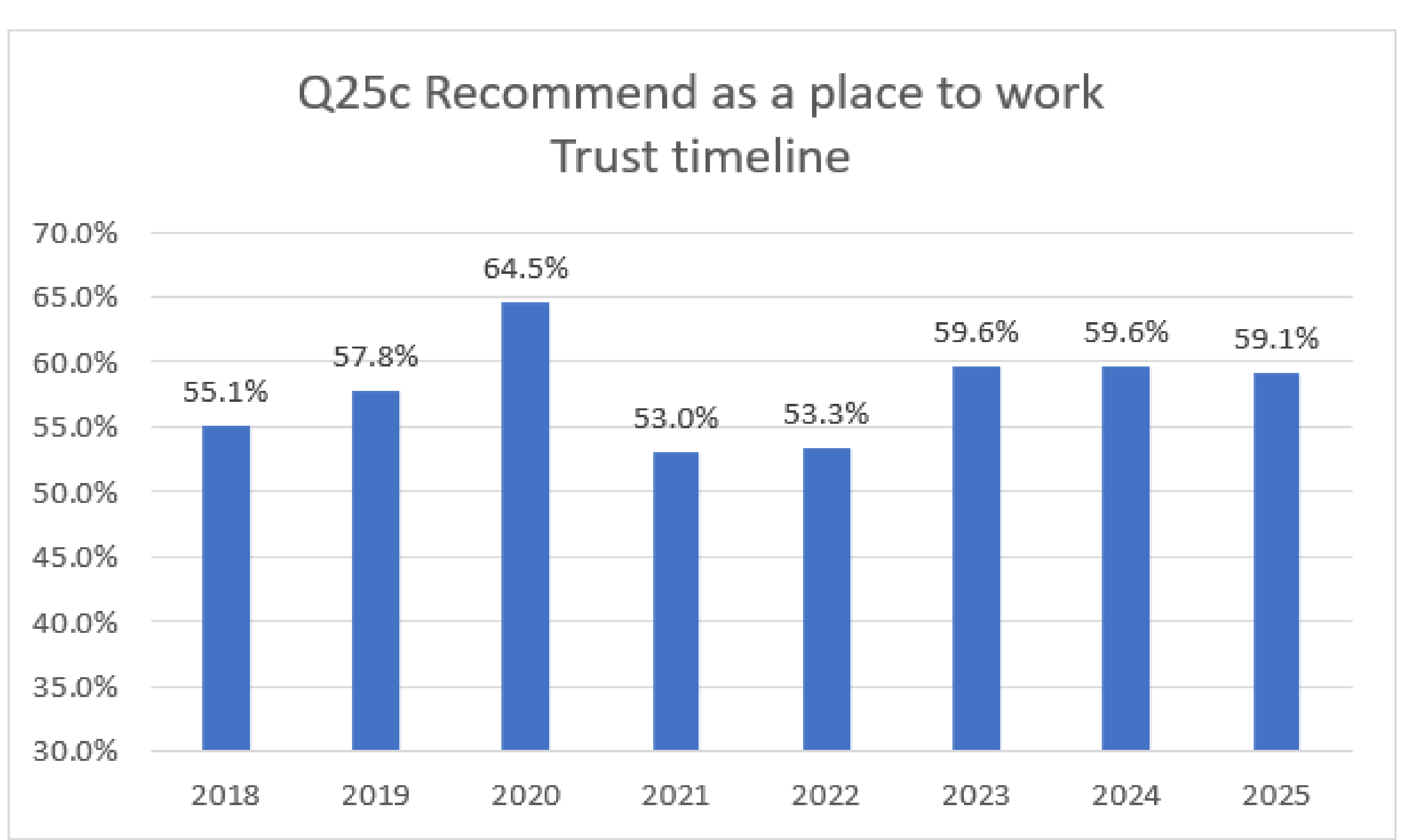
Promise/Theme	Sub-Promise/Theme	Question Number	Question	Scoring Methodology	2025 Result	2024 Result	Variance to 2024	Comparator	Variance to Comparator
Staff Morale	Thinking about leaving	26a	I often think about leaving this organisation (Agree/Strongly agree).	Lower = better	25.3%	26.8%	1.5%	29.8%	4.5%
Staff Morale	Thinking about leaving	26b	I will probably look for a job at a new organisation in the next 12 months (Agree/Strongly agree).	Lower = better	17.9%	17.7%	-0.2%	21.1%	3.1%
Staff Morale	Thinking about leaving	26c	As soon as I can find another job, I will leave this organisation (Agree/Strongly agree).	Lower = better	13.4%	12.9%	-0.5%	16.8%	3.4%
Staff Morale	Work pressure	3g	I am able to meet all the conflicting demands on my time at work (Agree/Strongly agree).	Higher = better	45.8%	45.1%	0.6%	46.1%	-0.4%
Staff Morale	Work pressure	3h	I have adequate materials, supplies and equipment to do my work (Agree/Strongly agree).	Higher = better	54.5%	54.8%	-0.3%	53.8%	0.7%
Staff Morale	Work pressure	3i	There are enough staff at this organisation for me to do my job properly (Agree/Strongly agree).	Higher = better	31.8%	30.4%	1.4%	31.3%	0.5%
Staff Morale	Stressors	3a	I always know what my work responsibilities are (Agree/Strongly agree).	Higher = better	87.6%	85.9%	1.7%	86.8%	0.8%
Staff Morale	Stressors	3e	I am involved in deciding on changes introduced that affect my work area / team / department (Agree/Strongly agree).	Higher = better	51.7%	50.2%	1.5%	49.6%	2.1%
Staff Morale	Stressors	5a	I have unrealistic time pressures (Never/Rarely).	Higher = better	22.9%	22.6%	0.3%	25.3%	-2.4%
Staff Morale	Stressors	5b	I have a choice in deciding how to do my work (Often/Always).	Higher = better	49.4%	50.2%	-0.8%	51.4%	-2.0%
Staff Morale	Stressors	5c	Relationships at work are strained (Never/Rarely).	Higher = better	44.0%	43.1%	0.9%	44.4%	-0.4%
Staff Morale	Stressors	7c	I receive the respect I deserve from my colleagues at work (Agree/Strongly agree).	Higher = better	70.3%	69.8%	0.5%	70.4%	-0.1%
Staff Morale	Stressors	9a	My immediate manager encourages me at work (Agree/Strongly agree).	Higher = better	73.3%	73.0%	0.3%	71.7%	1.6%

Responding through Improving Together

2025 Staff Survey Trust Breakthrough Metric

2025 Survey Trust Position – Pillar Metric

Pillar Metric	To achieve an improvement target of 2% above national average in the national staff survey question 'I would recommend my organisation as a place to work'	2025 Survey



Target: 60%
(IQVIA benchmark 57.8%
National average 58.05%)

Gap: 1%

Key: Pulse Survey Annual Staff Survey

2025 Survey Trust Position –Breakthrough Objective

Breakthrough Objective	To reach a target score of 75% in the annual 2025 staff survey national staff survey question ‘I receive the respect I deserve from my colleagues at work’	2025 Survey

Q7c I receive the respect I deserve from my colleagues at work Trust timeline

Year	Score
2018	69.4%
2019	75.4%
2020	70.4%
2021	68.9%
2022	70.8%
2023	69.5%
2024	69.8%
2025	70.3%

Target: 75%
(IQVIA benchmark 70.9%

Gap: 4.7%

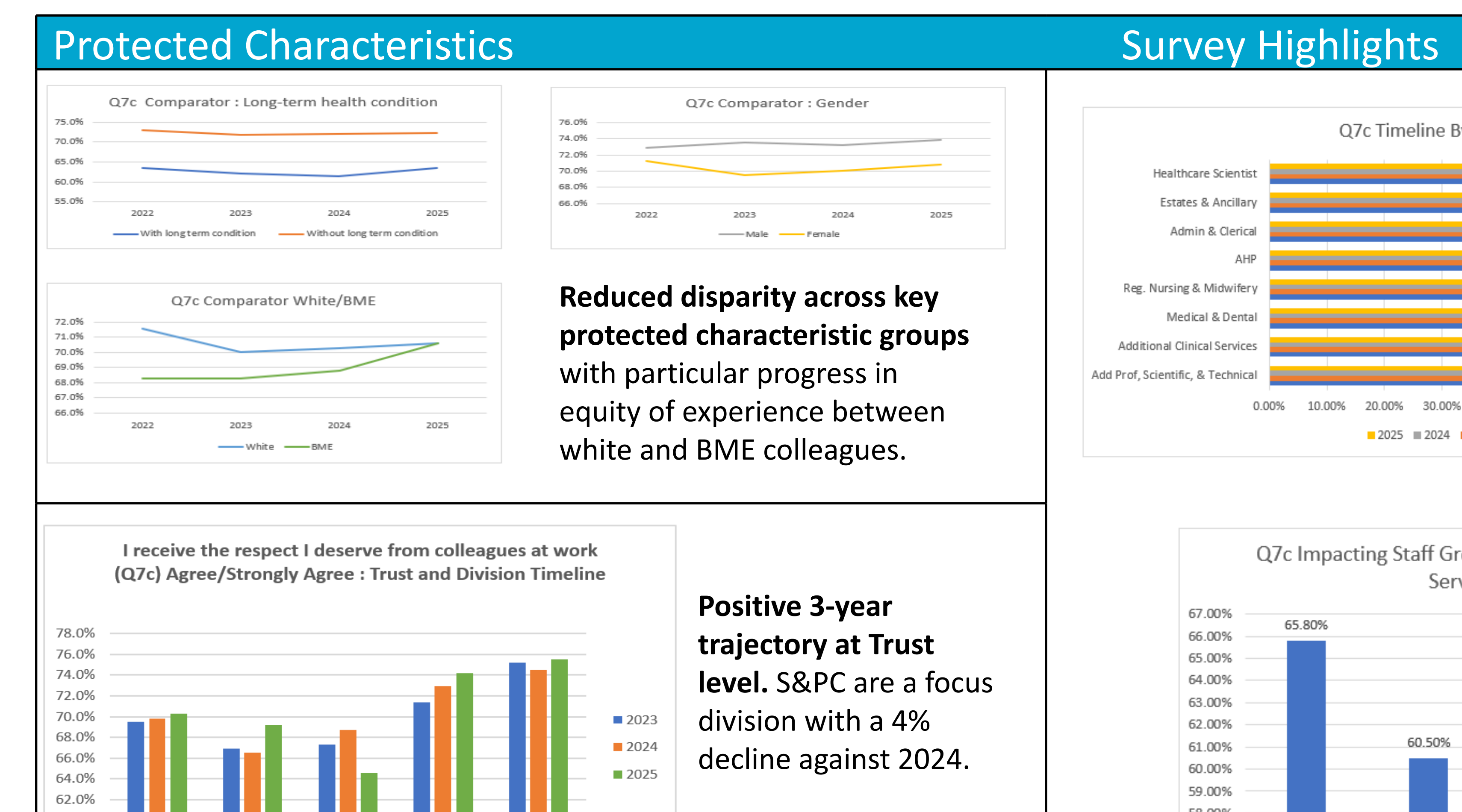
Key: Annual Staff Survey

2025 Breakthrough Objective Stratified Data

NHS
Great Western Hospitals
NHS Foundation Trust

I receive the respect I deserve from colleagues at work Q7c Stratified Data

Protected Characteristics



Reduced disparity across key protected characteristic groups with particular progress in equity of experience between white and BME colleagues.

Positive 3-year trajectory at Trust level. S&PC are a focus division with a 4% decline against 2024.

Survey Highlights

Q7c Timeline By Staff Group

Healthcare Scientist, Estates & Ancillary, Admin & Clerical, AHP, Reg. Nursing & Midwifery, Medical & Dental, Additional Clinical Services, Add Prof, Scientific, & Technical

2025, 2024, 2023, 2022

Significant improvement in Medical & Dental staff group. All other staff groups decline.

Q7c Impacting Staff Group : Additional Clinical Services

2022: 65.80%, 2023: 60.50%, 2024: 64.30%, 2025: 61.5%

Impacting staff group of Additional Clinical Services (predominantly unregistered nursing)

Improving Together | A3

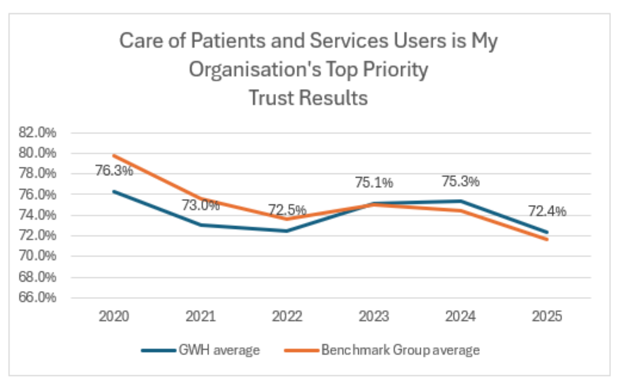
Metric: Breakthrough metric - Staff Survey 'Care of patients / service users is my organisation's top priority' Q25a

Lead(s): Claire Warner, Site People Services Director

Step 1: Problem Statement

Staff feedback shows a steady decline over the past 5 years in the belief that the organisation prioritises the care of patients and service users.
This trend suggests a growing gap between our stated values and staff experience, risking reduced engagement, impact on quality of care, and reduced number of colleagues recommending the organisation as a place to work.

Step 2: Current Situation

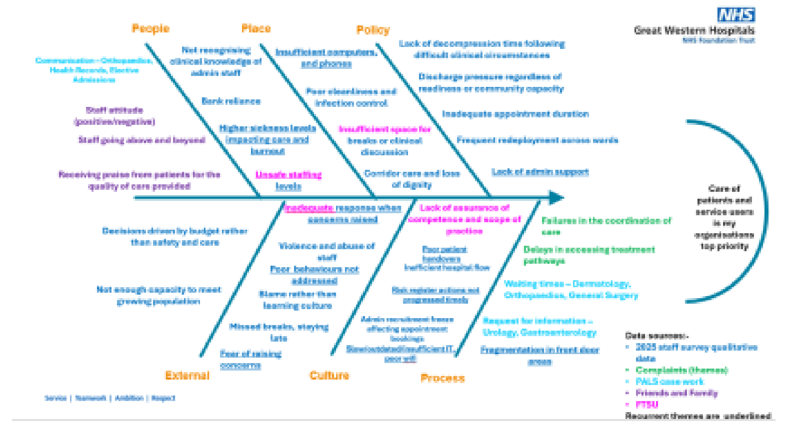


Step 3: Vision & Goals

We strive to be an organisation where every decision, action, and improvement is grounded in delivering outstanding, compassionate care; a place where colleagues feel confident that the needs of patients and service users are always highest priority.

Goal: Achieve a 5% improvement in the number of staff perceiving care as a top priority (Q25a).

Step 4: Root Cause / Gap Analysis



Priority themes influencing staff perception:-

1. Staffing shortages and unsafe staffing levels
2. Poor safety culture (fear, blame, speaking up)
3. Communication failures

Step 5: Countermeasures

Concern	Cause	Countermeasure
Staff believe current staffing levels are insufficient, creating a perception that patient care quality and safety are being compromised.	Gap between staffing reality and staffing experience —staff feel unsafe because key conditions around communication, workload, and support are missing.	Increase staff confidence that patient care remains safe by making staffing decisions transparent, predictable, and visibly supported.
Staff report a poor safety culture, characterised by fear of retaliation when speaking up, experiences of bullying or discrimination, a *blame-not-learning* mindset, and a general discouragement from raising safety issues. These conditions undermine psychological safety, reduce incident reporting, and increase the risk of harm to patients and staff.	Staff have witnessed or experienced poor behaviours and negative consequences after raising concerns. A lack of feedback and acknowledgement of concerns becomes a deterrent to speaking up.	Embed speaking-up behaviours across all teams by modelling psychological safety and reinforcing expected behaviours. Strengthen feedback loops by routinely communicating patient-experience improvements to administrative teams and ensuring they see the impact of their contributions.
Difficulties in navigating pathways for patients and managing next step expectations has a negative impact on the prioritisation of care.	Staff do not always have access to clear, up-to-date, or standardised information about patient pathways.	Provide staff with clear, accessible, and consistently updated pathway information. Integrate this work with the *What Matters to Me* project to ensure staff consistently apply and reinforce patient-care prioritisation in day-to-day practice.

Step 6: Actions

- 30 Apr: top 3 impacting priority areas identified based on data analysis
- 30 Apr: Q1 Pulse survey 17.3% response rate (965 number of staff)
- May: Analysis of Pulse results

Step 7: Progress & Benefits

- Top 3 priority themes identified
- Countermeasure aligned to priority themes agreed at TMC away day with engaged leads

Step 8: Insights

- Staff in administrative and clerical roles are more likely to feel that patient care is not consistently treated as a top priority.
- Corporate division shows the greatest decline 2025 vs 2024 and are below Trust average.
- S&PC also show a significant decline compared to the previous year.

Priority themes

Co-creation of trust-wide countermeasures for q25a

Theme	Evidence
Staffing shortages & unsafe staffing levels	• Present across all staff groups, comment themes of reduced time per patient, missed care, delays, corridor care • Free text mentions reliance on temporary staff and recruitment constraints, with admin shortages delaying referrals, bookings, and flow • *Q25a ↓ care not seen as top priority (capacity undermining care)* • *Q25b ↓ organisation not acting on patient concerns* • *Q11e ↓ pressure to come to work*
Lack of organisational responsiveness to concerns	• Comments state concerns raised not acted on, slow response to known risks, and risk-register actions not followed • Repeated escalation without resolution • *Q25b ↓ organisation acts on concerns* • *Q20b ↓ confidence unsafe practice would be addressed* • *Q19d ↓ feedback on changes made after incidents*
Poor safety culture (fear, blame, speaking up)	• Within comments, reference to fear of retaliation when speaking up, bullying/discrimination, a ‘blame not learning culture’, and staff discouraged from raising safety issues • *Q20a ↓ feeling safe to speak up on clinical practice* • *Q20b ↓ confidence unsafe practice would be addressed* • *Q19c ↓ organisation takes action on errors not happening again*
Leadership credibility & disconnect from frontline	• Free text themes of ‘detached leadership’, decisions being made without front-line feedback, and a finance/KPI driven decision making process over patient care • *Q25a ↓ organisation prioritises patient care* • *Q25b ↓ organisation acts on concerns* • *Q7i ↓ reduced team attachment (proxy for leadership impact)*
Communication failures & fragmented pathways	• Comment themes of poor handovers, fragmented care pathways, and delays/duplications between teams • General lack of coordination across services, and poor communication across staff groups • *Q19d ↓ lack of feedback loops* • *Q19c ↓ weak communication of learning/actions taken*

Countermeasures

Countermeasure No.	Concern	Cause	Countermeasure	Owner	Due Date	Status
1	Staff believe current staffing levels are insufficient, creating a perception that patient care quality and safety are being compromised.	Gap between staffing reality and staffing experience —staff feel unsafe because key conditions around communication, workload, and support are missing.	Increase staff confidence that patient care remains safe by making staffing decisions transparent, predictable, and visibly supported.	Chris Bull/Vicky Treadwell (Head of Business Partnering)		
2	Staff report a poor safety culture, characterised by fear of retaliation when speaking up, experiences of bullying or discrimination, a *blame-not-learning* mindset, and a general discouragement from raising safety issues. These conditions undermine psychological safety, reduce incident reporting, and increase the risk of harm to patients and staff.	Staff have witnessed or experienced poor behaviours and negative consequences after raising concerns. A lack of feedback and acknowledgement of concerns becomes a deterrent to speaking up.	Embed speaking-up behaviours across all teams by modelling psychological safety and reinforcing expected behaviours. Strengthen feedback loops by routinely communicating patient-experience improvements to administrative teams and ensuring they see the impact of their contributions.	Sonia Maciver, Freedom to Speak Up Guardian Amanda Wylie		
3	Difficulties in navigating pathways for patients and managing next step expectations has a negative impact on the prioritisation of care.	Staff do not always have access to clear, up-to-date, or standardised information about patient pathways.	Provide staff with clear, accessible, and consistently updated pathway information. Integrate this work with the *What Matters to Me* project to ensure staff consistently apply and reinforce patient-care prioritisation in day-to-day practice.	Chris Bull Supported by Tim Edmonds, Vicky Treadwell		

Actions

Countermeasure No.	Action	Owner	Due Date	Status
	Add questions to Q1 Pulse survey to provide further insights.	Angela Morris	31 March 2026	Completed
	Engage with senior leaders at TMC away day.	Amanda Wylie/OD team	30 Apr 2026	Completed
	Receive actions escalated by divisions as sitting outside of their control and requiring Trust level action. Divisions to design local countermeasures and escalate areas requiring support to the Trust-wide meeting 28 May.	Claire Warner	28 May 2026	In progress
1	Create and implement a structured approach that supports staff in recognising how their roles contribute to the overall patient experience.	Vicky Treadwell supported by Corporate Heads of Service	31 July 2026	Planned

Actions

Countermeasure No.	Action	Owner	Due Date	Status
1	Implement standardised communication that clearly explains how patient care is prioritised during staff redeployment, addressing expectations for both the departing and receiving wards.	Chris Bull	End of August	
2	Using the TMC Away Day as the starting point, ensure that all actions agreed by the Trust Management Committee are clearly recorded, formally agreed with named ownership and timescales, and then actively tracked through to completion.	Nic Green/Claire Warner	End of July	
2	Audit the consistency of Datix feedback/learning response to all staff groups. Where gaps, review mitigation to ensure feedback loop is consistent and clear	tbc	End of August	
2	Team leaders to introduce a standard process for giving regular improvement feedback to teams that receive mainly negative interactions.	Vicky Treadwell	End of July	

Actions

Countermeasure No.	Action	Owner	Due Date	Status
2	Freedom to speak up to join Staff Survey Task and Finish group and develop clear a clear action plan to raise speaking up within the organisation and incorporating feedback loop for learning	Sonia Maciver and Chris Bull (Action plan with deliverable by end of June)	Action plan end of June	
3	Identify opportunities to include an A&C representative on and patient improvement initiative.	Chris Bull	End of August	
3	Reflect the friends & family voice within comms, amplify the voice of patients, use patient forum, link with Patient Experience project.	Chris Bull Supported by Madeline Goodwin	End of July	

Driver Metric 2026/7

Timeline

- w\c 20 Apr — Go & See visits to impacting areas.
- 23 Apr — Receive escalations for Trust level countermeasures from divisions via staff survey working group. Maintain engagement and momentum with division survey leads through monthly meetings.
- 30 Apr — Co-creation of countermeasures at TMC away day.
- May — Update A3 with agreed countermeasures and engage with responsible leads to agree measurable outcomes and actions. Review against Group countermeasures to identify shared learning and resource opportunities.
- June-Mar — Implement focussed actions in focus areas with on-going PDSA review and response. Provide monthly progress update to TMC.
- July — Build insights into impacting themes through bespoke additional questions in Q2 Pulse survey.
- Sept — Launch of 2026 annual survey.

Report Title	Resident Doctor Peer Lead Board Report			
Meeting	Trust Board			
Date	11/06/2026	Part 1 - Public ✓		Part 2 - Private ☐
Accountable Lead	Dr Kathryn Bateman			
Report Author	Dr Eleanor Tindall & Dr Lynsey Hewitson – Chief Registrars, Resident Doctor Peer Leads for the 10-Point Plan			
Appendices				

Purpose

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

Assurance Level

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

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

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

Operational pressures continue to impact on the trust's ability to provide consistent opportunities for high quality training to resident doctors in some areas. The GWH data trends from the latest national training survey and other feedback mechanisms remain of concern around workload and speaking up around unwanted behaviours. Significant progress has been made against the national 10-point plan for resident doctors, but there is required improvement around payroll errors.

Report

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

Despite initiatives in the last 12 months, recent national survey results (NETs 2025) highlight ongoing concerns in the domains of bullying, discrimination and sexual safety from patients and/or staff. Resident doctors do not feel empowered to raise these occurrences or feel confident that they will be addressed if they do. The PGME team have initiated further work on

this, however we are concerned a cultural shift is needed to empower staff to speak up. This should include effective action to promote a zero-tolerance approach for both staff and patients and robust mechanisms to feedback to individuals when concerns are raised.

NETs 2025 highlights areas of improvement in multiple domains, reflecting positive work across the trust. However, there are significant concerns in specific medical departments around workload and quality of training: improvement work is underway to address these.

Overall, consistent progress has been made against most areas of the 10 Point Plan, though the reduction in payroll errors is not yet in line with targets.

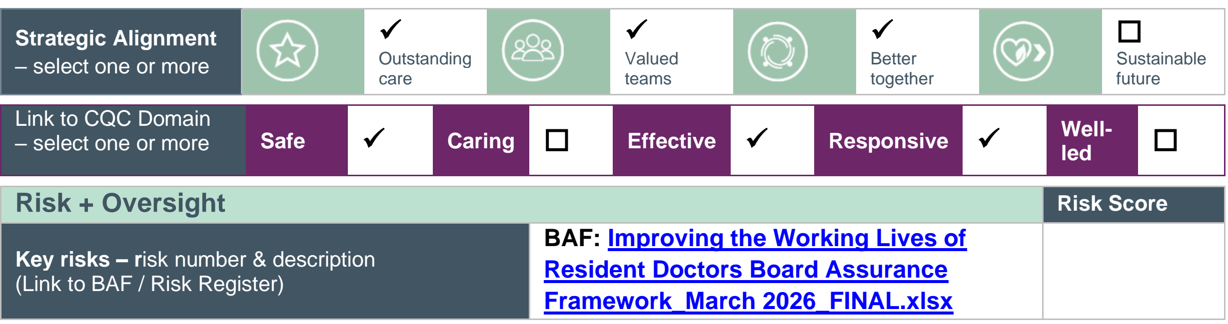
As previously reported, lack teaching and outpatient space remain a barrier to high quality training. Infrastructure development plans should account for this. There remains inconsistency in the educational provision for locally employed doctors (LEDs), however work is underway to outline a strategy for this group.

Key Requests for the Board

- Organisational and academy support to address cultural concerns emerging around staff experiencing, but not reporting, negative behaviours including bullying, discrimination and sexual safety.
- Recognition of the ongoing improvement work already initiated within UEC and the medical specialties highlighted, following concerns in resident doctor feedback.
- Note payroll errors as an area of the 10-point plan where more assurance is still required (we understand that work is underway on this), alongside the areas of improvement described.
- In the transition to the group board model, we request the board consider how the resident doctor voice from each care organisation is represented at group level.

Positive Achievements

- Engagement and execution of the 10-point plan is in line with other trusts in the Southwest region and changes have been made in response to the recommendations in most areas. In particular, the workforce intelligence team have recently done extensive work to ensure work scheduling is compliant, accurate and appropriately monitored.
- Improvements have been seen in multiple areas of national training survey responses, in line with PGME and departmental improvement initiatives.



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)	**BAF:** Improving the Working Lives of Resident Doctors Board Assurance Framework_March 2026_FINAL.xlsx	

Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Discussions with CMO, Medical Staff Support Group, Resident Doctor Forum, Chief Registrars	
Next Steps		

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

Explanation of above analysis:

The trust employs a significant number of locally employed resident doctors, in addition to those in a national training program. National data suggests locally employed doctors are more likely to be international medical graduates (IMGs). The report identifies a lack of unified educational strategy for these doctors and recommends the development of one. GWH has committed to ensuring all IMG's now attend GMC training as part of induction, effective from April 2026, to support IMG entry to NHS practice and training.

Recommendation / Action Required

The Board/Committee/Group is requested to:

- 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.

Accountable Lead Signature	Dr Kathryn Bateman
Date	03/06/26

INTRODUCTION

GWH employs more than 400 resident doctors, approximately 75% are in national training programmes and 25% are locally employed by the trust. The 10-point plan for resident doctors, published in August 2025, is a national initiative aimed at improved the working lives of resident doctors. The Resident Doctor Peer Lead (RDPL) role was established to ensure that resident doctors are meaningfully represented, that their concerns are heard, and that their insights inform organisational decision making. This report aims to represent resident doctor experience, informed by our engagement with the resident doctor workforce, Post Graduate Medical Education and the CMO Office.

TRAINING AND WELLBEING

Wellbeing

ALERT

Two national surveys provide insight into resident doctor experience: the GMC National Training Survey and the National Education and Training Survey (NETs). Since the last RDPL board report NETs 2025 has been reported on. Despite initiatives in the last 12 months, including active bystander training, the results still place the Trust in the lower quartile for feedback on bullying, discrimination, sexual safety and wellbeing within post-graduate medicine (resident doctors) when benchmarked to the rest of the country. This is a similar trend to other learners completing the survey in the organisation e.g. nursing and allied health professionals. RUH and SFT are similarly in the lower quartile although for post-graduate medicine scores are marginally better than GWH. These instances of unwanted behaviours experienced by resident doctors are more commonly from patients than other staff, although not exclusively.

A concerning trend has emerged from this reporting that resident doctors do not feel able to raise these instances, or if they are raised are not confident that they are addressed. The PGME team have initiated further work on this however we are concerned there is a cultural shift needed to empower staff to speak up. This should include effective action to promote a zero-tolerance approach for both staff and patients and robust mechanisms to feedback to individuals when concerns are raised.

Training

ADVISE

NETs reports improvements across multiple specialties and domains, including supervision, induction and overall experience, reflecting departmental and PGME improvement work. There are additional sources of educational feedback provided to PGME including quality panels and exception reporting. These have recently identified concerns regarding workload and quality of training in specific medical departments including acute medicine, stroke and elderly care. We are reassured that these concerns are being proactively triangulated by PGME and escalated to the chief medical office with targeted improvement plans. Although the trust is operating in the context of significant financial challenges, failure to address significant concerns raised in these areas, including requisite financial investment risks further deterioration in these educational outcomes and potential patient safety concerns and reputational damage.

Workload and patient safety concerns for weekend working raised through the resident doctor forum have been taken forwards as part of the wider UEC GIRFT improvement work. Data modelling of medical admissions has driven insights in to mismatched demand v. medical admissions capacity for the resident doctor workforce and an improvement plan has been made to address this. This has been supported by a change in electronic systems. We hope this improvement action will be reflected in future feedback results and highlights that data driven insights provide a potential mechanism to address these types of concern. As such, embedding this in the ethos of future decisions around the group adoption of EPR is key.

PROGRESS ON 10-POINT PLAN

NHS England has now issued a board assurance framework for reporting on progress against the 10-point plan (Appendix). Overall, GWH is making good progress in some areas such as work schedule issuing and rota compliance: however, there remains limited assurance that payroll errors have been addressed. The 10-point plan BAF will continue to be regularly reported to MSSG. In line with the transition to the group board model, we recommend that the board consider how the resident doctor voice from each care organisation is represented to group.

Payroll Errors and Governance Requirements

ALERT

- The 10-point plan requires the establishment of a governance framework for reporting payroll errors and a target of achieving a 90% reduction by March 2026. While payroll errors are now reporting monthly to MSSG, the 90% reduction target has not been met. We understand from the recent payroll report (presented at MSSG 3/6/26) that work is underway within relevant teams to provide more detailed reporting of these errors, alongside developing mechanisms to reduce their occurrence.
- Payroll errors have also been identified through the mechanism of multiple payslips. As previously noted, these can introduce significant errors into personal finances, through pension contributions and income tax. A further update on an action plan from finance and payroll to address this, for all staff groups, is also awaited.

Work Schedules and Rota Compliance:

ASSURE

- Resident doctor contracts stipulate issuing of work schedules 8 weeks in advance as is highlighted in the 10 Point Plan. The Workforce Intelligence Team (WiT) has been actively engaged with the delivery of the 10-point plan and has undertaken significant work to monitor and ensure compliance with these targets. As per the attached BAF this is now reported on monthly to MSSG.
- WiT have worked closely with the Guardian of Safe Working (GoSW) to prevent discrepancies between work schedules and rotas as well as supported additional roster training to departments.
- There is a new monitoring dashboard for work schedule and roster compliance, overseen by WiT, which now also captures disputed work schedules. We are assured that there are

robust processes for measuring performance in this, improving previous areas of concern and established routes of escalation if concerns emerge.

Annual Leave Processes

ASSURE

- Annual leave approval processes vary significant between departments, creating frustration for rotating resident doctors. The Trust's leave policy is currently being updated to include a dedicated section on resident doctor leave in line with the recently published NHS England » Minimum standards for annual leave for resident doctors.

EDUCATION

Teaching Programmes, Access to Education and Infrastructure

ALERT

- The Trust delivers a range of teaching programmes for resident doctors, including grade specific sessions and departmental teaching. As previously reported, the limited availability of teaching space remains a barrier to high quality training. Similar barriers to achieving adequate training exist due to the lack of outpatient clinic room space, particularly in outpatient predominant specialities. Infrastructure development plans and additional outpatient space are required to improve educational facilities.

ADVISE

- Work schedules are being updated in line with August 2026 rotations to reflect the full range of educational opportunities available within each specialty. This is intended to support accurate exception reporting when educational opportunities are missed and facilitate reinstatement where feasible.

Locally Employed Doctors (LEDs)

ADVISE

- Though LEDs constitute a substantial proportion of the resident doctor workforce, there is no trust-wide strategy for their supervision of education. Consequently, LEDs report considerable variation in supervision and access to training. Many do not receive the same educational opportunities as their trainee counterparts and may lack named clinical or educational supervisors.
- We are aware that funding constraints and consultant to trainee ratios limit educational capacity. However, there is a strategic opportunity for the Trust to develop structured local training pathways and position itself as a regional leader. Work is underway to outline a strategy for assuring the educational experience of this large area of the resident doctor workforce. We welcome efforts to improve the educational provision for this group and think investment in this area could support long term workforce retention and development of the "consultants of the future" for the Trust.

Report Title	Update on Resident Doctor payroll Accuracy				
Meeting	GWH Trust Board				
Date	11/06/2026	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Johanna Bogle, Site Finance Director				
Report Author	Peter Smith, Head of Financial Services				
Appendices					

Purpose

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

Assurance Level

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

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

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

Steps to achieve Good governance are to understand the causes for over and under payments and to take steps to reduce the frequency of such incidents.

Report

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

One element of the 10 Point Plan is that Resident Doctors should never experience payroll errors due to Rotations.

A review of overpayments and underpayments relating to resident doctors across the last year has been completed. While we can see the periods in which the majority occur, and the service in which the majority occur, the reasons for these errors are not included within

the system and require each incident to be audited through the paper trail. This has not yet been completed due to capacity within the payroll team. Where faster payments are raised the information is collected as part of the governance process, and we can see that most were due to late operational notifications to payroll or additional work not approved in time for payroll deadlines.

We have linked with neighbouring Trusts to learn from any best practice that we could apply to our own systems to improve the processing of Resident Doctor payroll and reduce errors, and are now working closely with UHBW and RUH to ascertain whether we could successfully replicate their processes in our system.

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

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

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

Equality, Diversity & Inclusion / Inequalities Analysis	Yes	No	N/A
Do any issues identified in the report affect any of the protected groups less / more favourably than any other?	☐	☐	✓
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	☐	☐	✓
Explanation of above analysis:			
Not related to EDI			

Recommendation / Action Required	
The Board/Committee/Group is requested to:	
Note the report and the next steps associated with improving under- and over-payments.	
Accountable Lead Signature	[signature]
Date	**04/06/2026**

Introduction

One element of the 10 Point Plan is that Resident Doctors should never experience payroll errors due to Rotations.

Findings to date

A review of overpayments and underpayments relating to resident doctors across the last year has shown the following:

- On average there are 5 incidences of overpayments a month with an average value of just over £3k.
- The highest number of incidences in the period reviewed occurred in May '25, and the service most impacted was the Anaesthetic service.
- On average there are 7 incidences of underpayments a month with an average value of just over £1.4k.
- Underpayments were higher in the months from August '25, dropping again in December '25 with most occurrences again arising in the Anaesthetics service.

Reasons for the under- and over-payments are currently not available on the workforce system, though steps are being taken to investigate how this can be improved. Where faster payments are raised the information is collected. This has shown that most faster payments were raised due to late notifications or additional work not approved in time for payroll deadlines.

Conversations have commenced with two other Foundation Trusts in the Region (UHBW and RUH) who have both brought in schemes to monitor incidences of under and over payments made to Resident Doctors.

Arrangements are currently being made to review the process used at UHBW to assess the viability of replicating it at GWH.

In conjunction with this, initial meetings have been arranged for more detailed conversations with RUH payroll as to their processes; as well as with our own payroll team to identify any difficulties in rolling out any of these initiatives across our own Trust.

At present these conversations have been centred around the reduction of over and under payments. However, whilst assessing the viability of these schemes for the Trust, investigations will also be undertaken to address the issue of multiple payslips being issued.

Next steps

1) Continued monitoring of the instances of over / under payments whilst the success of measures brought in is assessed.
2) Discussions with other Trusts as to how they have reduced errors and whether this could be replicated in our systems.

Report Title	**Delegation of Authority for approval of Annual Report & Accounts 2025/26**				
Meeting	**Trust Board**				
Date	**11/06/2026**	Part 1 - Public	✓	Part 2 - Private	☐
Accountable Lead	Simon Wade, Chief Financial Officer				
Report Author	Caroline Coles, Company Secretary				
Appendices	n/a				

Purpose

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

Assurance Level

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

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

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

Report

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

The Trust is required to comply with the guidance in the Annual Reporting Manual for Foundation Trusts for 2025/26 and submit a set of audited annual accounts including an Annual Report by the national deadline of 26 June 2026.

The process for the completion of Trust's Annual Report & Accounts is outlined below and in line with guidance from NHS England for the NHS accounts timetable and year-end arrangements.

Date	Action
11 June 2026*	Trust Board delegates authority to Audit, Risk & Assurance Committee to approve accounts and the Annual Report.
*Next Board meeting 2 July 2026	
24 June 2026	Audit, Risk & Assurance Committee receives annual report, audited accounts, certificates and audit opinion and approves accounts and annual report
26 June 2026 (12 noon)	NHS FTs submit (electronically) audited accounts, the external auditors ISA 260 report, the external audit opinion on the accounts, and the Annual Report to NHSE.
Date to be confirmed	Laying NHS foundation trust annual report and accounts before Parliament.
21 October 2026	Annual Members Meeting

*In order to meet the submission deadline, the Trust requires delegation of authority to approve its Annual Report and Accounts to the Audit, Risk & Assurance Committee.

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

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

Risk + Oversight		Risk Score
Key risks – risk number & description (Link to BAF / Risk Register)	n/a	
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	n/a	
Next Steps	Final approval at Audit, Risk & Assurance Committee before submission of Annual Report & Accounts 2024/25	

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

Recommendation / Action Required

The Board/Committee/Group is requested to:

The Board is requested to delegate authority to the Audit, Risk & Assurance Committee to sign-off the Trust's Annual Accounts and Annual Report for 2025/26.

Accountable Lead Signature	Simon Wade, Chief Financial Officer
Date	**02/06/2025**

Report to:	GWH Trust Board	Agenda item:	x
Date of meeting:	11 June 2926		

Report title:	Statutory Governance Framework to support implementation of the BSW Hospitals Group			
Status:	Information	Discussion	Assurance	Approval
				X
Approval Process: (where has this paper been reviewed and approved):	Group Executive Committee and Non-Executive Governance Reference Group have reviewed SoRD and SFIs.			
Prepared by:	Caroline Coles, Company Secretary, GWH Simon Hackwell, Governance Advisor, Teneo			
Executive Sponsor:	Lisa Thomas, Managing Director GWH, Group Governance Lead.			
Appendices	Appendix 1 : Scheme of Reservation and Delegation Appendix 2 : Standing Financial Instructions (SFIs) Appendix 3 : Audit Committee Terms of Reference Appendix 4 : Remuneration Committee Terms of Reference			
BAF Risk Link	-			

Recommendation:
The Board is asked to: 1. Approve the Scheme of Reservation and Delegation of Great Western Hospitals NHS Foundation Trust 2. Approve 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. 3. Approve the Terms of Reference for the Audit Committee. 4. Approve the Terms of Reference for the Remuneration Committee 5. Agree the amendment to the quoracy of the General Purpose Joint Committee (Group Board) to ensure at least one Executive Director is present.

Executive Summary:
This paper seeks approval of the remaining statutory governance instruments required to support the implementation of the BSW Hospitals Group model. This will create alignment of the governance arrangements across the three Care Organisations to ensure the Group can operate safely and effectively. The Group Governance Framework and Partnership Agreement, previously approved by the Board, established the legal basis for joint working and the creation of the Group Board. The instruments presented here complete that framework through alignment of the Scheme of Reservation and Delegation, Standing Financial Instructions (SFIs), and Committees in Common Terms of Reference. These changes do not alter the statutory powers of the Board. Each Trust Board retains full sovereignty, with the framework clarifying how certain functions are exercised jointly through the Group Board within defined limits. Approval will ensure a clear, consistent and legally robust governance framework is in place to support safe and effective Group working from 1 July 2026. The Board is also asked to make an amendment to the Partnership Agreement.

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

Statutory Governance Framework to support implementation of the BSW Hospitals Group

1. Introduction and Background

1.1 The Group Governance Framework establishes the statutory basis for governance within the Group model, confirming that governance is exercised through the NHS Act 2006, Trust Constitutions, and Standing Orders.

1.2 The Partnership Agreement and aligned Standing Orders, approved by the Board on 7 May 2026, established the General Purpose Joint Committee (the "Group Board") as the

mechanism for joint exercise of functions, while preserving the sovereignty of each Trust Board and the requirement that Reserved Functions remain with those Boards.

1.3 The governance instruments presented in this paper complete the statutory governance framework required for the lawful operation of the Group model.

2. What Has Changed

2.1 No new statutory powers are created. Each Trust Board retains full authority as defined in the NHS Act 2006 and its Constitution.

2.2 The change is in how those powers are exercised: certain functions are now discharged jointly through the Group Board, within the limits set out in the PCA and Scheme of Reservation and Delegation.

2.3 To support this, governance arrangements have been aligned across the three Trusts to ensure:

- Consistent application of governance frameworks
- Clear delegation and accountability arrangements
- A shared understanding of Reserved and Joint Functions

2.4 These changes enable coordinated decision-making at Group level while maintaining the sovereignty and statutory responsibilities of each Trust Board.

3. Statutory Governance Instruments

3.1 The statutory governance framework defines the authority of the Boards, supported by operational control systems (risk, assurance and internal control) to enable effective discharge of duties.

3.2 The framework comprises:

- *Foundation Trust Constitutions*
  Establish each Trust as a statutory corporation and confirm the Board as the decision-making body. These have been aligned (where applicable) to reflect Group arrangements and were approved on 7 May 2026 (Board) and 26 May 2026 (Council of Governors) effective from 1 July 2026.
- *Scheme of Reservation and Delegation*
  Defines matters reserved to each Trust Board and those delegated to the Group Board, establishing the boundary for lawful delegation. (Appendix 1 for approval)
- *Standing Financial Instructions (SFIs)*
  Set out the framework for financial control, stewardship, and value for money. These

apply to all functions, including those exercised through the Group Board, and have been aligned across the three Trusts. (Appendix 2 for approval).

The SFIs are very detailed and may require some further refinement as they are implemented. In approving the SFIs, the Board is asked to delegate authority to the Group Chief Finance Officer to make amendments between formal reviews, provided that any such amendment does not:

- materially alter the financial thresholds set out in Appendix 1 (minor adjustments, for example to reflect inflation, are permitted);
- vary any power reserved to the Board or Council of Governors under the Scheme of Reservation and Delegation;
- create any change that is in conflict with the Trust's Standing Orders or Constitution.

All amendments made under this authority shall be notified to the Company Secretary before taking effect and recorded in a change log. The change log shall be reported to the Board for ratification.

3.3 Together, these form the complete statutory governance framework. Approval remains a matter reserved to each Trust Board.

4. Committees in Common

4.1 As part of the Group model, the statutory Care Organisation committees below will operate as Committees in Common to support joint oversight and assurance. It is therefore necessary to align the terms of reference for these committees across the Care Organisations.

4.2 The following Terms of Reference are presented for approval:

- Audit Committee (appendix 3 for approval)
- Remuneration Committee (appendix 4 for approval)

4.3 These committees will support aligned assurance while maintaining reporting and accountability to individual Trust Boards.

5. Amendment to Partnership Agreement

5.1 The Partnership Agreement approved by the Board on 7th May 2026 requires an amendment. This is relation to the quorum arrangements for the Group Board. Currently the quorum arrangements set out in the Terms of Reference for the General Purpose Joint Committee (Group Board) state the quorum is:

- At least half of voting members are present

- At least half of those present are *Non-Executive Directors*

5.2 Therefore, the Group Board would be quorate if the Chair and 11 NEDs were present and no Executive Directors were present. While this does not directly infringe any legal requirements (as it is permissible for committees and joint committees to be comprised entirely of NEDs) it is not in keeping with the intention that decision should be made by a unitary board. It is proposed to amend the terms of reference to change the quoracy arrangements for the General Purpose Joint Committee to be:

- At least half of voting members are present
- At least half of those present are Non-Executive Directors
- At least one Executive Director is present.

6 Conclusion

6.1 Approval of this framework establishes a lawful, coherent and auditable basis for governance across the BSW Hospitals Group, enabling effective delegation while preserving Board sovereignty.

7. Recommendations

The Board is asked to:

1. Approve the Scheme of Reservation and Delegation of Great Western Hospitals NHS Foundation Trust
2. Approve 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.
3. Approve the Terms of Reference for the Audit Committee.
4. Approve the Terms of Reference for the Remuneration Committee
5. Agree the amendment to the quoracy of the General Purpose Joint Committee (Group Board) to ensure at least one Executive Director is present.

[Insert Trust Name]

Scheme of Delegation

This scheme sets out the powers of the Trust ("the Powers") that are reserved to the Board of Directors ("the Board") and the Scheme of Delegation.

All Powers which have not been retained by the Board or delegated to a committee of the Board shall be exercised on behalf of the Board by the Chief Executive. All powers delegated by the Chief Executive can be reassumed by him/her should the need arise. If the Chief Executive is absent powers delegated to him/her may be exercised by a nominated Officer after taking appropriate advice from the Chief Finance Officer.

The Board remains accountable for all of its functions, including those which have been delegated. The Board may request at any time information about the exercise of delegated functions to enable it to maintain its monitoring role. In the absence of a Director or Officer to whom powers have been delegated those powers shall be exercised by that Director's or Officer's superior.

The tables below show the scheme of reservation and delegation.

Section 1- Scheme of Reservation (Council of Governors)

THE COUNCIL	DECISIONS RESERVED TO THE COUNCIL
THE COUNCIL	The specific statutory powers and duties of the Council of Governors are to: • appoint and, if appropriate, remove the Chair of the Board; • appoint the Vice Chair of the Board; • appoint and, if appropriate, remove the other non-executive directors; • decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other non-executive directors; • approve the appointment of the chief executive; • appoint and, if appropriate, remove the external auditor; and • receive the annual accounts, any report of the auditor on them

	and the annual report; • hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; • approve significant transactions, mergers and acquisitions and applications for separation and dissolution; • decide, where the Trust intends to carry our activity which is not providing goods and services for the purposes of the health service in England, whether that work would significantly interfere with the Trust's principal purpose i.e. the provision of goods and services for the Health Service in England or the performance of other functions; • approve any proposed increases in private patient income of 5% or more in any financial year. • approve amendments to the Trust's Constitution (this function is shared with the Board of Directors).
COUNCIL OF GOVERNORS' NOMINATIONS AND REMUNERATION COMMITTEE	The Council of Governors shall establish the Council of Governors' Nominations and Remuneration Committee to: • Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Non-Executive Directors and make recommendations to the Council with regard to any changes; • Give full consideration to and make plans for succession planning for the Non- Executive Directors taking into account the challenges and opportunities facing the foundation trust and the skills and expertise needed on the Board of Directors in the future; • Agree with the Council of Governors a clear process for the nomination of a Non- Executive Director; • Be responsible for identifying and nominating for appointment, candidates to fill posts within the Committee's remit as and when they arise; • Evaluate the balance of skills, knowledge and experience on the Board of Directors, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular Non-Executive Director appointment;

	• The Committee will consider any matters relating to the continuation in office of any Non-Executive Director at any time including the suspension or termination of service; • The Committee shall make recommendations to the Council of Governors concerning the re-appointment of any Non-Executive Director at the conclusion of their three-year term of office having given due regard to their performance and ability to continue to contribute to the Board of Directors in the light of the knowledge, skills and experience required; • The Committee shall recommend to the Council of Governors a remuneration and terms of service policy for Non-Executive Directors, taking in account the viewsof the Chair (except in respect of his/her own remuneration and terms of service) and the Chief Executive, Director for People and any external advisers; • In accordance with all relevant laws and regulations, recommend to the Council, the remuneration and allowances, and the other terms of conditions of office of Non- Executive Directors; • Agree the process and receive and evaluate reports about the performance of individual Non-Executive Directors and consider this evaluation output when reviewing remuneration levels.

Section 2- Scheme of Reservation (Board of Directors)

THE BOARD	DECISIONS RESERVED TO THE BOARD
THE BOARD	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
THE BOARD	Regulations and Control 1. Approve the Standing Orders (SOs) as set out in the constitution, a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders (See SOs for procedure). 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO 5.3. 5. Approve a scheme of delegation of powers from the Board to Committees (SO5.2) 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member of the Board may remain involved with the matter under consideration. 7. Require and receive the declaration of Officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from Committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 13. Establish terms of reference and reporting arrangements of all

	Committees and Sub- Committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Ratify use of the Trust seal. 16. Discipline members of the Board or employees who are in breach of statutory requirements or Standing Orders.
THE BOARD	**Appointments/ Dismissal** 1. Appoint and dismiss Committees (and individual members) that are directly accountable to the Board. 2. Approve proposals on the appointment, appraisal, discipline and dismissal of Executive Directors made by the Nominations & Remuneration Committee of the Board, subject to the Trust's Constitution. 3. Confirm appointment of members of any Committee of the Trust as representatives on outside bodies. 4. Appoint, appraise, discipline and dismiss the Secretary. 5. Approve remuneration proposals of the Nominations & Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Nominations & Remuneration Committee. Note: (1) The Chief Executive is to be appointed (and removed) by the Non-Executive Directors, subject to the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors. (2) The Executive Directors are to be appointed (and removed) by a Committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors, being the Nominations & Remuneration Committee, acting in that capacity.
THE BOARD	**Strategy, Plans and Budgets** 1. Define the strategic aims and objectives of the Trust. 2. Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored. 3. Approve proposals for ensuring quality and developing clinical

	governance in services provided by the Trust, having regard to any guidance issued by the Secretary ofState. 4. Approve and monitor the Trust's policies and procedures for the management of risk. 5. Approve Outline and Final Business Cases for Capital Investment in excess of £1,000,000. 6. Commitment of capital expenditure up to and including £250,000 is delegated to the Capital Prioritisation and Management Group (CPMG). Commitment of capital expenditure between £250,001 and £1,000,000 is delegated to the Care organisation Management Committee. These sub-delegations are set out in section 3 and Standing Financial Instructions Appendix 1. 7. Approve Outline and Final Business Cases for Revenue Investment in excess of £1,000,000 8. Revenue business cases up to and including £1,000,000 are approved by the Care Organisation Management Committee. Revenue business cases up to £75,000 are approved by Divisional Review. These sub-delegations are set out in Section 3 and in Standing Financial Instructions Appendix 1. 9. Approve budgets. 10. Approve annually the Trust's organisational developmentproposals. 11. Ratify proposals for acquisition, disposal or significant change of use of land and/or buildings. 12. Approve the introduction or discontinuance of any significant activity oroperation. 13. Approve PFI proposals. 14. Approve the opening of bank or investmentaccounts. 15. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to, over £1,500,000. Note: following Board approval of the Contract Recommendation Report, contracts in the band £1,500,000–£1,999,999 are executed by the Managing Director. Contracts exceeding £2,000,000 are executed by the Group Chief Executive or Board Chair. See Standing Financial Instructions Appendix 1. 16. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the Board. 17. Approve individual compensation payments made outside of legal/

	statutory or mandatory requirements over £50,000. 18. Approve proposals for action on litigation against or on behalf of the Trust. 19. Review use of NHS Resolution risk pooling schemes (LTPS/PES/CNST/RPST).
THE BOARD	**Policy Determination** 1. Approve Trust's management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
THE BOARD	**Audit** 1. To approve audit arrangements (including arrangements for the separate audit of funds held on trust) and to receive reports of the Audit Committee and Charities Committee meetings and take appropriate action. 2. Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. Note: The appointment or dismissal of the Auditor is reserved to the Council of Governors. 3. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
THE BOARD	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust. 3. Receipt and approval of the Trust's Quality Accounts.
THE BOARD	**Monitoring** 1. Receipt of such reports as the Board sees fit from committees in respect of their exercise of powers delegated or from Directors and Officers of the Trust. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and Social Care and/ or NHS England and the Charity Commission where Board certification is required

	shall be reported, at least in summary, to the Board. 3. Receive reports from the Chief Finance Officer on financial performance againstbudget.

Section 3 - Decisions/duties delegated by the Board to Committees

COMMITTEE	DECISIONS/DUTIES DELGATED BY THE BOARD TO COMMITEES
RISK AND ASSURANCE COMMITTEE	The Committee will advise and support the Board through: • 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. • monitor the Group Risk Register and Board Assurance Framework content, ensuring effective risk management and appropriate assurance against the Group's principal risks. • review 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. • working in partnership with the Trust Audit Committee, which has 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
Audit Committee	The Committee will advise and support the Board through: • focusing on enhancing the Trust's governance, risk management, and internal control frameworks. • oversee the integrity of financial statements, ensuring the effectiveness of the internal audit function, monitoring compliance with legal and regulatory requirements, and assessing the independence and performance of external auditors. • scrutinise financial reporting processes, internal controls, and the management of financial and operational risks.

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ensure that the Trust operates in a transparent, efficient, and accountable manner, thereby contributing to the Trust's overall integrity and public confidence in its operation.

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<tr><td>BOARD OF DIRECTORS NOMINATIONS AND REMUNERATION COMMITTEE</td><td>
The Committee shall determine the appropriate remuneration and terms of service for the Chief Executive, Executive Directors and other senior employees. They shall:

advise about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (and other relevant senior employees),including:
(i) all aspects of salary (including any performance-related elements / bonuses);
(ii) provisions for other benefits, including pensions andcars.
determine arrangements for termination of employment and other contractualterms;
monitor and evaluate the performance of individual officer members (and other senior employees);
make such recommendations to the Board on the remuneration and terms of service of Executive Directors (and other relevant senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;
decide on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as isappropriate;
Monitor the skills and knowledge mix of the Board and make recommendations for future Executive and Non-Executive Director appointments;
The Committee shall report in writing to the Board its decisions and the basis for its recommendations;
The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and Officers not covered by theCommittee;

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<tr><td>CHARITIES COMMITTEE</td><td>In line with its role as a corporate trustee for any funds held in trust, whether charitable or non-charitable, the Board of Directors will establish a Charities</td></tr>
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	Committee to administer those funds in accordance with all applicable statutory, legal and regulatory requirements, including guidance issued by the Charity Commission. The Charities Committee is delegated authority to: (a) Administer charitable and non-charitable funds held on trust on behalf of the Board of Trustees, in accordance with the objects of each fund. (b) Exercise oversight of expenditure management (including dispositions) in respect of charitable funds, having regard to: the objects of each trust fund and designated objectives; the availability of liquid funds; the powers of delegation available to commit resources; and the avoidance of the use of exchequer funds to discharge trust fund liabilities. (c) Approve fund-raising appeals expected to raise less than £100,000. Note: fund-raising appeals expected to raise in excess of £100,000 require Board approval. (d) Receive and adopt the annual Trustees' Report and, where applicable, approve the return to the Charity Commission. (e) Receive regular reports from the Chief Finance Officer on the receipt of Funds held on Trust, investment performance and disposition of resources. This paragraph must be read in conjunction with Standing Financial Instructions section 27 and any separate Charities SFIs in force.
TRUST MANAGEMENT EXECUTIVE	The Trust Management Executive (operating as the Care Organisation Management Committee) is accountable to the Board of Directors for the operational management of the Trust and the delivery of objectives set by the Board of Directors. The Trust Management Executive will set appropriate frameworks, policies and procedures to support delivery of the organisational objectives and will continually monitor and review the operational performance of the Trust and put in place corrective measures where necessary. The Care Organisation Management Committee is delegated authority to: (a) Approve Outline and Final Business Cases for Capital Investment between £250,001 and £1,000,000 (see also Standing Financial Instructions Appendix 1 Capital Business Case Authorisation Limits).

	(b) Approve Outline and Final Business Cases for Revenue Investment up to and including £1,000,000 (see also Standing Financial Instructions Appendix1 Revenue Business Case Authorisation Limits).
Capital Prioritisation and Management Group (CPMG)	The CPMG is delegated authority to: (a) Approve Outline and Final Business Cases for Capital Investment up to and including £250,000 (see also Standing Financial Instructions Appendix 1). (b) Confirm capital affordability and prioritise schemes within the approved capital programme before commitment of expenditure. c) Approve property purchases, licences and leases up to £250,000 (including VAT) in accordance with SFI section 16.

Section 4 – Duties from the NHS Foundation Trust Accounting Officer Memorandum (IRG 24/15 5 August 2015)

DELEGATED TO	DUTIES DELEGATED
ACCOUNTING OFFICER	The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The Accounting Officer must ensure that: • there is a high standard of financial management in the NHS foundation trust as awhole; • financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the NHS foundation trust; • financial considerations are fully taken into account in decisions on NHS foundation trust policy proposals.
ACCOUNTING OFFICER	The essence of the accounting officer's role is a personal responsibility for: • the propriety and regularity of the public finances for which he or she is answerable • the keeping of proper accounts; • prudent and economical administration in line with the principles set out in Managing public money[1]; • the avoidance of waste and extravagance; • the efficient and effective use of all the resources in their charge.

[1] www.gov.uk/government/publications/managing-public-money

ACCOUNTING OFFICER	The Accounting Officer must: • personally sign the accounts and, in doing, so accept personal responsibility for ensuring • their proper form and content as prescribed by NHS England in accordance with the Act: • comply with the financial requirements of the NHS provider licence; • ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust); • ensure that the resources for which he or she is responsible as Accounting Officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official; • ensure that assets for which he or she is responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate; • ensure that any protected property (or interest in) is not disposed of without the consent of NHS England; • ensure that conflicts of interest are avoided, whether in the proceedings of the board of directors, council of governors or in the actions or advice of the NHS Foundation Trust's staff, including himself or herself; • ensure that, in the consideration of policy proposals relating to the expenditure for which he or she is responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the board of directors.
ACCOUNTING OFFICER	Ensure that effective management systems appropriate for the achievement of the NHS Foundation Trust's objectives, including financial monitoring and control systems, have been put in place. An Accounting Officer should also ensure that managers at all levels: • have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives; • are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made

	available to organisations or individuals outside the NHS Foundation Trust), including a critical scrutiny of output and value for money; • have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.
ACCOUNTING OFFICER	Must make sure that the arrangements he/she puts in place for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standard and practices set out in the *Public Sector Internal Audit Standards*[2]
ACCOUNTING OFFICER	See that appropriate advice is tendered to the board of directors and the council of governors on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. The Accounting Officer will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to their own duty as accounting officer to justify, to the Public Accounts Committee (PAC), transactions for which they are accountable.
ACCOUNTING OFFICER	Set out in writing his/her objection to any proposal or course of action of the Council of Governors or the Board of Directors which may infringe the requirements of propriety or regularity, and the reasons for this objection. Inform NHS England should any decision to proceed be taken which infringes the requirements of propriety or regularity despite his/her objection. Inform the Trust's External Auditors and NHS England if the decision is taken and the Accounting Officers objections are overruled.
ACCOUNTING OFFICER	Inform the Board of Directors and Council of Governors, of any issue relating to the wider responsibilities for economy, efficiency and effectiveness, and provide advice to the Board of Directors and Council of Governors on a recommended course of action. If the Accounting Officer's advice is not taken, he/she should seek an instruction to proceed in writing from the Board or Council before proceeding.

[2] www.gov.uk/government/publications/public-sector-internal-audit

ACCOUNTING OFFICER	The Accounting Officer may be required to appear before the Public Accounts Committee and will furnish the information and evidence required by the Committee.
BOARD OF DIRECTORS	Appoint an acting Accounting Officer (normally the Director of Finance) if an Accounting Officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more.

Section 5 – Authorities/duties delegated from Standing Orders

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
CHAIR	Final authority in interpretation of Standing Orders (SOs) as set out in the Constitution
CHAIR	Call meetings.
CHAIR	Chair all Board meetings.
CHAIR	Give final ruling in questions of order, relevancy and regularity of any matters.
CHAIR	Having a second or casting vote
BOARD	Suspend Standing Orders, provided that at least two-thirds of Directors are present (including at least one Executive Director and one Non-Executive Director) and a majority of those present vote in favour. Any decision and matters discussed during suspension shall be recorded and reviewed by the Audit Committee.
AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)

BOARD	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Board.) Decisions put to a vote shall be determined by a simple majority of Directors present and voting. The Chair has a casting vote in the event of equality. No business shall be transacted unless at least half of voting Directors are present, including at least one Executive Director and at least one Non-Executive Director. Directors excluded due to conflicts of interest do not count towards the quorum.
CHAIR & CHIEF EXECUTIVE	The powers which the Board has retained to itself within the Standing Orders and this scheme of reservation and delegation may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
CHIEF EXECUTIVE	Functions of the Trust which have not been retained as reserved by the Board or delegated to a committee of the Board, shall be exercised by the Chief Executive on behalf of the Board.
CHIEF EXECUTIVE	The Chief Executive shall prepare a scheme of delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
ALL	Disclosure of non-compliance with Standing Orders and this scheme of reservation and delegation to the Head of Corporate Governance as soon as possible.
THE BOARD	Declare relevant and material interests.
BOARD OF DIRECTORS' SECRETARY	Maintain Register(s) of Interests of members of the Board upon receipt of new or amended information.
ALL STAFF	Comply with the Directors' Code of Conduct and any guidance and best

	practice advice issued by NHS England.
ALL	Disclose relationship between self and candidate for staff appointment. (Board of Directors' Secretary to report the disclosure to the Board.)
HEAD OF CORPORATE GOVERNANCE/ NOMINATED OFFICER	Keep common seal of the Trust in safe place and maintain a register of sealing.
CHIEF EXECUTIVE	Sign all documents which will be necessary in legal proceedings.

Section 6 – Authorities/duties delegated from Standing Financial Instructions

DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Finance Officer as soon as possible.
CHIEF EXECUTIVE	Responsible as the Accounting Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
CHIEF EXECUTIVE, MANAGING DIRECTOR & CHIEF FINANCE OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
CHIEF FINANCE	To ensure all Board members, officers and employees, present and future, are

OFFICER / MANAGING DIRECTOR	notified of and understand Standing Financial Instructions.
CHIEF FINANCE OFFICER	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action; b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared, documented and maintained; c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include: i. Design, implementation and supervision of systems of internal financial control; ii. The provision of financial advice to members of Board and Officers; iii. Maintaining such accounts, certificates etc. as are required for the Trust to carry out its statutory duties.
ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions and the Scheme of Delegation.
MANAGING DIRECTOR	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
AUDIT COMMITTEE	Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control.
CHAIR OF AUDIT COMMITTEE	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.

CHIEF FINANCE OFFICER	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
CHIEF FINANCE OFFICER	Review, appraise and report in accordance with guidance within the Government Internal Audit Standards.
MANAGING DIRECTOR & CHIEF FINANCE OFFICER	Monitor and ensure compliance with any relevant guidance issued by NHS England or NHS Counter Fraud Authority.
CHIEF FINANCE OFFICER	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
MANAGING DIRECTOR	Compile and submit to the Board a Plan which takes into account financial targets and forecast limits of available resources.
CHIEF FINANCE OFFICER	Submit budgets to the Board for approval
CHIEF FINANCE OFFICER	Ensure adequate training is delivered on an ongoing basis to budget holders.
MANAGING DIRECTOR	Delegate budget to budget holders.
MANAGING DIRECTOR & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
CHIEF FINANCE OFFICER	Devise and maintain systems of budgetary control.
BUDGET HOLDERS	Ensure that: • they deliver their budgets as agreed in the Annual Plan

	• any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board • the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules ofvirement • no permanent employees are appointed without the approval of the Chief Finance Officer other than those provided for in the budgeted establishment as approved by theBoard • identifying and implementing cost improvements, cost savings and income generation initiatives to achieve a return that meets the requirements of NHS England;and • effective systems exist within the directorate to ensure that all expenditure is authorised in advance of commitment and that the individuals incurring expenditure fully understand their budgetary controlresponsibilities.
MANAGING DIRECTOR	Identify and implement cost improvements and income generation initiatives with budget holders in line with the Annual Plan and a balanced budget.
CHIEF FINANCE OFFICER	Submit financial monitoring returns.
EXECUTIVE DIRECTORS	Submit governance returns.
CHIEF FINANCE OFFICER	Preparation of annual accounts and reports.
CHIEF FINANCE OFFICER	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
CHIEF FINANCE OFFICER	Advise the Board on the Trust's ability to pay interest on and repay capital debt and new borrowing.

CHIEF FINANCE OFFICER	Report periodically on current debt, loans and overdrafts.
BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust.
CHIEF FINANCE OFFICER	Will advise the Board on investments and report, periodically, on performance of same.
CHIEF FINANCE OFFICER	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
CHIEF FINANCE OFFICER	Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
ALL EMPLOYEES	Duty to inform the Chief Finance Officer of money due from transactions which they initiate/deal with.
MANAGING DIRECTOR	Must ensure the Trust enters into suitable legally binding agreements with service commissioners for the provision of NHS services
MANAGING DIRECTOR	Waive formal tendering procedures where permitted under SFI section 10. All waivers to be reported to the Chief Finance Officer for onward reporting to the Audit Committee.
CHIEF FINANCE OFFICER	Report waivers of tendering procedures to the Audit Committee.
MANAGING DIRECTOR	The Managing Director or their nominated officer should evaluate the quotation and select the quote which gives the best value for money.
MANAGING DIRECTOR OR CHIEF FINANCE OFFICER	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Managing Director or the Chief Finance Officer.

MANAGING DIRECTOR OR NOMINATED REPRESENTATIVE	Responsible for the receipt and safe custody of tenders received.
MANAGING DIRECTOR	Shall maintain a register to show each set of competitive tender invitations despatched.
MANAGING DIRECTOR & CHIEF FINANCE OFFICER	Where one tender is received will assess for value for money and fair price.
MANAGING DIRECTOR	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Managing Director.
CHIEF FINANCE OFFICER	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
MANAGING DIRECTOR	The Managing Director shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
MANAGING DIRECTOR	The Managing Director shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
MANAGING DIRECTOR	The Managing Director shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
BOARD OF DIRECTORS	Establish a Board of Directors Nominations and Remuneration Committee.
	• Advise and make recommendations to the Board about remuneration and termsof service for the Chief Executive and other Executive Directors (and other senior Officers);

BOARD OF DIRECTORS NOMINATIONS AND REMUNERATION COMMITTEE	• Ensure they are fairly rewarded having proper regard to the Trust's circumstances and performance and provisions of national arrangements; • Monitor and evaluate performance of individual Executive Directors and some senior officers; • Decide on and oversee appropriate contractual arrangements for all Executive Directors and senior Officers; • Monitor skills and knowledge mix of the Board and make recommendations for future Director's appointments to the Board of Directors Nominations and Remuneration Committee.
BOARD OF DIRECTORS NOMINATIONS AND REMUNERATION COMMITTEE	Report in writing to the Board its decisions and its bases about remuneration and terms of service of directors and senior employees.
BOARD OF DIRECTORS	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Board of Directors Nominations and Remuneration Committee.
CHIEF FINANCE OFFICER	Approval of variation to funded establishment of any department.
CHIEF FINANCE OFFICER	Payroll: (a) specifying timetables for submission of properly authorised time records and other notifications; (b) final determination of pay and allowances; (c) making payments on agreed dates; (d) agreeing method of payment;
CHIEF FINANCE OFFICER	Issue instructions listed in the SFI.

NOMINATED MANAGERS*	(a) Submit time records and other notifications in accordance with agreed timetables. (b) Complete time records and other notifications in required form. (c) Submitting termination forms in prescribed form and on time.
CHIEF FINANCE OFFICER	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
BOARD	(a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and (b) Deal with variations to, or termination of, contracts of employment.
CHIEF FINANCE OFFICER	Determine the level of delegation of non-pay expenditure to budget managers. BOARD OF DIRECTORS — Purchase orders/invoices exceeding £1,000,000; other payments exceeding £100,000; non-SLA sales orders and credit notes exceeding £1,000,000. CHIEF EXECUTIVE — Purchase orders/invoices up to £1,000,000; other payments up to £100,000; non-SLA sales orders and credit notes up to £1,000,000. CHIEF FINANCE OFFICER — Purchase orders/invoices up to £1,000,000; other payments up to £100,000; non-SLA sales orders and credit notes up to £1,000,000. CARE ORGANISATION MANAGING DIRECTOR — Purchase orders/invoices up to £1,000,000; other payments up to £100,000; non-SLA sales orders and credit notes up to £1,000,000. EXECUTIVE DIRECTORS — Purchase orders/invoices up to £500,000; other payments up to £50,000; non-SLA sales orders and credit notes up to £500,000. DIVISIONAL DIRECTOR — Purchase orders/invoices up to £50,000; other payments up to £1,000; non-SLA sales orders and credit notes up to £10,000.

	BUDGET HOLDERS / HEADS OF SERVICE — Purchase orders/invoices up to £10,000; other payments up to £500; non-SLA sales orders and credit notes up to £1,000. BUDGET MANAGER — Purchase orders/invoices up to £2,000; other payments up to £100; non-SLA sales orders and credit notes up to £500. Note: All figures exclude VAT. 'Other payments' includes overtime, waiting list initiatives and travel and subsistence. Petty cash: budget holder approval only for amounts under £25; above £25 requires advance approval from the Head of Financial Services. Full limits are set out in SFI v0.4 Appendix 1.
CHIEF FINANCE OFFICER	(a) Set out the list of managers who are authorised to place requisitions/ orders for the supply of goods and services. (b) Set out the maximum financial level for each requisition/ order and the system for authorisation above that level.
CHIEF FINANCE OFFICER	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
CHIEF FINANCE OFFICER	Shall be responsible for the prompt payment of accounts and claims in accordance with contract terms or national guidance.
CHIEF FINANCE OFFICER	(a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; (b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; (c) Be responsible for the prompt payment of all properly authorised accounts and claims; (d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; (e) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise

	requiring early payment; (f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; (g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
CHIEF FINANCE OFFICER	Approve proposed prepayment arrangements.
BUDGET HOLDER	Ensure that all items due under a prepayment contract are received and immediately inform the appropriate Director or Chief Executive if problems are encountered.
MANAGING DIRECTOR	Authorise who may use and be issued with official orders.
OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Director of Finance.
MANAGING DIRECTOR	Capital investment programme: (a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans (b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; (c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences;
CAPITAL PRIORITISATION AND MANAGEMENT GROUP	Ensure that a business case is produced for every significant capital expenditure proposal.

CHIEF FINANCE OFFICER	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
CHIEF FINANCE OFFICER	Issue procedures for management of contracts involving stage payments.
CHIEF FINANCE OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
CHIEF FINANCE OFFICER	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successfultender.
MANAGING DIRECTOR	Issue a Scheme of Delegation for capital investment management.
CHIEF FINANCE OFFICER	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
CHIEF FINANCE OFFICER	Maintenance of asset registers and arranging for a physical check of assets against the asset register.
CHIEF FINANCE OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
MANAGING DIRECTOR	Overall responsibility for fixed assets.
CHIEF FINANCE OFFICER	Approval of fixed asset control procedures.
BOARD, EXECUTIVE MEMBERS AND STAFF	All significant discrepancies revealed by verification of physical assets to fixed asset registers to be notified to the Chief Finance Officer.
BOARD, EXECUTIVE MEMBERS AND STAFF	Responsibility for security of Trust property.

DIRECTORS AND SENIOR OFFICERS	Apply such appropriate routine security practices in relation to Trust property.
BOARD, EXECUTIVE MEMBERS AND STAFF	Report any damage to the Trust's premises, vehicles and equipment or any losses in accordance with Trust procedure.
MANAGING DIRECTOR	Delegate overall responsibility for control of stores (subject to the Director of Finance's responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks.
DESIGNATED ESTATES MANAGER	Responsible for control of stocks of fuel oil and coal.
DESIGNATED MANAGER / PHARMACEUTICAL OFFICER	Security arrangements and custody of keys.
CHIEF FINANCE OFFICER	Set out procedures and systems to regulate the stores.
CHIEF FINANCE OFFICER	Agree stocktaking arrangements.
CHIEF FINANCE OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
CHIEF FINANCE OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
DESIGNATED PHARMACEUTICAL	Operate system for slow moving and obsolete stock, and report to the Chief Finance Officer evidence of significant overstocking.

OFFICER	
CHIEF FINANCE OFFICER	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of department or nominated officer. The head of department / nominated officer should then inform the Managing Director and the Chief Finance Officer.
CHIEF FINANCE OFFICER	Where a criminal offence is suspected, the Chief Finance Officer must inform the police if theft or arson is involved. In cases of fraud and corruption the Chief Finance Officer must inform the relevant LCFS and NHS Counter Fraud Authority Regional Team in line with Secretary of State directions.
CHIEF FINANCE OFFICER	Notify Local Counter Fraud Service and External Audit of all frauds.
CHIEF FINANCE OFFICER	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
CHIEF FINANCE OFFICER	Approve write off of losses (within limits delegated by Board).
CHIEF FINANCE OFFICER	Consider whether any insurance claim can be made.
CHIEF FINANCE OFFICER	Maintain losses and special payments register.
CHIEF DIGITAL AND INFORMATION OFFICER	Responsible for accuracy and security of computerised data.
CHIEF FINANCE	Satisfy him/her that new computer systems (including finance systems) and

OFFICER	amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.
CHIEF DIGITAL AND INFORMATION OFFICER	Shall publish and maintain a Freedom of Information Scheme or adopt a model Publication Scheme approved by the information Commissioner.
RELEVANT OFFICERS	Send proposals for general computer systems to the Chief Digital and Information Officer.
CHIEF FINANCE OFFICER	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.
CHIEF FINANCE OFFICER	Seek periodic assurances from the provider that adequate controls are in operation.
CHIEF DIGITAL AND INFORMATION OFFICER	Ensure that risks to the Trust from use of IT are identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans
CHIEF FINANCE OFFICER	Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that: (a) systems acquisition, development and maintenance are in line with corporate policies such as an Digital Strategy; (b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists; (c) Finance staff have access to such data; (d) Have adequate controls in place; and (e) such computer audit reviews as are considered necessary are being carried out

MANAGING DIRECTOR	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission and that the Trust will not accept responsibility or liability for patient's property unless the procedures are followed.
CHIEF FINANCE OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
MANAGING DIRECTOR	Retention of document procedures in accordance with Department of Health Guidance.
CHIEF RISK OFFICER	Develop a risk management programme in line with NHS assurance framework requirements, which must be approved and monitored by the Board.
BOARD OF DIRECTORS	Approve and monitor risk management programme.
BOARD OF DIRECTORS	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self- insure should be reviewed annually.
CHIEF FINANCE OFFICER	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme.
CHIEF FINANCE OFFICER	Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this

	decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
CHIEF FINANCE OFFICER	Establish procedures for the management of expense claims.
CHIEF FINANCE OFFICER	Approve the contract or transaction in relation to credit finance commitments
CHIEF FINANCE OFFICER	Approve leasing agreements and hire purchase undertakings.
CHIEF FINANCE OFFICER	Maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of non-exchequer funds.
CHIEF FINANCE OFFICER	Arrange for the administration of all existing charitable Funds held on Trust
CHIEF FINANCE OFFICER	Ensure that all charitable Funds held on Trust are currently registered with the Charities Commission in accordance with the Charities Act 2016 or subsequent legislation.
CHIEF FINANCE OFFICER	The Chief Finance Officer shall recommend the creation of a new charitable fund where funds and/or other assets, received in accordance with the Trust's policies cannot adequately be managed as part of an existing fund
ALL OFFICERS	Immediately hand over all gifts, donations and proceeds of fund-raising activities, which are intended for the Trust’s use to the Chief Finance Officer.
CHIEF FINANCE OFFICER	Produce guidelines to Officers as to how to proceed when offered funds.

CHIEF FINANCE OFFICER	Ensure that in respect of legacies and bequests, • all correspondence concerning a legacy is dealt with on behalf of the Trust; • where necessary, grant of probate is obtained or apply for a grant of letters of administration, where the Trust is the beneficiary;and • that arrangements regarding the administration of a will are negotiated with executors and to discharge them from theirduty
THE BOARD	Give final approval for major appeals, defined as events raising in excess of £100,000.
CHARITIES COMMITTEE	Give final approval for smaller appeals, defined as events anticipating to raise less than £100,000
CHARITIES COMMITTEE	Be responsible for all aspects of the management of the investment of Funds held on Trust.
CHIEF FINANCE OFFICER	Be responsible for the appropriate treatment of all investment income.
CHARITIES COMMITTEE	Exercise of expenditure discretion (can be delegated to the Chief Finance Officer).
CHIEF FINANCE OFFICER	Advise the Charities Committee and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee
CHIEF FINANCE OFFICER	• Appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account; • appropriate measures are taken to protect and/or toreplace assets; • donated assets received on trust shall be accounted for appropriately;

	and • all assets acquired from charitable Funds held on Trust which are intended to be retained within the trust funds are appropriately accountedfor.
CHIEF FINANCE OFFICER	Ensure that regular reports are made to the Charities Committee and the Board with regard to, inter alia, the receipt of Funds held on Trust, investments of these trust funds and the disposition of resources
CHIEF FINANCE OFFICER	Prepare the Annual Accounts
CHIEF FINANCE OFFICER	In relation to the non-charitable trust funds prepare any required returns to NHS England.
CHIEF FINANCE OFFICER	Prepare an annual trustees report regarding charitable trust funds and make the required return to the Charities Commission
CHIEF FINANCE OFFICER	Maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.
CHIEF FINANCE OFFICER	Determine a basis for the distribution of investment income to the charitable Funds held on Trust and the recovery of administration costs.
CHIEF FINANCE OFFICER	Ensure that the records, accounts and returns receive adequate scrutiny by the Trust's Internal Audit during the year
CHIEF FINANCE OFFICER	Advise the Board of Trustees Committee of the outcome of the annual audit.
CHIEF FINANCE OFFICER	Identify all costs directly incurred in the administration of all Funds held on Trust and charge such costs to the appropriate trust accounts
CHIEF FINANCE	Ensure that the Trust's liability to taxation and excise duty is managed

OFFICER	appropriately
MANAGING DIRECTOR	Ensure that all intellectual property is identified, protected and used for the benefit of the Trust, the NHS and service users.
MANAGING DIRECTOR	Ensure that all intellectual property is identified and properly recorded in the Trust's Intellectual Property register.
MANAGING DIRECTOR	Ensure all third party intellectual property, upon which the Trust's intellectual property relies is properly licensed and confers rights to sub-license as part of the Trust's intellectualproperty.
ALL STAFF	Required to identify and protect the intellectual property of the Trust and ensure that is properly recorded in the Trust's Intellectual Property register.
MANAGING DIRECTOR	Responsible for compliance with the SFIs as they relate to the identification, protection, use and licensing of Trust and third party intellectual property.

[Insert Trust Name]
Standing Financial Instructions

Reference Number:	
Author & Title:	
Responsible Director:	
Review Date:	
Ratified by:	
Date Ratified:	
Version:	

Related Policies and Guidelines	

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CONTENTS

1. Policy Summary ... 3

2. Policy Statements ... 3

3. Duties and Responsibilities ... 4

4. Audit ... 6

5. Business Planning, Budgets, BudgetaryControl and Monitoring ... 12

6. Annual Report and Accounts and Quality Accounts ... 15

7. Bank Accounts ... 16

8. Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments ... 18

9. Contracts for the Provision of Healthcare Services ... 20

10. Tendering, quotation and contracting procedure ... 21

11. Terms of Service, Allowances and Payment of Members of the Board and Employees ... 33

12. Terms of Service, Allowances and Payment of Members of the Board and Employees ... 36

13. Wholly Owned Subsidiaries, Hosted Bodies, Partnerships and Collaborations ... 41

14. External Borrowing, Public Dividend Capital and Investments ... 41

15. Capital Investment, Private Financing, Fixed Assets and Security of Assets ... 43

16. Property (Land and Buildings) ... 46

17. Inventory and Receipt of Goods ... 47

18. Disposals and Condemnations, Losses and Special Payments ... 49

19. Information Technology ... 51

20. Patients' Property ... 53

21. Standard of Business Conduct ... 54

22. Freedom of Information and Information Requests ... 54

23. Retention of Records ... 55

24. Risk Management and Insurance ... 55

25. Staff Expenses ... 56

26. Credit finance Arrangements including Leasing Commitments ... 57

27. Charitable Funds Held on Trust ... 57

28. Intellectual Property ... 62

29. Monitoring Compliance ... 64

30. Review ... 64

31. Training ... 65

32. Definitions of Terms Used ... 65

Appendix 1: Authorisation Limits ... 69

1. Policy Summary

1.1 [Insert Trust name] (the "Trust") was authorised as an NHS Foundation Trust by NHS England, the Independent Regulator of NHS Foundation Trusts pursuant to the National Health Service Act 2006 (the "NHS 2006 Act" or "2006 Act") on [Insert date]

1.2 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect, as if incorporated in the Standing Orders (SOs) of the Foundation Trust's Board of Directors (note that SOs are a statutory requirement for Foundation Trusts (FTs) but SFIs are not termed as such, although an equivalent set of rules is required by NHS England, which this document represents).

1.3 The NHS England Single Oversight Framework details how NHSE oversees and supports providers in delivering consistently safe, effective, compassionate patient care within health systems that are financially and clinically sustainable. Additional financial guidance includes *Code of Practice issued by the National Audit Office (NAO)*, and the most recent *DHSC Group accounting Manual*. Other relevant guidance may be issued which should be applied alongside these instructions.

1.4 References to Managing Director and Care Organisation Managing Director are the same role. References to Chief Executive and Chief Finance refer to the Group Chief Executive and Group Chief Finance Officer respectively.

2. Policy Statements

2.1 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust (collectively called the "Scheme of Delegation").

2.2 These SFIs identify the financial responsibilities which apply to everyone employed by, or working for the Foundation Trust and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial policies and procedures.

2.3 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Chief Finance Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders of the Board of Directors (as well as the separate Standing Orders of the

Council of Governors). Failure to comply with Standing Financial Instructions and Standing Orders of the Board of Directors can in certain circumstances is regarded as a disciplinary matter that could result in an employee's dismissal.

2.4 Overriding Standing Financial Instructions – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the Chief Finance Officer, as soon as possible

3. Duties and Responsibilities

Foundation Trust Board of Directors

3.1 The Board exercises financial supervision and control by:

a. Formulating the financial strategy of the Trust;
b. Requiring the submission and approval of Budgets within approved allocations and overall income;
c. Defining and approving essential features in respect of important procedures and financial systems (including (but not limited to) the need to obtain value for money) and the Trust's statutory duty under Section 63 of the 2006 Act (General duty of NHS foundation trusts) to exercise its functions effectively, efficiently and economically; and
d. Defining specific responsibilities placed on Directors and employees as indicated in the Scheme of Delegation.

3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Delegation. All other powers have been delegated to such executive directors in the Scheme of Delegation or, committees of the Board, as established by the Trust. The Board must approve the terms of reference of all committees reporting directly to the Board.

3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Regulatory Framework and the Scheme of Delegation. The extent of delegation shall be kept under review by the Board

The Chief Executive, Managing Director and Chief Finance Officer

3.4 The Chief Executive and the Chief Finance Officer will delegate their detailed

responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control. Following the establishment of the BSW group the Chief Executive retains all statutory functions and remains the Accountable and Accounting Officer. The day-to-day discharge of these duties will be through the Managing Director. Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as accounting officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for [Insert Trust name] activities; is responsible to the Chair and members of the Board for ensuring that its financial obligations and targets are met and has overall responsibility for [Insert Trust name] system of internal control.

3.5 It is a duty of the Managing Director to ensure that existing Directors and Officers and all new appointees are notified of and put in a position to understand their responsibilities within these SFIs.

Chief Finance Officer

3.6 The Chief Finance Officer is responsible for:

These SFIs and for keeping them appropriate and up to date;

a. Implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
b. Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
c. Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and
d. Without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Chief Finance Officer include:

    i. Design, implementation and supervision of systems of internal financial control;
    ii. The provision of financial advice to members of the Trust Board and employees
    iii. The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties.

Council of Governors

3.7 All members of the Council of Governors, severally and collectively are responsible for:

a. Holding the Non – Executive Directors individually and collectively to account for the performance of the Board of Directors, and
b. Representing the interest of the members of the Trust as a whole and the interests of the public.

Board of Directors and Employees

3.8 All directors and employees, severally and collectively, are responsible for:

a. The security of Trust property
b. Avoiding loss;
c. Exercising economy and efficiency in the use of resources; and
d. Conforming to the requirements of NHSE, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Delegation of Powers.

Contractors and their employees

3.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Managing Director to ensure that such persons are made aware of their duties under these Standing Financial Instructions.

3.10 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Finance Officer.

4. Audit

Audit Committee

4.1 In accordance with the Constitution the Board of Directors shall establish an Audit Committee, with clearly defined terms of reference. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives. The

Committee is also responsible for:

a. overseeing Internal and External Audit services with an active involvement in the selection and performance monitoring of the assurance providers to ensure a cost-efficient service is provided;
b. all audit recommendations will be reported and monitored by the Audit & Risk Committee;
c. reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;
d. monitoring compliance with the Constitution and Standing Financial Instructions;
e. examining the circumstances associated with occasions when the Constitution and associated Standing Financial Instructions are waived, and
f. reviewing schedules of losses, compensations, and settlements with staff, and making recommendations to the Board;
g. reviewing schedules of debtors/creditors balances over 6 months old and over a de minimis limit as defined by the Audit Committee and related explanations/action plans;
h. reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board on the adequacy of internal mechanisms for identifying all principal risks and providing reasonable assurance that risk management arrangements are robust;
i. where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair of the Audit Committee should immediately inform the Managing Director and raise the matter at the next meeting of the Board. Exceptionally, the matter may need to be referred to NHS England.

4.2 It is the responsibility of the Chief Finance Officer to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if the Internal Audit service provider is changed.

Chief Finance Officer

4.3 To support the Audit Committee in their role, it is the responsibility of the Chief Finance Officer is to:

a. Ensure there are arrangements to review, evaluate and report on the effectiveness of internal financial control, including the establishment of an internal audit function;
b. Decide at what stage to involve the police in cases of misappropriation of assets and any other irregularities (subject to the provisions of section 5.1.5 of this document, in relation to fraud and corruption);
c. Ensure that an annual internal audit report is prepared (with interim progress reports) for the consideration for the Audit Committee. The report must cover:

d. A clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the DHSC. This opinion provides assurances to the Accounting Officer, especially when preparing the Statement of Internal Control and also provides assurances to the Audit Committee;

    i. Any major internal financial control weaknesses discovered;
    ii. Progress on the implementation of internal audit recommendations;
    iii. Progress against plan over the previous year;
    iv. Strategic audit plan covering the coming three years;
    v. A detailed work-plan for the coming year.

4.4 The Chief Finance Officer and designated auditors are entitled without necessarily giving prior notice to require and receive:

i. Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
ii. Access at all reasonable times to any land, premises or members of the Board or employee of the Trust;
iii. The production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and
iv. Explanations concerning any matter under investigation.

Role of Internal Audit

4.5 Internal Audit provides an independent and objective opinion to the Managing Director, the Audit Committee and the Board on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

4.6 Internal Audit will review, appraise and report upon:

a. The extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
b. The adequacy and application of financial and other related management controls;
c. The suitability of financial and other related management data;
d. The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

    i. Fraud and other offences (responsibility for investigation of any suspected or alleged fraud is held by the Local Counter Fraud Specialist);
    ii. Waste, extravagance, inefficient administration;
    iii. Poor value for money or other causes;

iv. Any form of risk, especially business and financial risk but not exclusively so.

e. The adequacy of management action in response to audit recommendations;
f. Any investigations / project work agreed with and under terms of reference laid down by the Chief Finance Officer;
g. The Trust's compliance with the Care Quality Commission Essential Standards of Quality and Safety.

4.7 Internal Audit shall also independently verify the Assurance Statements in accordance with guidance within the Government Internal Audit Standards.

4.8 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Finance Officer must be notified immediately.

4.9 The Head of Internal Audit, or equivalent title, will normally attend the meetings of the Audit Committee and has a right of access to all Audit Committee members, the Chair and Managing Director.

4.10 The Head of Internal Audit shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the "Code of Practice issued by the National Audit Office (NAO)," the "DHSC Group Accounting Manual" and the "NHS FT Accounting Officer memorandum."

4.11 The Head of Internal Audit shall report to the Chief Finance Officer and shall refer audit reports to the appropriate officers designated by the Managing Director. Failure to take remedial action within a reasonable period shall be reported to the Managing Director. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit, the Head of Internal Audit shall have the right to report direct to the Chair or any Non-Executive Director. The reporting system shall be reviewed at least every 3 years.

4.12 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial action within the timescales specified in the report. The Chief Finance Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action had failed to take place within a reasonable period, the matter shall be reported to the Chief Finance Officer. Changes implemented must be maintained in the future and not viewed as merely satisfying an immediate audit point.

External Audit

4.13 The External Auditor is appointed by the Council of Governors with advice from the Audit Committee. If there are any problems relating to the service provided by the External Auditor this should be resolved in accordance with the Code of Practice issued by the National Audit Office (NAO)

4.14 The Trust and the External Auditor must comply with the Code of Practice issued by the National Audit Office (NAO), and fulfil the relevant responsibilities laid out in schedule 7 and schedule 10 of the 2006 Act.

4.15 Officers in receipt of audit reports referred to them, have a duty to take appropriate remedial action, if any, within the agreed time-scales specified within the audit reports.

4.16 Prior approval must be sought from the Audit Committee (the Council of Governors may also be notified) for each discrete piece of additional external audit work (i.e. work over and above the audit plan, approved at the start of the year.) awarded to the external auditors. Competitive tendering is not required and the Chief Finance Officer is required to authorise expenditure.

4.17 The External Auditor shall be routinely invited to attend and report to meetings of the Audit Committee, and shall be entitled to meet the Audit Committee in the absence of Trust employees, if they so desire.

Fraud and Corruption

4.18 In line with their responsibilities, the Managing Director and the Chief Finance Officer shall monitor and ensure compliance with any relevant guidance issued by NHS England or NHS Counter Fraud Authority on fraud and corruption.

4.19 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the Standards for Providers – Fraud, Bribery and Corruption.

4.20 The Chief Finance Officer is responsible for notifying the police when appropriate, during an investigation, following advice from the LCFS in line with the NHS Counter Fraud Authority Fraud and Corruption Manual and guidance.

4.21 The LCFS shall report to the Chief Finance Officer and shall work with staff in the NHS Counter Fraud Service (NHS Counter Fraud Authority) in accordance with the NHS Counter Fraud and Corruption Manual.

4.22 The Chief Finance Officer should also prepare a "Counter Fraud Policy and Response Plan" that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

4.23 The LCFS will attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Managing Director of [Insert Trust name]

4.24 The LCFS shall be accountable to the Chief Finance Officer. The reporting system for Counter Fraud services shall be agreed between the Chief Finance Officer, the Audit Committee and the LCFS. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Counter Fraud and Corruption Manual and guidance. The reporting system shall be reviewed at least every 3 years.

4.25 The LCFS will provide a written report, at each Audit Committee meeting, on counter fraud work within [Insert Trust name].

4.26 The LCFS will, at the beginning of each Financial Year, prepare a written work plan outlining the LCFS' projected work for that Financial Year.

The LCFS shall:

a. Keep full and accurate records of any instances of fraud and suspected fraud;
b. Report to the Audit Committee any weaknesses in fraud-related systems and any other matters which may have fraud-related implications for the Trust;
c. Request from the Managing Director all necessary support to enable him/her to efficiently, effectively and promptly carry out his/her functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of his work;
d. Participate in activities which NHS England directs, or in which NHS Counter Fraud Authority is engaged, including national anti-fraud measures.

4.27 Any Officer discovering or suspecting a loss of any kind must immediately inform the Managing Director, the Chief Finance Officer, or the LCFS.

4.28 In accordance with the Freedom to Speak Up (Raising Concerns Policy), the Trust shall have whistle – blowing mechanism to report any suspected or actual fraud, bribery or corruption matters and internally publicise this, together with the national fraud and corruption reporting line provided by NHS Counter Fraud Authority (NHS CFA).

4.29 The Trust will report annually on how it has met the standards set by NHS Counter Fraud Authority (NHS CFA) in relation to anti-fraud, bribery and corruption work and the Chief Finance Officer shall sign off the annual review and authorise its submission to NHS Counter Fraud Authority (NHS CFA).

Security management

4.30 In line with their responsibilities, the Trust Managing Director will monitor and ensure compliance with the Directions issued directly by the Secretary of State for Health on

NHS security management.

4.31 The Trust shall nominate an Executive Director to be responsible to the Board for security management matters and the promotion of security management measures within the Trust.

4.32 The Trust will appoint at least one person as a Local Security Management Specialist, in accordance with any guidance issued by NHS England or the NHS Counter Fraud Authority on suitability criteria for such appointees.

4.33 The Local Security Management Specialist will report directly to the nominated Executive Director lead and will work with NHS England and the NHS Counter Fraud Authority.

4.34 The Local Security Management Specialist will, at the beginning of each Financial Year, prepare a written work plan outlining the Local Security Management Specialist's projected work for that Financial Year.

4.35 The Local Security Management Specialist shall be afforded the opportunity to attend Audit Committee meetings and other meetings of the Board, or its committees, as required.

4.36 The Trust shall also nominate a Non-Executive Director to be the lead Non-Executive Director for security management matters

5. Business Planning, Budgets, Budgetary Control and Monitoring

Preparation and Approval of Business Plans and Budgets

5.1 The Managing Director, with the assistance of the Chief Finance Officer, will compile and submit to the Board of Directors, the Council of Governors, and NHS England strategic plans and operational business plans in accordance with the guidance issued by NHS England with regards timing and Trust financial duties. The Trust operational business plans will contain:

5.2 A statement of the significant assumptions on which the plan is based;

a. Details of major changes in workload, delivery of services or resources required to achieve the plan.
b. The Financial Plan for the Year

c. Such other contents as may be determined by NHS England.

5.3 The annual plan must be approved by the Trust board and submitted to the NHSE in accordance with their requirements.

5.4 In a suitable timeframe to enable compliance with NHS England's Risk Assessment Framework, the Chief Finance Officer will, on behalf of the Managing Director, prepare and submit an annual budget for approval by the Board of Directors. Such budgets will:

a. Be in accordance with the Trust values, and the aims and objectives set out in the annual Business Plan;
b. Accord with workload and manpower plans;
c. Be produced following discussion with appropriate budget holders;
d. Be prepared within the limits of available funds;
e. Identify potential risks and mitigating actions;
f. Be based on reasonable and realistic assumptions; and
g. Enable the Trust to comply with the whole regulatory framework for Foundation Trusts. Officers shall provide the Chief Finance Officer with all financial, statistical and other relevant information as necessary for the compilation of such business plans, estimates and forecasts.

5.5 The Chief Finance Officer has overall responsibility to ensure that adequate financial systems are in place to monitor and control financial performance to enable [Insert Trust name] to fulfil its statutory responsibility to meet its annual revenue and capital targets.

5.6 The Chief Finance Officer has the authority to request budget holders to formally sign off annual budgets, as an acknowledgement of ownership.

Budgetary Control and Reporting

5.7 The Chief Finance Officer shall monitor financial performance against budget and business plan, projecting anticipated performance for future periods, report to the Board, and advise on any actions he or she deems appropriate.

5.8 All officers whom the Board of Directors may empower to engage staff, to otherwise incur expenditure, or to collect or generate income, shall comply with those systems. The systems of budgetary control shall incorporate the reporting of, and investigation into, financial, activity, or workforce variance from the budget. The Chief Finance Officer shall be responsible for providing budgetary information and advice to enable the Managing Director and other officers to carry out their budgetary responsibilities.

5.9 The Chief Finance Officer shall keep the Managing Director and the Board of Directors informed of financial consequences of changes in policy, pay awards and other events

and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

5.10 The Chief Finance Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

5.11 No budget-holder is authorised to overspend their budget. Where overspending is occurring, the budget holder must account to their Divisional Management Team or line manager for the overspending and identify means of addressing it. It is accepted that a budget may be exceeded for a short period in the year due to the phasing of expenditure.

5.12 Each budget holder is responsible for ensuring that no permanent employees are appointed without going through the Trust's recruitment process to ensure budgetary approval has been agreed, other than medical and nursing staff provided for within the budgeted workforce establishment.

5.13 The Managing Director will delegate to budget holders responsibility for identifying and implementing cost improvement programmes and income generation initiatives in order to deliver a budget that will enable compliance with NHS England's Single Oversight Framework, finance and use of resources.

Budgetary Delegation

5.14 The Managing Director, through the Chief Finance Officer may delegate the management of a budget to permit the performance of a defined range of activities, This delegation must be in writing and be accompanied by a clear definition of:

a. The amount of the budget;
b. The purpose of each budget heading;
c. Individual and group responsibilities;
d. Authorities to exercise virement;
e. Achievement of planned levels of service; and
f. Provision of regular reports.

5.15 The Managing Director and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.16 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Managing Director, subject to any authorised use of virement.

5.17 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Managing Director or the Chief Finance Officer.

Capital Expenditure

5.18 The general rules applying to delegation and reporting shall also apply to capital expenditure. Accounting for fixed assets must comply with the most recent version of the DHSC Group Accounting Manual. (The particular applications relating to capital are contained in section 15 of these SFIs)

Performance Monitoring Forms and Returns

5.19 The Chief Finance Officer is responsible for ensuring that the appropriate financial monitoring forms are submitted to the requisite monitoring organisations. The relevant Executive Director is responsible for ensuring that the appropriate Governance returns are submitted to the requisite monitoring organisations. The figures reported should reflect the same figures, though not necessarily presented in the same format, as those reported to the Board of Directors.

6. Annual Report and Accounts and Quality Accounts

6.1 The Chief Finance Officer, on behalf of the Trust, will keep accounts in such form as NHS England may direct, and produce annual accounts and financial returns for NHS England.

6.2 The Head of the Corporate Governance will prepare an Annual Report in accordance with the guidance in the DHSC Group Accounting Manual.

6.3 The Trust's Annual Report and the Annual Accounts and financial returns to NHS England must be audited by the external auditor in accordance with appropriate international auditing standards.

6.4 The Annual Report and Accounts (including the auditor's report) shall be approved by the Board of Directors.

6.5 The Annual Report and Accounts (including the auditor's report) is submitted to NHS England (in accordance with its timetable) by the Chief Finance Officer and put forward to be laid before Parliament each year.

6.6 The Annual Report and Accounts (including the auditor's report) must be published and presented to a general meeting of the Council of Governors by 30th September each year and made available to the public for public inspection at the Trust's headquarters and

made available on the Trust's website. Any summary financial statements published are, in addition to, and not instead of, the full annual accounts.

6.7 The Chief Nurse will prepare the Trust Quality Account in the format prescribed by NHS England.

7. Bank Accounts

General

7.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by NHS England.

7.2 The Board shall approve the banking arrangements.

Bank and Government Banking Services (GBS)

7.3 **In line with public sector practice, the Trust's principal bankers are those** commercial banks working in partnership with the GBS; however, these SFIs will apply to any other accounts opened in the name of the Trust or its subsidiaries from time to time.

7.4 The Chief Finance Officer is responsible for:

a. Bank accounts and GBS accounts;
b. Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;
c. Ensuring payments made from bank or Government Banking Service accounts do not exceed the amount credited to the account except where arrangements have been made;
d. Ensuring cash is managed in line with [Insert Trust name] Licence Conditions and its Investment and Borrowing Strategies. Further details of which can be found in the Finance Department's Treasury Management Policies;
e. Establishing separate bank accounts for the Trust's non-exchequer funds;
f. Ensuring covenants attached to bank borrowings are adhered to.

Banking Procedures

7.5 The Chief Finance Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

a. Those members of staff with mandated authority to carry out transactions (by signing transfer authorities or cheques or other orders) drawn on the Trust's accounts; and
b. The conditions under which each bank and GBS account is to be operated.

7.6 The Chief Finance Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated. All funds shall be held in accounts in the name of the Trust. No officers other than the Chief Finance Officer shall open any bank account in the name of the Trust.

Tendering and Review

7.7 The Board of Directors will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7.8 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board.

7.9 If however, the Chief Finance Officer decides, that it is not in Trust's best interests to use commercial banking services, but instead to solely use the GBS services, then no tender will be required. This should be reported to the Board of Directors.

External Borrowing

7.10 The Chief Finance Officer will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing. The Chief Finance Officer is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans and overdrafts

7.11 The Board of Directors will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Managing Director and the Chief Finance Officer.

7.12 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Managing Director or the Chief Finance Officer. The Board of Directors must be made aware of all short term borrowings at the next Board meeting.

7.13 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. All short-term borrowing requirements must be authorised by the Chief Finance Officer.

7.14 All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

Investments

7.15 Temporary cash surpluses may be held only in such public or private sector investments as authorised by the Board.

7.16 The Chief Finance Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

7.17 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

8. Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments

Income Systems

8.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection, and coding of all monies due.

8.2 The Chief Finance Officer is also responsible for the prompt banking of all monies received.

Fees and Charges

8.3 The Trust shall follow the financial regime as determined by the Department of Health.

8.4 The Chief Finance Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's "Commercial Sponsorship – Ethical standards in the NHS" shall be followed.

8.5 All employees must inform the Chief Finance Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

8.6 Contracts must confirm to the strategy and business plans of the Trust and shall be approved according to the limits specified at SFI Appendix 1.

Debt Recovery

8.7 The Chief Finance Officer is responsible for the appropriate recovery action on all outstanding debts.

8.8 Any potential write off of bad debt shall be processed through the losses and special payments process, and shall be authorised by the Chief Finance Officer or Deputy Chief Finance Officer. All write offs will be reported to the Audit Committee detailing the actions taken to recover the debt and the factors considered in making the decision to write off the debt.

8.9 Overpayments should be detected (or preferably prevented) and recovery initiated under normal procedures. Where overpayments have been made for 3 or more occasions and the individual or organisation is refusing to pay the Trust Local Counter Fraud Specialist should be consulted.

Security of Cash, Cheques and Other Negotiable Instruments

8.10 The Chief Finance Officer shall be responsible for:

a. Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
b. Ordering and securely controlling any such stationery;
c. The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
d. Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

8.11 Trust monies shall not, under any circumstances, be used for the encashment of private cheques or IOUs. All cheques, postal orders, cash, etc., shall be banked promptly and intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Finance Officer.

8.12 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in appropriate sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the depositors absolving the Trust from responsibility for any such loss.

8.13 All cheques must be dispatched to Financial Services. A record of all cheques received must be maintained at point of receipt before being despatched to Financial Services. A

list of these cheque details is to be sent to the Financial Services Manager.

Money Laundering

8.14 To minimise the risk of being used for money laundering purposes and avoid the need to comply with Money Laundering Regulations the Trust will not accept payment in cash exceeding £1000 for any single transaction other than in respect of funds banked on behalf of a patient who has been admitted with such funds.

9. Contracts for the Provision of Healthcare Services

Commissioning

9.1 The Board of Directors shall regularly review and shall at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services referred to in its Terms of Authorisation and related schedules.

9.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable legally binding agreements with service commissioners for the provision of NHS services. This responsibility has been delegated to the Chief Finance Officer who is responsible for commissioning NHS service agreements for the provision of services to patients in accordance with the Business Plan and for establishing the arrangements for non-contracted activity. In carrying out these functions, the Chief Finance Officer will pay due regards to:

a. The costing and pricing of services (in accordance with the National Tariff) and the activity / volume of services planned;
b. The standards of service quality expected;
c. Payment terms and conditions;
d. Amendments to NHS contracts and contracted activity;
e. The relevant national service framework, if any; and
f. Any other matters relating to contracts of a legal or non-financial nature.

Contract Pricing and Reporting

9.3 NHS contracts should comply with the most recent guidance from the DHSC and be so devised as to minimise risk whilst maximising the Trust‘s opportunity to generate income.

9.4 The Chief Finance Officer will need to ensure that regular reports are provided to the

Board detailing actual and forecast income from the contract. This will include information on costing arrangements; any pricing of NHS contracts at marginal cost must be undertaken by the Chief Finance Officer and reported to the Board.

9.5 The Chief Finance Officer must ensure that the process undertaken to cost procedures provided at the Trust as part of the annual reference cost collection adheres to the guidance published by the DHSC annually. The Trust's process must be reported to Audit Committee to provide assurance that the submission will accurately represent the cost of each procedure,

Content of Contracts

9.6 All agreements should aim to implement the agreed priorities contained within the relevant plans and wherever possible, be based upon integrated care pathways to reflect expected patient experience.

9.7 Where the Trust makes arrangements for the provision of services by non- NHS providers, the Managing Director is responsible for ensuring that the agreements put in place have due regard to the quality and the cost- effectiveness of the services provided.

9.8 Where the Trust enters into a relationship with another organisation for the supply or receipt of other services (clinical or non-clinical), the responsible Officer should ensure that an appropriate contract is present and signed by both parties. The Procurement team will provide professional advice on the structure and content on this type of contract and should approve the contract before being signed by the delegated Officer.

9.9 Contracts should be reviewed and agreed on an annual basis or as determined by the term of the agreement if shorter than one year so as to ensure value for money.

10. Tendering, quotation and contracting procedure

Duty of compliance

10.1 The procedure for awarding all contracts by or on behalf of the Trust shall comply with Trust SOs and SFIs.

10.2 Procurement and contracting shall be undertaken in accordance with all applicable UK procurement legislation and statutory guidance, including the Procurement Act 2023 and associated regulations, the Provider Selection Regime where applicable, and any directions or guidance issued by the Department of Health and Social Care or the Cabinet Office. These requirements shall have effect as if incorporated into these Standing

Orders and Standing Financial Instructions.

10.3 The Trust has policies and procedures in place for the control of all tendering activity carried out on behalf of the Trust.

10.4 The Trust shall comply as far as is reasonably practicable with the requirements of the latest DHSC guidance on capital investment and the procurement and management of consultants within the NHS.

Thresholds Tender Guide/Placing Contracts/Waivers

10.5 The Trust shall ensure that competitive tenders or quotations are invited for:

a. The supply of goods, materials and manufactured articles;
b. The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);
c. For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
d. Where the Trust elects to invite bids for the supply of healthcare services these SOs and SFIs shall apply as far as they are applicable to the respective competitive exercise.

10.6 The following table outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

10.7 Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract and include the whole life costs, not the annual value and should not seek to circumvent public sector procurement regulations.

10.8 For the purpose of these SFI's the definition of a Contract is a voluntary, deliberate, and legally binding agreement between two or more competent parties. Contracts are usually written but may be spoken or implied, and generally have to do with employment, sale or lease, or tenancy.

10.9 A contractual relationship is evidenced by (1) an offer, (2) acceptance of the offer, and a (3) valid (legal and valuable) consideration. Each party to a contract acquires rights and duties relative to the rights and duties of the other parties. However, while all parties may expect a fair benefit from the contract (otherwise courts may set it aside as inequitable) it does not follow that each party will benefit to an equal extent.

10.10 Where the opportunity has been advertised the Trust may shortlist suppliers, via a transparent supplier selection process, to take forward to the next stage of the procurement process.

10.11 Threshold limits represent the contract's lifetime value (e.g. a 5 year contract of £25,000 per year requires £125,000 method, sign off and authorisation).

10.12 The cumulative amount spent with the supplier over a rolling 12 month period (e.g. 5 separate spends of £5k each will trigger the appropriate procurement process in line with the values above).

10.13 In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the Contract Recommendation Report (CRR).Where market engagement outcomes meet the criteria set out above, this shall be recorded within the CRR and no separate Waiver (STA/STW) approval is required

10.14 Authorisation to sign a Contract and recommendation report requirements are detailed in Table below.

Financial Limits for the Procurement Process & Placing Contracts

10.15 Under no circumstances should any member of the Trust sign and authorise a Contract from a supplier unless they are permitted under SFI's to do so as detailed in this Table.

Contract Value Thresholds and Approval Requirements Table

Contract value excl. VAT	quotes / tenders	Min number invited to quote / tender where available	Form of Contract	CRR required	Authorisation to approve CRR	Authority to sign a contract
<10k	Quotation may be obtained by end user	1	PO	No	NA	Associate Director of Procurement
>10k - 24,999k	Quotations may be obtained by end user - CRR & Procurement Act 2023 notices issued by procurement	2	PO	No	NA	Associate Director of Procurement
25 - 149,999k	Quotations obtained by Procurement - CRR & Procurement Act 2023 notices issued by procurement	3	Purchase Order and/or contract, as appropriate to the procurement	yes - Level 1 CRR	Associate Director of Procurement	Associate Director of Procurement
150 - 499k	Tender by procurement	4	Purchase Order or contract, as appropriate to the procurement	Yes - Level 2 CRR	Director of Procurement	Director of Procurement
500 - 999k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 2 CRR	Care Organisation Finance Lead	Care Organisation Finance Lead
1,000 - 1,499k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 2 CRR	Group CFO or Managing Director	Group CFO or Managing Director
1,500 - 1,999k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 3 CRR	Group CFO	Group CFO or Group CEO
>2,000k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 3 CRR	Board	Group CEO / Board Chair

10.16 The Managing Director, Chief Finance Officer, Director of Procurement, Associate Director of Procurement, and Chief Pharmacist are authorised to sign and enter into contracts on behalf of the Trust, subject to their delegated limits as set out in the above table.

This authority applies only where a valid Contract Approval Document (Contract Recommendation Report) has been approved by the relevant Executive Director or the Trust Board Chair.

The Chief Pharmacist's authority to sign contracts is limited to pharmaceutical contracts only.

10.17 The Managing Director shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract.

Electronic Tendering

10.18 All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal. This requirement applies to formal competitive procurement exercises as defined in the Contract Value Thresholds and Approval Requirements table

10.19 All tendering carried out through e-tendering will be compliant with the Trust policies and procedures as set out in SFIs 10.2 – 10.13 Issue of all tender documentation should be undertaken by the Procurement Department electronically through a secure website with controlled access using secure login, authentication and viewing rules.

10.20 All tenders will be received into a secure electronic vault so that they cannot be accessed until an agreed opening time. Where the electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

Manual Tendering – General Exception Rules

10.21 No tenders should be conducted manually unless there is a clear valid exception that is signed off by the Director of Procurement. All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

a. A plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender);

Or

b. In a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

10.22 Every tender for goods, materials or manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 7.5.

10.23 Where appropriate tenders for building and works, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or NEC 3 form of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers.

10.24 Every tender for goods, materials, services (including consultancy services) or disposals shall embody the NHS Standard Contract Terms and Conditions as are applicable. Every supplier must have given a written undertaking not to engage in collusive tendering or other restrictive practice.

Receipt, Safe Custody and Record of Formal Tenders submitted manually

10.25 All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified in the Contract Value Thresholds and Approval Requirements Table

10.26 The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

10.27 The appropriate officer shall designate an officer or officers, not from the originating department, to receive tenders on his/her behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with SFI 10.7.

Opening Formal Tenders

10.28 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened either electronically or if manually by two officers designated by the officer as appropriate.

10.29 Every tender received shall be stamped with the date of opening and if manually opened they shall be initialled by two of those present at the opening.

10.30 A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

a. The names of firms/individuals invited;
b. The names of and the number of firms/individuals from which tenders have been received;
c. The total price(s) tendered;

d. Closing date and time;
e. Date and time of opening; and
f. The persons present at the opening shall sign the record, where a manual process has been conducted.

10.31 Except as in the paragraph below, a record shall be maintained of all price alterations on tenders, i.e. where a price has been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be logged and where a manual process has been conducted it should be initialled by two of those present at the opening.

10.32 A report shall be made in the record if, on any one tender, price alterations are considered so numerous as to render the procedure set out in the paragraph above unreasonable.

Admissibility and Acceptance of Formal Tenders (Electronically & Manually)

10.33 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Finance Officer, Director of Procurement or nominated officer. All decisions should be recorded in line with the procurement process.

10.34 Tenders received after the due time and date may be considered only if the Chief Finance Officer or Director of Procurement or nominated officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Finance Officer, or nominated officer, shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting. All decisions in relation to tenders received after the due time and date should be recorded in the procurement log.

10.35 Technically late tenders (i.e. those despatched in good time but delayed through no fault of the supplier) may at the discretion of the Chief Finance Officer or nominated officer be regarded as having arrived in due time. A record supporting this decision should be recorded in the procurement log.

10.36 Materially incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the supplier upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under SFI 10.33.

10.37 Where examination of tenders reveals a need for clarification, the supplier is to be given details of such clarifications and afforded the opportunity of confirming or withdrawing his offer.

10.38 Necessary discussions with a supplier of the contents of their tender, in order to elucidate technical points etc., before the award of a contract, will not disqualify the tender.

10.39 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Finance Officer.

10.40 Where only one tender/quotation is received the Director of Procurement /nominated officer (within delegated limits) shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

10.41 All tenders shall be evaluated on the basis of Most Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

10.42 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Managing Director or nominated officer (within Contract Value Thresholds and Approval Requirements Table)

10.43 All tenders should be treated as confidential and should be retained for inspection.

Extensions to Contract

10.44 In all cases where optional extensions to contract are outlined at the time of tendering, in the recommendation report, the authority to approve contract extensions is given to the Director of Procurement up to the value of the original contract (including formally agreed variations).

Quotation & Tendering Procedures

10.45 Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified with Contract Value Thresholds and Approval Requirements Table.

10.46 Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in Contract Value Thresholds and Approval Requirements Table

10.47 Tender documents will be issued by procurement on behalf of the Trust. Procurement will arrange for them to be opened in accordance with the SFIs of the Trust.

10.48 No tender shall be considered which bears any mark or name indicating the sender.

10.49 Where the total contract value exceeds £25,000, the Trust shall ensure that appropriate transparency and advertising requirements are met in accordance with applicable UK procurement legislation and statutory guidance, including publication of required notices on the Central Digital Platform or other prescribed portals. The Trust must also ensure that contract award information is published where required. Transparency requirements apply below statutory thresholds, but they do not, on their own, trigger a requirement to run a competitive procurement.

10.50 Where the total contract value exceeds the relevant statutory procurement thresholds, the Trust is committed to conducting a legally compliant procurement process in accordance with applicable UK procurement legislation, including the Procurement Act 2023 and associated regulations, or the Provider Selection Regime where applicable.

10.51 Where appropriate, pharmacy orders must be placed against nationally or regionally/divisionally agreed pharmacy contracts, which should cover the majority of Pharmacy Department activity, and the Chief Pharmacist is responsible for signing pharmaceutical contracts on behalf of the Trust in accordance with delegated authority.

10.52 Tender lists for building and engineering works will be compiled from “Construction line” the Trust’s approved list of Contractors.

10.53 Where there is a wide discrepancy between the estimate and / or approved funding and the final total tendered cost involving an increase in expenditure this is to be reported to the Chief Finance Officer for further instructions.

10.54 The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in Contract Value Thresholds and Approval Requirements Table

10.55 Quotation/tenders will be completed accordance with these SFIs.

10.56 Adjudication must be made in accordance with SFI 10.33 to 10.43 a recommendation report shall be prepared by procurement for approval or to seek authorisation, according to delegated limits.

10.57 Acceptance of the tender/quotation must comply with the financial limits set out in Contract Value Thresholds and Approval Requirements Table. All contract documentation must be finalised promptly (ideally prior to the commencement of the contract) after the award of contact.

10.58 The waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee regularly.

Quotation & Tendering Procedures Summary – Contracts

10.59 Competitive quotation/tenders will be obtained for all items according to the financial limits specified in Contract Value Thresholds and Approval Requirements Table

10.60 Any selection or pre-qualification stage shall be conducted in accordance with applicable UK procurement legislation and statutory guidance, including the Procurement Act 2023 and associated regulations, with requirements being proportionate and limited to the supplier's capacity and capability to perform the contract.

10.61 Where goods, services, disposals and/or capital works are to be supplied over a period of time, the values listed must be taken as the value of the contract, not the annual value and should not seek to circumvent public sector procurement regulations. Appropriate contractual arrangements will be required for all Waiver(STA/STW) over £25,000 as per Contract Value Thresholds and Approval Requirements Table

10.62 Quotations/ tenders shall be invited for all purchases over a period of time in line with Contract Value Thresholds and Approval Requirements Table.

10.63 Quotations/ tenders will be issued in accordance with these SFI's and shall incorporate standard NHS Terms and Conditions of Contract or applicable building works and capital projects terms and conditions such as JCT and NEC.

10.64 After tenders/quotations have been opened, procurement will arrange for adjudication of the tenders/quotations. Adjudication must be made in accordance with SFI 10.33 to 10.43.

10.65 A Recommendation Report prepared by the Procurement Team should be submitted for approval or to seek authorisation as per Contract Value Thresholds and Approval Requirements Table according to delegated limits.

10.66 All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit Committee regularly highlighting all waivers over £10,000 in line with waivers approved by the Chief Finance Officer or Nominated Officer (Site Director of Finance)

10.67 All competitive quotations and tenders shall be conducted through the Trust's e-tendering portal in accordance with applicable UK procurement legislation and transparency requirements All Trust quotation/tenders or waivers over £25,000 in value must result in a signed contract between the supplier and the Trust under agreed terms and conditions, clear specifications and KPI's where appropriate. These will be retained through the Trust Procurement Source to Contract System. Any exceptions to this are at

the discretion of the Director of Procurement.

Waiving or Variation of Competitive Tendering/Quotation Procedure

10.68 Appropriate contractual arrangements will be required for all Waivers (STA/STW) over £25,000 as per Contract Value Thresholds and Approval Requirements Table

10.69 In circumstances after market engagement has been conducted, where the specified number of quotations/tenders cannot be obtained (e.g. where there is a limited number of suppliers), the reasons for receiving a lower number of quotations/tenders must be recorded in the recommendation report and in this event a Waiver (STA/STW) will not be required.

10.70 Formal competition need not be applied (and therefore a Waiver (STA/STW) is not required) where:

a. The estimated expenditure does not, or is not reasonably expected to, exceed the Contract value set out in Contract Value Thresholds and Approval Requirements Table
b. The supply is proposed under special arrangements negotiated by the Department of Health, which the Trust is required by the Independent Regulator to comply with
c. The requirement is covered by an existing contract, and the additional expenditure does not either constitute a material difference (e.g. change of scope, or increase in value of 20% of more), or result in a shift in the economic balance of the contract in favour of the contractor
d. The expenditure relates to agency pay however internal governance and authorisation will apply
e. National public sector or NHS agreements including NHS Supply Chain are in place and have been approved by the Department of Health
f. A direct award to a supplier on a national or regional framework is permissible and recommended according to the rules of the framework. On these occasions a recommendation report will require authorisation in accordance with Contract Value Thresholds and Approval Requirements Table the Trust will be required to demonstrate in the report, with supporting evidence, that a direct award offers value for money and is in the best interests of the Trust

g. Attendance at seminars, conferences, training, or participation in mandatory accreditation, quality assurance schemes or similar unique events
h. A consortium arrangement is in place, and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members

i. A commissioning body is market testing the whole business to ensure value for money and the Trust requires a partner or subcontractor to respond to the invitation to tender. The selection of the partner by the Trust need not be separately competed

j. The requirement is for the securing of a named individual on a temporary basis to fulfil a role and where substitution of another resource is not acceptable. In this case this does not constitute a procurement, but the nominated Officer must still ensure value for money

Applicability of SFIs on Tendering and Contracting to funds held on trust

10.71 These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's funds held on trust and private resources.

10.72 Where a requirement has been identified for goods and services to be paid for by charitable funds additional authorisation is required from the Charities and Technical Accountant.

10.73 The Charities and Technical Accountant will ensure that the particular fund in question has had a spending plan for the relevant financial year submitted and approved by the Charities Committee. In the instance where no plan has been approved, the request will be returned to the relevant department.

10.74 Tenders funded by charitable monies must be carried out in accordance with the Procurement Act 2023 and associated regulations. The appropriate procurement route and applicable threshold will be determined by the nature and total value of the project.

Financial Standing and Technical Competence of Suppliers

10.75 The Chief Finance Officer may make or organise any enquiries they deem appropriate concerning the financial standing and financial suitability of Suppliers. The Delegated Officer with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

10.76 If in the opinion of the Chief Finance Officer or Delegated Officer, with lead responsibility for clinical governance, specialist services or skills are required then appropriate checks must be carried out as to the technical and financial capability of those suppliers that are invited to tender.

Governance

10.77 Separation of Duties: The principles of public accountability require a total separation of the responsibilities of finance staff and purchasing staff. For this reason, finance staff are not permitted to raise orders; neither are they permitted to authorise the payment of orders without the necessary signatures. Equally, procurement staff are not permitted to authorise the payment of invoices other than from their own management budgets.

11. Terms of Service, Allowances and Payment of Members of the Board and Employees

Board of Directors Nominations and Remuneration Committee

11.1 The Board of Directors has constituted a Nominations and Remuneration Committee to be responsible for identifying and nominating for appointment, candidates to fill executive director posts, and with approval by the Council of Governors, to fill the position of Managing Director. The Committee is also responsible for determining the Chief Executive, Managing Director, and Executive Directors' level of remuneration.

11.2 Full details of the responsibilities of the Board of Directors Nominations and Remuneration Committee are included in the Scheme of Reservation and Delegation.

11.3 The Committee shall report in writing to the Board its decisions and the basis for its recommendations.

Council of Governors' Nominations and Remuneration Committee;

11.4 The Council of Governors has constituted a Nominations and Remuneration Committee to be responsible for identifying and nominating for appointment, candidates to fill Non-Executive Director (including the Chair) posts as and when they arise. The Committee's recommendation(s) for appointments are referred to the full Council of Governors for approval. The Committee shall recommend to the full Council of Governors, the level of remuneration for the Chair and Non- Executive Directors.

11.5 Full details of the responsibilities of the Council of Governors Nominations and Remuneration Committee are included in the Scheme of Reservation and Delegation.

Funded Establishment

11.6 The manpower plans incorporated within the annual budget will form the funded establishment.

11.7 The funded establishment of any department may not be increased without the approval of the Chief Finance Officer.

Staff Appointments

11.8 No Director or Officer may engage, re-engage or re-grade Officers, re- deploy either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

11.9 Authorised to do so by the Managing Director or the Chief Finance Officer;

11.10 Within the limit of his approved budget and funded establishment as defined in the Scheme of Delegation;

11.11 All changes with a financial impact have been through the appropriate Divisional process for authorisation.

11.12 Divisional management shall maintain good controls with regards staff appointments to ensure each department remain within their delegated budgetary limits.

11.13 All appointments must adhere to the Trust Recruitment and Selection Policy.

11.14 The Board will approve procedures presented by the Managing Director for the determination of commencing pay rates, condition of service, etc., for employees.

11.15 Managers will ensure that all new employees and bank workers have produced the relevant documentation and completed the relevant signing on procedure with People Directorate prior to starting.

11.16 The People Directorate shall be notified immediately upon the effective date of any change in state of employment or personal circumstances of an employee being known.

11.17 All time records, pay sheets, and other pay records and notifications shall be in a form approved by the Trust Executive and shall be certified and submitted in accordance with agreed instructions.

11.18 The Chief Finance Officer shall devise and maintain a system of establishment controls which shall include regular reports to each manager on the staff in post in their departments.

Contracts of Employment

11.19 The Board shall delegate responsibility to a manager for:

a. ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
b. dealing with variations to, or termination of, Contracts of Employment.

Processing Payroll

11.20 The Chief Finance Officer is responsible for:

a. Specifying timetables for submission of properly authorised time records and other notifications;
b. The final determination of pay;
c. Making payment on agreed dates; and
d. Agreeing method of payment.

11.21 The Chief Finance Officer will issue instructions regarding:

a. Verification and documentation of data;
b. The timetable for receipt and preparation of payroll data and the payment of employees;
c. Maintenance of subsidiary records for superannuation, income tax, national insurance and other authorised deductions from pay;
d. Security and confidentiality of payroll information;
e. Checks to be applied to completed payroll before and after payment;
f. Authority to release payroll data under the provisions of the Data Protection Act;
g. Procedures for payment by bank credit to employees
h. Procedures for the recall of bank credits;
i. Pay advances and their recovery;
j. The recovery of salary overpayments;
k. Maintenance of regular and independent reconciliation of pay control accounts;
l. Separation of duties for preparing records and handling cash; and
m. A system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

11.22 Appropriately nominated managers have delegated responsibility for:

a. Submitting time records, and other notifications in accordance with agreed timetables;

b. Completing time records and other notifications in accordance with the Chief Finance Officer instructions and in the form prescribed by the Chief Finance Officer; and
c. Submitting termination forms in the prescribed form immediately upon knowing the effective date of any employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Payroll Department must be informed immediately.

11.23 Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that a suitable arrangement is made for the collection of payroll deductions and payment of these to appropriate bodies.

11.24 The Chief Finance Officer shall ensure adequate internal controls and audit review procedures are in place, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.25 Managers and employees are jointly responsible and accountable for ensuring claims for pay and expenses are timely, correct and any under or over payments are highlighted as soon as discovered.

12. Terms of Service, Allowances and Payment of Members of the Board and Employees

Delegation of Authority

12.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Finance Officer will determine the level of delegation to Budget Managers.

12.2 The Council of Governors will need to be consulted on significant transactions which the Trust are obliged to report to NHS England prior to entering the transaction. Such transactions may take the form of Assets, Income or capital as set out in Annex 9 of the Trust constitution.

12.3 Organisational transactions that meet the following criteria must be reported to NHS England:

a. Most mergers and acquisitions as well as larger capital investment projects and property transactions, and potentially some major service contracts. Potential transactions

should be reported if the ratio of the gross assets, income or consideration attributable to the transaction exceeds 10% of the trust's gross assets, income or total capital respectively.

b. A transaction that could be reviewed by the Competition and Markets Authority (under the Enterprise Act 2002).
c. A statutory transaction.

12.4 The Chief Finance Officer will set out:

a. The list of managers who are authorised to place requisitions/orders for the supply of goods and services
b. The maximum financial level for each requisition/order and the system for authorisation above that level (see Appendix 1).
c. The Chief Finance Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

Choice, Requisitioning, Ordering, Receipt And Payment For Goods And Services

Requisitioning

12.5 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice from Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Managing Director) shall be consulted.

System of Payment and Payment Verification

12.6 All goods and services must be supported by an approved requisition and purchase order before being ordered or supplied. Ordering without a purchase order is only permitted for specific, pre-approved categories (e.g. agency staff or utilities). Any other non-compliant spend will be treated as unauthorised

12.7 The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. For the avoidance of doubt, all contract-based expenditure must be supported by either an approved purchase order or an approved contract mechanism authorised by Finance

12.8 The Chief Finance Officer will:

a. Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; once approved, the thresholds are incorporated in these SFIs and regularly reviewed;
b. Prepare procedural instructions (where not already provided in the Scheme of

Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds;

c. Be responsible for the prompt payment of all properly authorised accounts and claims as per the current Department of Health guidance;
d. Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).
e. Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

   i. **Authorisation:** A list of directors/employees authorised to certify invoices and the expenditure that has been authorised.
   ii. **Certification** that:

      - Goods have been duly received, examined and are in accordance with specification and the prices are correct;
      - Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
      - In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the timesheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined and are reasonable;
      - Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
      - The account is arithmetically correct;
      - The account is in order for payment.

   iii. **Payments and Creditors**: A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts for otherwise requiring early payment.

   iv. **Financial Procedures**: Instructions to employees regarding the handling and payment of accounts within the Finance department.

Prepayments

12.9 Prepayments are only permitted where exceptional circumstances apply. In such instances:

a. Prepayments are only permitted where the financial advantages outweigh the

disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

b. The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments.
c. There are adequate administrative procedures to ensure that where payments in advance are made the goods or services are received or refunds obtained.
d. The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed.

12.10 The Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Managing Director if problems are encountered.

Duties of Managers and Officers

12.11 Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

a. Official orders must be made electronically in accordance with the Scheme of Delegation set out in Appendix 1.
b. all contracts (except as otherwise provided for in the Scheme of Delegation and the associated Limits of Delegation Policy), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;
c. All contracts above the specified thresholds must be advertised and awarded in accordance with this policy and applicable UK procurement legislation.
d. For all contracts with a single supplier whose value exceeds £2m p.a. the lead officer within the Trust shall be designated as the "contract owner" for that contract and shall:-

    i. Ensure the contract is entered on the central contact register maintained by the Procurement & Supply Chain department.
    ii. Ensure that all contract documentation is lodged with the Procurement & Supply Chain department (a copy may also be retained within the originating department for administrative convenience).

    iii. Ensure appropriate contract management is in place.
    iv. Ensure that any significant change to the contract/service is formally agreed and documented as required by the SFI's or Limits of Delegation Policy and current Procurement regulation

e. where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health / NHS England; this is available from the central procurement team on request.
f. no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
g. isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
h. conventional hospitality, such as lunches in the course of working visits in accordance with the Trusts hospitality policy;

12.12 **(This provision needs to be read in conjunction with paragraph 33 of the Constitution and the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff");**

a. no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Managing Director;
b. all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash (subject to the petty cash limit – see scheme of delegated limits) .
c. when commissioning consultancy provision, with a total value exceeding £50,000 (inclusive of VAT and all associated costs), including where this threshold is reached through a contract extension or variation will require prior approval from NHSE. Applies only to contracts accounted for as revenue expenditure
d. verbal orders must only be issued very exceptionally - by an employee designated by the Managing Director and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

i. orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
ii. goods and services are not taken on trial, pilot or loan in circumstances that could commit the Trust to a future uncompetitive purchase; procurement advice should be sought
iii. changes to the list of employees and officers authorised to certify invoices are notified to the Chief Finance Officer;
iv. purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by Chief Finance Officer;
v. petty cash records are maintained in a form as determined by the Chief Finance Officer.
vi. Appropriate segregation of duties shall be maintained. While the requisitioner and goods receiver may be the same individual, no individual shall raise a requisition, receipt goods or services, and certify an invoice for payment. System controls prevent self-approval.
vii. The financial limits for officers' approval of payments are set out in the Scheme of Delegated limits
viii. Under no circumstances should goods be ordered through the Trust for personal

or private use.

12.13 The Chief Finance Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and HBN00-08 (formally ESTATECODE). The technical audit of these contracts shall be the responsibility of the relevant Director.

13. Wholly Owned Subsidiaries, Hosted Bodies, Partnerships and Collaborations

Wholly Owned Subsidiaries

13.1 Subsidiary companies are separate, distinct legal entities for commercial purposes and have distinct taxation, regulatory and liability obligations. As a separate, independent company, wholly owned subsidiaries are subject to their own governance arrangements, which are the responsibility of the subsidiary's board of directors, and therefore these Standing Financial Instructions are not applicable. Reference to the subsidiary's documentation will need to be made.

Hosted Bodies, Partnerships and Collaborations

13.2 Hosted bodies are organisations for which the Trust provides services under a service level agreement (SLA). The arrangements for administration of hosted bodies are managed by the Contracts Team.

13.3 Partnerships are organisations for which the Trust, in conjunction with other organisations, creates another separate entity under a Member's Agreement. These agreements are also managed by the Contracts Team

13.4 Dependent on the terms of the SLA, memorandum of understanding etc. these standing financial instructions may or may not be applicable. Individual SLAs, memorandum of understanding etc. should be referred to on a case-by-case basis.

14. External Borrowing, Public Dividend Capital and Investments

Public Dividend Capital (PDC)

14.1 The Accounting Officer is responsible for ensuring that the Trust pays annually to the

Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time by the Secretary of State in accordance with the 2006 Act and the Regulatory Framework.

14.2 The Trust will comply with the guidance on dividend payments in the DHSC Group Accounting Manual.

Other External Borrowing

14.3 The Trust may borrow money for the purposes of, or in connection with, its strategic objectives and its operational functions.

14.4 The total amount of the Trust's borrowing must be affordable within NHS England's risk framework and the related ratings.

14.5 Any application for a loan or overdraft facility must be approved by the Board of Directors, and will only be made by the Chief Finance Officer, or a person with specific delegated powers from the Chief Finance Officer.

14.6 All borrowing must be consistent with the plans outlined in the current Trust Business Plan approved by the Board.

Investments

14.7 The Trust may invest money for the purposes of its strategic objectives and operation functions. NHS England guidance is to be followed

14.8 The Audit Committee shall set the investment policy and oversee all investment transactions by the Trust. The Chief Finance Officer must ensure compliance with this policy at all times.

14.9 The Chief Finance Officer is responsible for advising the Board on investments and shall periodically report the performance of all investments held, to the Board through the Audit Committee.

14.10 The Chief Finance Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

15. Capital Investment, Private Financing, Fixed Assets and Security of Assets

Capital Investment

15.1 The Trust will establish a Capital Prioritisation and Management Group (CPMG) to:

a. Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon Business Plans;
b. Be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
c. Ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including depreciation and interest payable.

15.2 For every significant capital expenditure proposal CPMG shall ensure that a business case is produced setting out:

a. An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
b. An appropriately detailed analysis of expenditure and income flows anticipated, including documented responses from purchasers as appropriate, where significant a risk analysis testing the assumptions made;
c. Appropriate project management and controls are in place;
d. The involvement of appropriate Trust personnel and external agencies; and
e. Clear objectives that can be reviewed and measured as part of the post project evaluation (PPE), along with a date when the PPE will be completed.
f. That the Chief Finance Officer has certified professionally to the costs (including full VAT liability) and revenue consequences detailed in the business case.

15.3 Capital business cases shall be approved as follows:

a. Commitment of expenditure up to £250,000: Capital Prioritisation and Management Group;
b. Commitment of expenditure in excess of £250,000 and up to £1,000,000: Management Committee; and
c. Commitment of expenditure in excess of £1,000,000: Board of Directors.

The values quoted above are inclusive of VAT.

15.4 For capital schemes where the contracts stipulate stage payments, the Chief Finance Officer will issue procedures for their management. The Chief Finance Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.5 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme. The Chief Finance Officer shall issue to the Manager responsible for any scheme:

a. Specific authority to commit expenditure;
b. Authority to proceed to tender; and
c. Approval to accept a successful tender.

15.6 The Managing Director will issue a Scheme of Delegation for capital investment management.

15.7 The Chief Finance Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

15.8 The Chief Finance Officer shall assess on an annual basis the requirement for the operation of the "Construction Industry Scheme" in accordance with any guidance issued by HM Revenue and Customs.

Private finance

15.9 Proposals to use private sector finance for capital schemes need to be approved by CPMG prior to requesting approval by the Board of Directors. Both CPMG and the Board of Directors should be satisfied that the use of private finance represents value for money and genuinely transfers risk to the private sector as appropriate.

Asset registers

15.10 The Chief Finance Officer is responsible for the maintenance of registers of assets, and arranging for a physical check of assets against the asset register to be conducted once a year.

15.11 The Chief Finance Officer shall prepare procedural instructions on the disposal of assets.

15.12 The Trust will maintain an asset register recording fixed assets. As a minimum, the data set to be held within these registers shall be as specified in the Group Accounting Manual

as issued by NHS England.

15.13 Additions to the fixed asset register must be clearly identified to a scheme which will in turn have an identified and appropriate budget holder / project manager and be validated by reference to:

a. Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
b. Stores, requisitions and wages records for own materials and labour including appropriate overheads; and
c. Lease agreements in respect of assets held under a finance lease and capitalised.

15.14 Where capital assets are sold, scrapped, lost or otherwise disposed of, theirvalue must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). It is the responsibility of the appropriate manager to inform the Chief Finance Officer that an asset is to be disposed of.

15.15 The Chief Finance Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

15.16 The value of each asset shall be depreciated using methods and rates as specified in the Group Accounting Manual issued by the DHSC.

Security of assets

15.17 The overall control of fixed assets is the responsibility of the Chief Executive.

15.18 Asset control procedures (including fixed assets, cash, cheques, negotiable instruments and donated assets) must be approved by the Chief Finance Officer. This procedure shall make provision for:

a. Recording managerial responsibility for each asset;
b. Identification of additions and disposals;

c. Identification of all repairs and maintenance expenses;
d. Physical security of assets;
e. Periodic verification of the existence of, condition of, and title to, assets recorded;
f. Identification and reporting of all costs associated with the retention of an asset; and
g. Reporting, recording and safekeeping of fixed assets, cash, cheques and negotiable instruments.

15.19 All significant discrepancies revealed by verification of physical assets to fixed asset registers shall be notified to the Chief Finance Officer.

15.20 Whilst each Officer has a responsibility for the security of property of the Trust, it is the responsibility of Directors and Senior Officers in all disciplines to apply appropriate routine security practices in relation to Trust property. Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

15.21 Where practical, assets should be marked as "Trust Property".

15.22 Any employee wishing to use Trust assets for private use must comply with the Trust's policies. The use of Trust assets for these purposes must not impact negatively on the services provided for NHS patients, both operationally and financially.

16. Property (Land and Buildings)

16.1 Significant changes relating to the Trust's Estate must receive the prior approval of CPMG and the Board of Directors.

16.2 The following matters related to property must be approved by the Trust Board:

a. Estates Strategy;
b. Acquisition of freehold property over £100,000 (including VAT); and
c. Acquisition of property where the total value of the agreement is over £100,000 (including VAT) by means of as lease, whether it is deemed to be an operating or finance lease.

16.3 Property purchases, licenses and leases up to £250,000 each (including VAT) may be authorised by CPMG, provided that they fall within the Board's approved Estates Strategy and that the costs are within 10% of an independent valuation.

16.4 The detail of required in any property report to the Board of Directors should be determined by the materiality of the purchase or lease payments and any contentious issues, and must contain:

a. Details of the purchase or lease payments;
b. Details of the period of the lease;
c. Details of the required accounting treatment;
d. Annual running costs of the property;

e. Funding sources within the Trust of both capital and revenue aspects of the acquisition;
f. The results of property and ground surveys;
g. Professional advice taken and the resultant cost;
h. Details of any legal agreement entered into;
i. Any restrictive covenants that exist on the property; and
j. Planning permission.

16.5 Any property acquisition should be in accord with Estate code, the Department of Health and Social Care guidance.

16.6 The contracts to acquire the property must be signed by two Executive Directors, one of whom must be the Chief Executive or Managing Director.

16.7 Board of Directors approval must be obtained for the disposal of any property over £100,000 (including VAT) which is recorded on the balance sheet of the Trust, A business case must be presented to the Trust which must include:

a. The proceeds to be received;
b. Any warrants or guarantees being given; and
c. Independent valuations obtained.
d. The disposal must be effected in full accord with Estate code.
e. Disposals of protected assets require the approval of NHS England

16.8 Major divestments as defined in the Foundation Trust Compliance Framework require the approval of NHS England.

16.9 The granting of property leases by the Trust must have Board approval where the annual value of the lease in in excess of £250,000.

17. Inventory and Receipt of Goods

General

17.1 Inventory stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a. Kept to a minimum practical level;
b. Subjected to regular stock take – perpetual and/or annual
c. Valued at the lower of cost and net realisable value;
d. Controlled on a First In First Out (FIFO) logic wherever possible, and

e. Be kept as secure as practically possible.

17.2 The cost of inventory shall be determined on the FIFO basis, and shall be the purchase price without overhead, but include VAT where this cannot be reclaimed on purchase.

Control of Stores and Stocktaking

17.3 Subject to the responsibility of the Chief Finance Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Managing Director. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Finance Officer. The control of pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer, the control of fuel oil by a designated Estates Manager.

17.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/pharmaceutical officer. Wherever practicable, stocks should be marked as Trust property.

17.5 The Chief Finance Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

17.6 Stocktaking arrangements shall be agreed with the Chief Finance Officer and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one officer other than the storekeeper, and a member of the Finance Department shall be invited to attend.

17.7 Any surplus or deficiencies revealed on stocktaking shall be reported to the Chief Finance Officer and correctly reflected in the accounts.

17.8 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Finance Officer.

17.9 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Chief Finance Officer for a review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles. The designated Officer shall report to the Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice (see also SFI 18, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

17.10 Breakages and other losses of goods in stock shall be recorded as they occur.

17.11 Inventory that has deteriorated, or are not usable for any other reason for their intended purposes, or may become obsolete, shall be written down to their net realisable value. The write down shall be approved by the Chief Finance Officer and recorded.

17.12 It is a duty of officers responsible for the custody and control of inventory to notify all losses, including those due to theft, fraud and arson, in accordance with SFI 18.

Goods supplied by NHS Supply Chain

17.13 The authorised person shall check receipt against the delivery note and report any exceptions to the delegated officer as approved by the Chief Finance Officer. The delegated officer will be responsible for satisfying himself that the goods have been received before accepting the recharge.

18. Disposals and Condemnations, Losses and Special Payments

Disposals and Condemnations

18.1 The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations and capital assets, and ensure that these are notified to managers.

18.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will:

a. Establish whether it is needed elsewhere in the Trust
b. Determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.

18.3 All unserviceable articles shall be:

a. Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer; and
b. Recorded by the condemning officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of.

c. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.

18.4 The Condemning Officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

Losses and Special Payments

18.5 The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments in accordance with the DHSC Group Accounting Manual and prepare a register. The Chief Finance Officer must ensure that a Counter Fraud Policy is in place that sets out the action to be taken both my persons detecting a suspected fraud and those persons responsible for it investigating it.

18.6 In cases involving suspected fraud, the Chief Finance Officer must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

18.7 Any employee discovering or suspecting a loss of any kind must immediately act according to the Trusts Counter Fraud and Corruption Policy.

18.8 Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the LCFS and/or NHS Counter Fraud Authority (NHSCFA) in accordance with NHS Standard Contract and NHSCFA Standards for Providers: Fraud, Bribery and Corruption.

18.9 The Chief Finance Officer must notify the NHS Counter Fraud Authority and the External Auditor of all frauds, and monitor compliance with the NHS Standard Contract and with any other instructions issued by NHS Counter Fraud Authority.

18.10 The Directorate or Service Manager shall inform the Chief Finance Officer of all other losses or recoveries of losses so that they can be entered in the losses and special payments register.

18.11 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:

a. The Board, and
b. The External Auditor.

18.12 Within limits delegated to it by the Board, the Chief Finance Officer shall approve the

writing off of losses.

18.13 The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in personal and company insolvencies.

18.14 For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.

18.15 The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write off action is recorded.

18.16 All losses and special payments must be reported to the Audit Committee annually.

19. Information Technology

Responsibilities and duties of the Chief Finance Officer

19.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised data of the Trust, shall:

a. Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act and UK GDPR;
b. Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;
c. Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment and have relevant technical and organisational security measure in place, including data security measures, disaster recovery and back-up arrangements;
d. Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as may be considered necessary are being carried out;

19.2 Ensure that any personal data breach under the UK GDPR or the Data Protection Act 2018, or any other incident required by law to be reported, is reported to the Information Commissioner's Office;

a. Prepare and maintain an IT strategy and Cyber Security strategy for regular approval by the Management Board; and

b. Ensure that all purchases of hardware/software are in compliance with the Trust's IT strategy.

System Development

19.3 The Chief Finance Officer shall be satisfied that new computer systems (including finance systems) and amendments to current systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

19.4 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of NHS bodies in the local health economy or nationally wish to sponsor jointly) all responsible Directors and employees will send to the Chief Finance Officer:

a. Details of the outline design of the system;
b. In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

19.5 The Chief Finance Officer shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

Contracts for Computer Services with other health bodies or outside agencies

19.6 The Chief Finance Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

19.7 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

19.8 The Chief Finance Officer will ensure that relevant security details are provided in the contract in line with UK GDPR requirements and the Data Protection Act 2018. A Data

Protection Impact Assessment (DPIA), Data Processing Agreement or an Information Sharing Agreement (ISA) if required, will be undertaken with the support of the Information Governance Team.

Risk Assessment

19.9 The Chief Finance Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

Requirements for Computer Systems which have an impact on corporate financial systems

19.10 Where computer systems have an impact on corporate financial systems the Chief Finance Officer shall need to be satisfied that:

a. Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
b. Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
c. Finance staff have access to such data;
d. Have adequate controls in place; and
e. Such computer audit reviews as are considered necessary are being carried out.

20. Patients' Property

20.1 The Trust has a responsibility to provide safe custody for money and other Personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival. This includes items of daily living such as glasses, false teeth, hearing aids etc.

20.2 The Managing Director is responsible for ensuring that patients or their carers', as appropriate, are informed before or at admission that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt. This can be done by:

a. Notices and information booklets;
b. Hospital admission documentation and property records;
c. The oral advice of administrative and nursing staff responsible for admissions.

20.3 The Chief Finance Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of patients' money in order to avoid loss.

20.4 Where current guidance requires the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Chief Finance Officer.

20.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965) the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of indemnity shall be obtained.

20.6 Staff should be informed, on appointment, by appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

20.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

21. Standard of Business Conduct

21.1 The Trust's policy on acceptance of gifts and other benefits in kind by staff is embodied in the Trust's 'Managing Conflicts of Interest Policy.

21.2 Declarations of gifts or other benefits must be made to the Head of Corporate Governance for the inclusion in the Register of Interests.

21.3 Staff should make themselves aware of, and comply with, the Trust policy on acceptance of gifts and other benefits in kind by staff.

22. Freedom of Information and Information Requests

22.1 The Trust's Information Governance Officer shall ensure that freedom of information requests are made available in line with the Trust Freedom of Information Publication Scheme.

23. Retention of Records

23.1 The Managing Director, through the Chief Digital and Information Officer shall be responsible for maintaining archives for all records required to be retained in accordance with official guidelines.

23.2 The records held in archives shall be capable of retrieval by authorised persons.

23.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Managing Director. Detail shall be maintained of records so destroyed.

24. Risk Management and Insurance

Risk Management Programme

24.1 The Managing Director shall ensure that the Trust has a programme of risk management, in accordance with current NHS assurance framework requirements, which must be approved and monitored by the Board.

24.2 The programme of risk management shall include:

a. A process for identifying and quantifying risks and potential liabilities;
b. The maintenance of a comprehensive risk register and assurance framework;
c. Engendering among all levels of staff a positive attitude towards the control of risk;
d. Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

e. Reports to the Board on significant risks and progress against action plans to address those risks;
f. Reports to the Board on the Assurance Framework and progress on action plans to address gaps in control and/or assurance as prioritised by the Board;
g. Contingency plans to offset the impact of adverse events;
h. Audit arrangements including; Internal Audit, clinical audit, health and safety review;
i. A clear indication of which risks shall be insured; and
j. Arrangements to review the Risk Management programme.

24.3 The existence, integration and evaluation of the above elements will assist in providing a basis for the Annual Governance Statement within the Annual Report and Accounts as required by current Department of Health and Social Care and NHS England guidance.

24.4 All staff have responsibility in their own sphere of operation, every working day. Accordingly, all staff are responsible for ensuring that their own practice, and that of anyone whom they manage, reflects the principles outlined in the Risk Management Strategy.

Insurance: Risk Pooling Schemes administered by NHS Litigation Authority

24.5 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority under Section 71 (Schemes for meeting losses and liabilities, etc. of certain health service bodies) of the 2006 Act (the "Schemes") for some or all of the risks covered by the Schemes. If the Board decides not to use the Schemes for any of the risk areas covered by the Schemes, this decision shall be reviewed annually.

24.6 Where the Board decides to use the Schemes for one or other of the risks covered by the Schemes, the Chief Finance Officer shall ensure that the arrangements entered into are appropriate and complementary to the Trust's risk management program.

24.7 Where the Board decides not to use the Schemes for one or other of the risks covered by the Schemes, the Chief Finance Officer shall ensure that the Board is informed of the nature and extent of the risks that are to be insured under alternative arrangements (if any) as a result of this decision. The Chief Finance Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

24.8 Insurance arrangements with commercial insurers and self-insurance are co- ordinated by the Head of Corporate Governance.

24.9 The Trust may enter into insurance arrangements with commercial insurers on the open market for one or other of the risks covered by the Schemes, or for any risks not covered by the Schemes.

24.10 The Trust may self-insure either on an individual basis or as part of a risk-pooling scheme with other organisations for one or other of the risks covered by the Schemes, or for any risks not covered by the Schemes.

25. Staff Expenses

25.1 Chief Finance Officer shall be responsible for establishing procedures for the management of expense claims submitted by Trust employees. The Chief Finance Officer

shall arrange for duly approved expense claims to be processed through the Trust's payroll system. Expense claims shall be authorised in accordance with the Scheme of Delegation.

25.2 The Chief Finance Officer shall refer to the Trust's general policies on staff expenses and may reject expense claims where there are material breaches of Trust policies. In this regard the Chief Finance Officer shall liaise with the Managing Director where appropriate.

26. Credit finance Arrangements including Leasing Commitments

26.1 There are no grounds where any employee of the Trust can approve any contract or transaction which binds the Trust to credit finance commitments without the clear prior authority of the Chief Finance Officer. This includes all Executive Directors of the Trust as well as all officers. The Board has provided the Chief Finance Officer with sole authority to enter into such commitments, although these powers can be delegated by him/her to appropriate officers under his/her organisational control.

26.2 This instruction applies to leasing agreements and Hire Purchase undertaking which must be sent to the Chief Finance Officer for prior approval. No officer of the Trust outside the - organisational control of the Chief Finance Officer has any powers to approve such commitments.

27. Charitable Funds Held on Trust

General

27.1 This section must be taken in conjunction with the separate document, the Charities SFIs, which lays out, in more detail, the standards expected with regards the managements and use of charitable funds held on trust.

Corporate Trustee

27.2 The Trust is the sole corporate Trustee of the [Insert Trust name] Charitable Funds, and is responsible for the management of funds it holds on trust.

27.3 The discharge of the Trust's corporate trustee responsibilities are exercised separately and distinctly from its powers exercised as the Trust, and therefore these powers may not necessarily be discharged in the same manner. Nevertheless, there must still be

adherence to the overriding general principles of financial regularity, prudence and propriety. The Trustees responsibilities cover both charitable and non-charitable purposes.

27.4 The Chief Finance Officer shall ensure that each Fund held on Trust which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements. The Chief Finance Officer shall, in exercising his/her responsibilities have regard to appropriate and independent legal advice, as and when required.

27.5 Oversight of the management of Funds held on Trust is delegated to the Board of Trustees Committee (Charity Committee) which will act as sub-committee of the Board chaired by a Non-Executive Director.

27.6 The overriding principle in managing Funds held on Trust is that the integrity of each trust fund must be maintained and all statutory and Trust obligations must be satisfied.

27.7 Charitable Funds held on Trust are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Board acting as Trustees for the Trust.

27.8 The Board shall delegate the majority of this Trustee role to the Charity Committee, as set out in the Committee's terms of reference.

Administration and Management of Charitable Funds

27.9 The Chief Finance Officer shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of non-exchequer funds, including an Investment Register.

27.10 The Chief Finance Officer shall arrange for the administration of all existing Charitable Funds held on Trust. The [Insert Trust name] Charitable Fund has been formed under an [Insert Trust name] Deed dated [insert Date] as amended by a Supplemental Deed dated [Insert date]. Cost Centres and procedures shall be produced covering every aspect of the financial management of charitable Funds held on Trust, for the guidance of all Officers. Additional Deeds of Establishment shall identify the restricted nature of certain funds, as listed on the Charity Commission website, and it is the responsibility of fund managers, within their delegated authority, and the Board of Trustees Committee, to ensure that funds are utilised in accordance with the terms of the Deed of Establishment.

27.11 The Chief Finance Officer shall ensure that all Charitable Funds held on Trust are currently registered with the Charities Commission in accordance with the Charities Act 2016 or subsequent legislation.

27.12 The Chief Finance Officer shall recommend the creation of a new charitable fund where funds and/or other assets, received in accordance with the Trust's policies cannot adequately be managed as part of an existing fund. All new funds should be covered by the Deed of Establishment and must be formally approved by the Board.

27.13 Where a new fund cannot be covered by an existing Deed of Establishment such as for a Restricted Fund, a new Deed will be required. The Deed must clearly identify, inter alia, the objects of the new fund, the capacity of the Trust to delegate powers to manage the fund and the power to assign the residue of the charitable fund to another fund contingent upon certain conditions (e.g. discharge of original objects).

27.14 All gifts accepted shall be received and held in the name of the Trust and administered in accordance with the Trust's policy, subject to the terms of specific funds. As the Trust can accept gifts only for all or any purposes relating to the NHS, Officers (including Directors) shall, in cases of doubt, consult the Chief Finance Officer before accepting any gifts.

27.15 All gifts, donations and proceeds of fund-raising activities, which are intended for the Trust's use, must be handed immediately to the Chief Finance Officer via the Finance Department or the Fundraising Office to be banked directly to the charitable funds bank account.

27.16 In respect of donations, the Chief Finance Officer shall provide:

a. Guidelines to Officers as to how to proceed when offered funds. These are to include:-

    i. The identification of the donors' intentions;
    ii. Where possible, the avoidance of new trusts; the avoidance of impossible, undesirable or administratively difficult objectives;

    iii. Sources of immediate further advice; and
    iv. Treatment of offers for personal gifts;
    v. Secure and appropriate receipting arrangements, which will indicate that funds have been accepted directly into the Trust's donated funds and that the donor's intentions have been noted and accepted.

b. In respect of legacies and bequests, the Chief Finance Officer, shall where required, after the death of a testator ensure that:

    i. All correspondence concerning a legacy is dealt with on behalf of the Trust. Only the Chief Finance Officer shall be empowered to give an executor a good discharge;

ii. Where necessary, grant of probate is obtained or apply for a grant of letters of administration, where the Trust is the beneficiary; and
iii. Arrangements regarding the administration of a will are negotiated with executors and to discharge them from their duty.

27.17 In respect of fund-raising, the final approval for major appeals, defined as events raising in excess of £100,000 will be given by the Board. Final approval for smaller appeals, defined as events anticipating raising less than £100,000 are delegated to the Charities Committee.

Investment Management

27.18 The Charities Committee shall be responsible for all aspects of the management of the investment of Funds held on Trust and shall ensure that there is a clear policy outlining the procedures and decision making required. The Chief Finance Officer shall be responsible for the appropriate treatment of all investment income including all dividends, interest and other receipts.

27.19 Any significant concerns with regards returns on investments or risk with the investments must be reported to the Board of Trustees.

Expenditure management

27.20 The exercise of expenditure discretion (including dispositions) shall be managed by the Board of Trustees Committee. Day to day management may be delegated to the Director of Finance. In so doing the Board of Trustees Committee shall be aware of the following:

a. The objects of various trust funds and the designated objectives;
b. The availability of liquid funds within each trust fund;

c. The powers of delegation available to commit resources;
d. The avoidance of the use of exchequer funds to discharge trust fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;
e. That trust funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust; and
f. The definitions of “charitable purposes” as agreed by the Charity Commission.

27.21 The Fund Managers must adhere to the Charities Policy, Charity Commission Guidance and any other statutory rules that affect charitable funds when planning expenditure. Levels of authority with regards expenditure are outlined in the charities SFIs.

Banking Services

27.22 The Chief Finance Officer shall advise the Board of Trustees Committee (the Charity Committee) and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by NHS England or the Charity Commission.

Asset Management

27.23 Assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Chief Finance Officer shall ensure that:

a. Appropriate records of all donated assets owned by the Trust are maintained, and that all assets, at agreed valuations are brought to account;
b. Appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;
c. Donated assets received on trust shall be accounted for appropriately;
d. All assets acquired from charitable Funds held on Trust which are intended to be retained within the trust funds are appropriately accounted for.

Reporting, Accounting and Audit

27.24 The Chief Finance Officer shall ensure that regular reports are made to the Board of Trustees Committee and the Board with regard to, inter alia, the receipt of Funds held on Trust, investments of these trust funds and the disposition of resources.

27.25 The Chief Finance Officer shall prepare the Annual Accounts in the required manner, which shall be submitted to the Board within agreed timescales.

27.26 The Chief Finance Officer shall:

a. In relation to the non-charitable trust funds prepare any required returns to NHS England; and
b. Prepare an annual Trustees report regarding charitable trust funds and make the required return to the Charity Commission for adoption by the Board of Trustees Committee as required.

Accounting and Audit

27.27 The Chief Finance Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

27.28 Distribution of investment income to the Charitable Funds held on Trust and the recovery of administration costs shall be on a basis determined by the Chief Finance Officer unless otherwise dictated by Charity SORP (Statements of Recommended Practice).

27.29 The Chief Finance Officer shall ensure that the records, accounts and returns receive adequate scrutiny by the Trust's Internal Audit during the year. She/he will liaise with the Internal Auditor and provide them with all necessary information.

27.30 The Board of Trustees Committee shall be advised by the Chief Finance Officer on the outcome of the annual audit.

27.31 The Chief Finance Officer shall identify all costs directly incurred in the administration of all Funds held on Trust, and subject to any legal restrictions, and with the agreement of the Board, shall charge such costs to the appropriate Trust accounts.

Administration Costs

27.32 The Chief Finance Officer shall identify all costs directly incurred in the administration of all Funds held on Trust, and subject to any legal restrictions, and with the agreement of the Board, shall charge such costs to the appropriate Trust accounts.

Taxation and Excise Duty

27.33 The Chief Finance Officer shall ensure that the Trust's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of all required returns, and the recovery of deductions at source

28. Intellectual Property

28.1 The Chief Executive, as the accounting officer, will need to ensure that all intellectual property is identified, protected and used for the benefit of the Trust, the NHS and service users. Such intellectual property shall consist of creations of the Trust for which it holds exclusive rights which includes, but is not limited to, trade secrets, publications, trademarks, designs and patents.

Identify and protect all intellectual property and trade secrets

28.2 The Managing Director will ensure that all intellectual property is identified and properly recorded in the Trust's Intellectual Property register.

28.3 The Managing Director will ensure that all third party Intellectual Property, upon which the Trust's Intellectual Property relies and is recorded in the register, is properly licensed from the third party for the intended usage and confers rights to sub-license as part of the Trust's Intellectual Property.

28.4 All staff are required to identify and protect the intellectual property of the Trust and ensure that is properly recorded in the Trust's Intellectual Propertyregister.

28.5 The Managing Director will ensure that a Non-Disclosure Agreement is signed with any third party before disclosure or receipt of confidential information with the third party.

28.6 The Managing Director will ensure that all contracts of employment include conditions under which confidentiality of Trust and third party information should be maintained as part of the staff conditions ofemployment.

28.7 All documents containing commercially sensitive information must be marked 'Commercial in confidence'.

28.8 The Managing Director will ensure that all publications produced by the Trust are marked as Trust copyright. This will include, amongst other items, research reports, manuals, policydocuments.

Registering of trademarks and patents

28.9 The Managing Director will identify trademarks and patents of specific value to the Trust and wider NHS and ensure that it is appropriately registered with the relevant authorities.

Licensing of Intellectual Property

28.10 The Managing Director is responsible for ensuring that the Trust licenses Intellectual Property to protect the property and reputation of the Trust from misuse, and to derive benefit for the Trust, NHS and serviceusers.

28.11 All uses of the Trust's intellectual property by a third party must be licensed, whether there is a fee for usage or not. The license should take intoaccount:

a. The scope of usage of Intellectual Property, including territories where the Intellectual Property may be used and the uses to which it may be put.
b. Conditions of usage setting out how the Intellectual Property may, or may not be used, both to protect the property's value and the reputation of the Trust.
c. The term of the license, including any conditions by which the Trust may terminate the license, including misuse.
d. The benefit accruing to the Trust from the licensee's use of the Intellectual Property. This may include a financial benefit, or where no financial benefit is requested, may include promotion of the Trust, sharing of information, or other non-financial benefit which is to the benefit of the Trust, the NHS or service users.

28.12 The Managing Director is responsible for ensuring that the Trust enters into legal agreements with third parties where there is joint ownership of Intellectual Property.

28.13 The Managing Director is responsible for entering into agreements to share Intellectual Property between the Trust and the staff who created the Intellectual Property. In making such agreements should take into account:

a. The Trust's ability to use the Intellectual Property should not be limited;
b. Staff members will have no ability to sub-license the Intellectual Property;
c. The benefits from usage or licensing of the Intellectual Property may be distributed to all parties of the agreement, including staff.

29. Monitoring Compliance

29.1 The SFIs detail the method of control, review and assessment required to seek assurance that the instructions laid down by the Trust are adhered to. Annual reports to the relevant Board or Committee are produced as required to demonstrate compliance and performance against the SFIs.

30. Review

30.1 This policy will be subject to a planned review every three years as part of the Trust's Policy Review Process. It is recognised however that there may be updates required in the interim arising from amendments or release of new regulations, Codes of Practice or statutory provisions or guidance from the Department of Health or professional bodies. These updates will be made as soon as practicable to reflect and inform the Trust's revised policy and practise.

31. Training

31.1 Managers are responsible for ensuring all their staff receive the type of initial and refresher training that is commensurate with their role(s).

31.2 Staff must refer to the Mandatory Training Profiles, available on the intranet, to identify what training in relation to [insert subject here] is relevant for their role and the required frequency of update. Further information is available on the statutory and mandatory training web pages about each subject and the available training opportunities.

31.3 The Mandatory Training Policy identifies how training non-attendance will be followed up and managed and is available on the intranet.

31.4 Training statistics for mandatory training subjects are collated by the Learning & Development team, and are reported to the Strategic Workforce Committee

31.5 Staff must keep a record of all training in their portfolio.

31.6 All staff and managers can access their mandatory training compliance records via the Trust's mandatory reporting tool (STAR) available on the intranet.

32. Definitions of Terms Used

32.1 Any expression, to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions.

32.2 Wherever the title Chief Executive, Managing Director, Director, or other nominated officer is used in these instructions, it should be deemed to include other officers who have been duly authorised to represent them in their absence.

32.3 Save as otherwise permitted by law, at any meeting of the Board the Chair of the Trust (or the person presiding over the meeting) shall be the final authority on the interpretation of the SFIs (on which she/he should be advised by the Chief Executive, Managing Director, or the Chief Finance Officer) and her/his decision shall be final and binding except in the case of manifest error.

32.4 Wherever a financial limit is stipulated in these SFIs but no value is given, reference should be made to the Trust's Financial Limits contained within the Scheme of Delegation, which shall be issued to accompany the SFIs and Standing Orders. The Board should periodically review the Financial Limits.

32.5 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SFIs shall bear the same meaning as in the Constitution.

In these SFIs:

the 2006 Act means the National Health Service Act 2006 (as amended);

the 2012 Act means the Health and Social Care Act 2012;

Accounting Officer means a person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 of the 2006 Act. The Chief Executive of the Trust is the Accounting Officer;

Annual Accounts means those accounts prepared by the Trust pursuant to paragraph 25 of Schedule 7 to the 2006 Act;

Annual Report means a report prepared by the Trust pursuant to paragraph 26 of Schedule 7 to the 2006 Act;

Auditor means the Auditor of the Trust appointed by the Council of Governors pursuant to the Constitution;

Audit Committee means a committee of the Board as established pursuant to the Constitution;

Authorisation means the authorisation issued to the Trust by NHS England(formally Monitor) under section 35 of the 2006 Act;

Board means the Board of Directors as constituted in accordance with the Constitution;

Budget means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the business functions of the Trust;

Budget Holder means the Director or Officer with delegated authority to manage business activity for a specific area of the Trust;

Budget Manager means the Officer who has daily operational responsibility for the management of the Budget;

Chair means the Chair of the Trust;

Council of Governors means the Council of Governors as constituted in accordance with the Constitution;

Chief Executive accountable Officer for all aspects of performance of the three organisations with the BSW system particularly around quality and safety, performance, and finance;

Constitution means the Constitution of the Trust together with the annexes;

Director means a member of the Board who has voting rights;

Executive Director means an executive member of the Board of the Trust;

Chief Finance Officer means the Chief Financial Officer of the Trust;

Financial Limits means the financial limits set out in the Scheme of Delegation;

Financial Year means each successive period of twelve months beginning with 1 April;

Funds held on Trust means those funds which the Trust holds at the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers gained under the 2006 Act and shall include the income and interest derived from the holding of such funds all or some of which may or may not be charitable;

Local Counter Fraud Specialist means the person appointed by the Trust to carry out the responsibilities and functions set out in Section 24 of the NHS National Contract and NHS Counter Fraud Authority Anti-Fraud & Bribery Standards for Provider organisations;

Local Security Management Specialist means the person appointed by the Trust to carry out the responsibilities and functions set out in Section 24 of the NHS National Contract and NHS Counter Fraud Authority Security Management Standards for Provider organisations;

Managing Director Responsible for the overall management and performance of their Trust

Member means a member of the Trust;

NHS England means the body which from the 1 April 2016 which brought together Monitor, NHS Trust Development Authority, Patient Safety, Advancing Change Team and Intensive Support Teams.

NHS Counter Fraud Authority means the division established by Direction 2 of the NHS Business Services Authority Directions 2006 (as amended by the NHS Business Services Authority Amendment Directions 2011);

Non-Executive Director means a non-executive member of the Board of the Trust including the Chair;

Officer means an employee of the Trust and for the avoidance of doubt does not include

Non-Executive Directors;

Nominations and Remuneration Committee shall have the meaning ascribed to it in SFI 11;

Secretary means the Secretary of the Trust or any other person or body corporate appointed to perform the duties of the Secretary of the Trust, including a joint, assistant or deputy secretary;

Standing Financial Instructions (SFIs) means these Standing Financial Instructions which regulate the conduct of the Trust's financial matters;

Standing Orders means the Standing Orders for the Council of Governors and the Standing Orders for the Board;

Trust means [Insert Trust name]

Appendix 1: Authorisation Limits

Business Case Approval

Capital Business Cases Authorisation Limits – Values include VAT

Spend (incl. VAT)	Who Approves
Up to £250,000	Capital Prioritisation and Management Group (CPMG)
£250,001 – £1,000,000	Care Organisation Management Committee
Over £1,000,000	Board of Directors

Revenue Business Cases Authorisation Limits – Values include VAT

Spend (incl. VAT)	Who Approves
Up to £75,000	Divisional Review
Up to £1,000,000	Care Organisation Management Committee
Over £1,000,000	Board of Directors

Financial Approval

Financial limits for the Procurement Process and Placing Contracts

Contract value excl. VAT	quotes / tenders	Min number invited to quote / tender where available	Form of Contract	CRR required	Authorisation to approve CRR	Authority to sign a contract
<10k	Quotation may be obtained by end user	1	PO	No	NA	Associate Director of Procurement
>10k - 24,999k	Quotations may be obtained by end user - CRR & Procurement Act 2023 notices issued by procurement	2	PO	No	NA	Associate Director of Procurement
25 - 149,999k	Quotations obtained by Procurement - CRR & Procurement Act 2023 notices	3	Purchase Order and/or contract, as appropriate to the procurement	yes - Level 1 CRR	Associate Director of Procurement	Associate Director of Procurement

	issued by procurement					
150 - 499k	Tender by procurement	4	Purchase Order or contract, as appropriate to the procurement	Yes - Level 2 CRR	Director of Procurement	Director of Procurement
500 - 999k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 2 CRR	Care Organisation Finance Lead	Care Organisation Finance Lead
1,000 - 1,499k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 2 CRR	CFO or Managing Director	Group CFO or Managing Director
1,500 - 1,999k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 3 CRR	CFO	CFO or CEO
>2,000k	Tender by procurement	4	Purchase Order and/or contract, as appropriate to the procurement	Yes - Level 3 CRR	Board	CEO / Board Chair

For contracts that cover more than one financial year this should include the total value of contracts, over the 5 years including whole life cost not just the annual charge.

Revenue Authorisation Limits – Values exclude VAT

Role / Authority	Purchase Orders and Invoices	Other Payments *	Non-SLA sales orders & Credit Notes
Board of Directors	>£1,000,000	>£100,000	>£1,000,000
Chief Executive	£1,000,000	£100,000	£1,000,000
Chief Finance Officer	£1,000,000	£100,000	£1,000,000
Care Organisation Managing Director	£1,000,000	£100,000	£1,000,000
Executive Directors	£500,000	£50,000	£500,000
Divisional Director	£50,000	£1,000	£10,000
Budget Holders / Heads of Service	£10,000	£500	£1,000
Budget Manager	£2, 000	£100	£500

*Inclusive of but not limited to all additional staff payments such as overtime, waiting list initiatives and travel and subsistence payments. Petty cash can only be issued with approval from the budget holder for amounts less than £25. Amounts above £25 need to be agreed in advance of the expenditure being incurred by the Head of Financial Services and reported to the Divisional Finance Manager.

Audit Committee

Terms of Reference

Audit Committee (AC) – provides an independent and objective review of financial and corporate governance, assurance processes and risk management; is authorised to seek information and obtain independent professional advice; and focuses on internal/external audit, counter-fraud, and compliance with licences, standing orders and codes of conduct.

It is proposed that for the BSW Group the three Audit Committees will meet in common.

1. Authority

1.1 The Committee is established by the Board of Directors and will be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

1.2 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of representatives from partner organisations or other external bodies or organisations with relevant experience and expertise if it considers this necessary, subject always to compliance with Trust delegated authorities.

1.4 The Committee provides independent and objective oversight of the adequacy and effectiveness of the Trust's governance, risk management and internal control arrangements, and works closely with other Audit Committees within the BSW Hospitals Group to support alignment of work plans, oversight activities and shared learning.

1.5 In conducting its business, members must demonstrably consider the equality, diversity and inclusion implications of decisions they make and consider whether in the management of risk control, the Trust achieves positive change around inclusion, equality and diversity.

2. Purpose

2.1 The Audit Committee serves a crucial oversight role, primarily focused on enhancing the Trust's governance, risk management, and internal control frameworks. Its core purpose includes overseeing the integrity of financial statements, ensuring the effectiveness of the internal audit function, monitoring compliance with legal and regulatory requirements, and assessing the independence and performance of external auditors. By scrutinizing financial reporting processes, internal controls, and the

management of financial and operational risks, the Audit Committee helps to ensure that the Trust operates in a transparent, efficient, and accountable manner, thereby contributing to the Trust's overall integrity and public confidence in its operations.

3. Membership and attendance

3.1 The Committee shall be composed of a minimum of:-

- Four Non-Executive Directors of the Trust with the exception of the Trust Chair.
- At least one of the members should have recent and relevant financial experience and should be appointed Chair of the Committee by the Board.
- The Deputy Chair of the Trust and the Senior Independent Director (SID) will not Chair the Committee.

3.2 The composition of the Committee should be given in the Trust's Annual Report.

3.3 The Chair of the Trust shall not be a member of the Committee.

3.4 A quorum will be two members.

3.5 The following are required to attend meetings of the Audit Committee in a non-voting capacity:

- Chief Financial Officer
- Head of Internal Audit
- Representatives of the External Auditors
- Anti-Fraud Specialist
- Company Secretary
- The Chief Executive Officer*

3.6 *Compulsory attendance* - The Chief Financial Officer (or in their absence their deputy and another Executive Director) is expected to attend regularly. The External and Internal Auditors shall normally attend as agreed by the Chair of the Committee. The Counter Fraud Specialist shall attend at least 2 meetings each year as agreed by the Chair of the Committee.

*The Chief Executive, as Accounting Officer, shall be invited to attend meetings and should discuss at least annually with the Committee, the process for assurance that supports the annual governance statement. The Chief Executive should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

3.7 Oher Executive Directors or relevant members of staff may be co-opted or requested to attend for specific agenda items as necessary by invitation of the Audit Committee Chair.

3.8 *Substitutes/Deputies* - Where a member of the Committee is unable to attend a nominated representative may attend in their absence on approval of the Chair. A nominated representative will contribute towards quoracy.

3.9 *Voting* - Only the Non-Executive Directors who are members of the Committee may vote. When a vote is requested, the question shall be determined by a majority of the votes of the members present for the item. In the event of an equality of votes, the person presiding shall have a second or casting vote.

3.10 *Additional meetings* – The External Auditor, the Head of Internal Audit and Counter Fraud Specialist have a right of direct access to the Chair. The Accounting Officer, external auditors, or Head of Internal Audit may request a meeting of the Committee if they consider that this is necessary. At least once each year the Committee will meet privately with the internal and external auditors.

3.11 *Frequency* **-** Meetings of the Committee shall take place at the frequency and timing necessary to enable discharge of its responsibilities and the Committee will routinely meet on a quarterly basis. Responsibility for calling meetings of the Committee shall rest with the Committee Chair.

3.12 Virtual meetings, subject to minimum quoracy requirements, will have full authority to take decisions; meetings will be recorded, and Minutes/Action Logs produced, in the normal way.

4. Duties

The Committee is responsible for:

4.1 Governance, risk management and internal control

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievements of the Trust's objectives. It will provide an independent and objective view on internal control and probity. In addition, the committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance, reviewing significant financial reports and the judgements contained in them.
- In particular, the Committee will review the adequacy of:
  - All risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance to external bodies), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.
  - The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
  - The policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
  - The Trust's standing orders, standing financial instructions and scheme of delegation.

- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State directions and as required by the NHS Counter Fraud Authority.
- The arrangements by which Trust staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In so doing the Committee's objective should be to ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

- In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

4.2 Internal Audit

The Committee will ensure that there is an effective internal audit function established by management that meets mandatory government and Public Sector Internal Auditing Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- Consideration of the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal
- Review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- Reviewing the internal audit programme, considering the major findings of internal audit investigations (and management's response), and ensuring coordination between internal and external auditors
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- Annual review of the effectiveness of internal audit.

4.3 External Audit

The Committee shall review the independence, objectivity and work of the external auditor appointed by the Council of Governors and consider the implications and management's response to this work. This will be achieved by:

- Consideration of the appointment and performance of the external auditor, including making recommendations to the Council of Governors regarding the former.
- Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure coordination with internal auditors and with other external auditors
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Reviewing all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any audit work performed outside the annual audit plan, together with the appropriateness of management's response
- Recommending to the Council of Governors the engagement of the external auditor in respect of non-audit work, taking into account relevant ethical guidance regarding the provision of such services
- Annual review of the effectiveness of external audit.

4.4 Other assurance functions

- The Committee will review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to, reviews and reports by the Department of Health and Social Care, arm's length bodies or regulators/inspectors (e.g. Care Quality Commission, NHS Resolution, etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc) or the Local Anti-Fraud Specialist.
- The Committee will receive the Clinical Audit Annual Plan on an annual basis, together with an update on progress of the plan at the mid-year point. The Annual Plan should be presented to the Committee alongside the Internal Audit Annual Plan to ensure a cross-referencing of items. The Committee's remit in receiving the plan will be to ensure transparency and accountability. The Committee will ensure appropriate consideration is given to alignment with relevant Group priorities and assurance plans.
- The Committee will provide oversight and monitor the effectiveness of the processes in place for delivery of the plan.
- The Committee will also review all suspensions of standing orders and variation or amendment to standing orders.
- The Audit Committee will report to the Board and to the Council of Governors any matters in respect of which it considers action or improvement is needed.

4.5 Counter fraud

The Audit Committee will satisfy itself that the Trust has adequate arrangements in place for countering fraud and will approve the appointment of the Local Anti-Fraud Specialist. The Committee will review the outcomes of counter fraud work.

4.6 Group / System Collaboration

The Committee will consider the implications of Group and system working on the Trust's governance, risk and control environment and provide assurance to the Board as required.

In order to ensure an integrated approach and carry out the above duties effectively, the Committee will have effective relationships with all Board committees so that it understands processes and linkages and seeks assurance on their work.

The Committee may request specific reports from individual functions within the organisation in pursuance of its duties.

4.7 Financial reporting

- The Audit Committee shall monitor the integrity of the Annual financial statements of the Trust.
- The Audit Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.
- The Audit Committee will review the Trust's annual report and financial statements before submission to the Board, focusing particularly on:
  - The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
  - Changes in, and compliance with, accounting policies and practices
  - Unadjusted misstatements in the financial statements
  - Major judgmental areas, and
  - Significant adjustments resulting from the audit
  - Letter of representation
  - Qualitative aspects of financial reporting.

4.8 Systems for raising concerns

The committee shall review the effectiveness of the arrangements in place to allow staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

5. 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, they will declare that interest as early as possible and act in accordance with the Trust's 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.

6. Reporting

6.1 The Audit Committee will report to the Board of Directors.

6.2 A Chair's Report will be submitted to the next following Board of Directors for assurance. Approved minutes will be made available to all Board members.

6.3 The Committee will report to the Board annually on its work and performance in the preceding year and, as part of this report, will provide commentary in support of the Annual Governance Statement (AGS), specifically dealing with the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the Trust, the integration of governance arrangements and the appropriateness of the evidence compiled to demonstrate fitness to register with the Care Quality Commission and the robustness of the processes behind the quality accounts.

6.4 Trust standing orders and standing financial instructions apply to the operation of the Audit Committee.

7. Administration of meetings

7.1 The 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 members.

7.2 Agendas and papers will be circulated at least five working days in advance of the meeting.

7.3 Minutes will be circulated to members as soon as is reasonably practicable.

7.4 A forward planner of agenda items shall be determined by the Chair.

8. Review

The Terms of Reference of the Audit Committee shall be reviewed and submitted for approval to the Board of Directors at least annually.

Approved by: [Trust Board]
Date of Approval: [Date]
Review Date: [Date - annually]
Version: Draft v0.5

Remuneration Committee

Terms of Reference

Remuneration Committee (RemCo) – provides independent and objective oversight of executive remuneration, senior appointments and workforce reward policy; is authorised to obtain information and independent professional advice; and focuses on fair, transparent and merit-based remuneration arrangements, recruitment processes, and alignment with NHS frameworks, organisational performance and good governance standards.

It is proposed that for the BSW Group the three Remuneration Committees will meet in common.

1. Authority

1.1 The Committee is established by the Board of Directors and will be known as the Remuneration Committee (the Committee). The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

1.2 The Committee is authorised by the Board to act within its terms of reference. All members of staff are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Purpose

2.1 The Committee's primary responsibilities include overseeing the processes for recruiting and appointing senior leadership positions within the Trust, and ensuring there is a transparent and merit-based selection process. Additionally, the Committee is tasked with developing and reviewing policies related to the remuneration, incentives and terms of service for the Executive Directors, ensuring these are fair, competitive, and capable of attracting and retaining high-calibre talent necessary for the Trust's success.

2.2 The Committee will recommend and monitor the structure of remuneration including setting pay ranges and receiving relevant reports (at least annually) for the layer of management under the Executive Director not covered under Agenda for Change (AfC).

3. Duties

The Committee shall:

3.1 Coordinate the recruitment and appointment process for Executive Director roles.

3.2 Align job descriptions, person specifications and remuneration benchmarks.

3.3 Consider and discuss proposals for appointment and remuneration packages.

3.4 Review the structure, size and composition of the Board and make recommendations where appropriate.

3.5 It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors.

3.6 Both the appointment and removal of the Company Secretary should be a matter for the whole Board of Directors.

3.7 Ensure that the contractual terms of severance payments on termination of office for the CEO/Executive Directors are fair to the individual/organisation and in line with associated national guidance.

3.8 To ensure compliance with the requirement that the performance of Directors is reviewed annually through appraisal

4. Membership and Attendance

4.1 The members of the Committee shall be:

- The Chair of the Trust
- The Non-Executive Directors of the Trust.

4.2 The Committee will be chaired by the Chair of the Trust. In the absence of the Chair, the Vice-Chair or Senior Independent Director will chair the meeting.

4.3 In addition to members of the Committee, the following are required to attend and participate in the meetings of the Committee in a non-voting capacity except on those occasions when discussions or decisions relate to their own remuneration or terms of office:

- Group Chief Executive Officer
- Group Chief People Officer
- Director of Corporate Governance / Company Secretary

4.4 Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations, at the discretion of the Chair.

Quorum

4.6 The quorum for meetings and necessary for the transaction of business is a minimum of 3 Non-Executive Directors (including the Chair or deputy Chair).

5. Conduct of Business

5.1 In conducting its business, the Committee will at all times seek to promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users including those who have protected characteristics and vulnerable members of our community.

Administration

5.2 The Company Secretary or their nominee will act as secretary to the Committee. The secretary will minute the proceedings and decisions of all meetings of the Committee, including recording the names of those present and in attendance.

5.3 Any member of the Committee can ask for an extraordinary meeting to be convened to meet business needs.

Notice of meetings

5.4 Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be available to each member of the Committee and where appropriate, other persons required to attend, no later than five working days before the date of the meeting.

Reporting

5.5 The minutes of all meetings of the Committee shall be formally recorded and submitted to the next meeting for approval. An assurance report shall be available to the Board of Directors on request. Identified risks are to be escalated to the Board of Directors in accordance with the agreed assurance and escalation procedure.

5.6 The Committee will report annually to the Board of Directors in respect of the fulfilment of its functions in connection with these terms of reference. This will include an evaluation of its performance according to a standardised framework and process.

6. Review

6.1 These Terms of Reference will be subject to an annual review or following any significant changes in the governance or legal frameworks.

Approved:
Version:
Date: