GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS

Thursday 3 August 2023, 9.30am to 12.45pm
Kennet Room, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ

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

		PAPER	BY	ACTION	TIME
OPENING BUSINESS					
1.	**Apologies for Absence and Chair's Welcome** Kevin McNamara, Bernie Morley, Paul Lewis, Claudia Paoloni	Verbal	LC	-	9.30
2.	**Declarations of Interest** Members are reminded of their obligation to declare any interest they may have in any issue arising at the meeting, which might conflict with the business of the Trust	Verbal	LC	-	-
3.	**Minutes of the previous meeting (public)** Liam Coleman, Chair • 1 June 2023	1 – 12	LC	Approve	-
4.	**Outstanding actions of the Board (public)**	13	LC	Note	-
5.	**Questions from the public to the Board relating to the work of the Trust**	14 – 16	CC	Receive	9.45
6.	**Care Reflection (Staff Story) – Experience of the Oxford Brookes University and Great Western Hospital Student Council** To be presented by Wangari Murigu, who will share her experiences of the Student Council	17 – 25	WM	Note	9.50
7.	**Chair's Report** Liam Coleman, Chair	26 – 31	LC	Note	10.20
8.	**Chief Executive's Report** Simon Wade, Chief Financial Officer	32 – 40	SW	Note	10.30
9.	**Integrated Performance Report** • Integrated Performance Report – Pillar Metric deep dive and refresh • Performance, Population & Place Committee Board Assurance Report (June & July) – Peter Hill, Non-Executive Director & Committee Chair • Quality & Safety Committee Board Assurance Report (June & July) – Lizzie Abderrahim, Non-Executive Director & Deputy Committee Chair	 41 – 87 88 – 92 93 – 102	 Executive Directors PH EKA	Assurance	10.50

	• Finance, Infrastructure & Digital Committee Board Assurance Report (June & July) – Faried Chopdat, Non-Executive Director & Committee Chair	103 – 106	FC		
	• People & Culture Committee Assurance Report (June) – Paul Lewis, Non-Executive Director & Committee Chair	107 – 109	PL		
BREAK (10 minutes) at 11.40am					
10.	**Audit, Risk & Assurance Committee Assurance Report (June)** Helen Spice, Non-Executive Director & Committee Chair	110 -111	HS	Assurance	11.50
11.	**Three year Maternity and Neonatal Services Single Delivery Plan** Lisa Cheek, Chief Nurse Lisa Marshall, Director of Midwifery & Neonatal Services Kat Simpson, Head of Midwifery & Neonatal Services (received at Quality & Safety Committee 20 July 2023)	112 – 120	LCh/ LM/KS	Receive	12.00
12.	**Standing Financial Instructions, Scheme of Delegation and Powers Reserved to the Board** Simon Wade, Chief Financial Officer (received at Audit, Risk & Assurance Committee 23 June 2023 and Finance, Infrastructure & Digital Committee 26 June 2023)	121 – 240	SW	Approve	12.30
CONSENT ITEMS **These are items that are provided for consideration. Members are asked to read the papers prior to the meeting, and unless the Chair/Secretary receives notification before the meeting that a member wishes to debate the item or seek clarification on an issue, the items and recommendations will be approved without debate at the meeting in line with process for consent items. The recommendations will then be recorded in the minutes of the meeting.**					
13.	**Ratification of Decisions made via Board Circular** Caroline Coles, Company Secretary	Verbal	CC	Note	12.40
14.	**Responsible Officer Annual Report** Jon Westbrook, Chief Medical Officer (received at Quality & Safety Committee 20 July 2023)	241 – 261	JW	Note	-
15.	**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	-	-
16.	**Date and Time of next meeting** Thursday 7 September 2023 at 9.30am, DoubleTree by Hilton Hotel, Lydiard Fields, Swindon, Wiltshire, SN5 8UZ	Verbal	LC	Note	-
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"*	-	-	-	12.45

Board Meeting Timetable

2023											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Board	Board	Board	Seminar	Board	Board	Seminar	Board	Board	Seminar	Board	Board
			Workforce, Culture & EDI			Patient Voice/Patient Safety Framework			Strategy		

Great Western Hospitals NHS Foundation Trust

MINUTES OF A MEETING OF BOARD OF DIRECTORS HELD IN PUBLIC
DOUBLETREE BY HILTON HOTEL, SWINDON, SN8 5UZ
AND VIA MS TEAMS
1 JUNE 2023 AT 9.30AM

Present:
Voting Directors

Liam Coleman (LC)	Chair
Lizzie Abderrahim (EKA)	Non-Executive Director
Nick Bishop (NLB)	Non-Executive Director
Lisa Cheek (LCh)	Chief Nurse
Faried Chopdat (FC)	Non-Executive Director
Jude Gray (JG)	Chief People Officer
Peter Hill (PH)	Deputy Chair/Non-Executive Director
Paul Lewis (PL)	Non-Executive Director
Bernie Morley (BM)	Non-Executive Director
Claudia Paoloni (CP)	Non-Executive Director
Will Smart (WS)	Non-Executive Director
Helen Spice (HS)	Non-Executive Director
Claire Thompson (CT)	Chief Officer of Improvement & Partnerships
Simon Wade (SW)	Chief Financial Officer
Jon Westbrook (JW)	Chief Medical Officer

In attendance:

Caroline Coles (CC)	Company Secretary
Naginder Dhanoa (ND)	Chief Digital Officer
Julian Duxfield (JD)	Non-Executive Director
Claire Lehman (CL)	Associate Non-Executive Director
Rommel Ravanan (RR)	Associate Non-Executive Director
Deborah Rawlings (DR)	Board Secretary
Claire Warner (CW)	Deputy Chief People Officer
Jill Kick	Head of Integrated Services & Community Therapy (agenda item 46/23)
Sarah Knight	Head of Patient Flow (agenda item 46/23)
Tania Currie	Head of Patient Experience & Engagement (agenda item 46/23)
Jon Burwell	Chief Information Officer (agenda item 54/23)

Apologies:

Kevin McNamara	Chief Executive
Felicity Taylor-Drewe	Chief Operating Officer

Number of members of the Public: 2 members of public* (2 Governors: Chris Shepherd and Mufid Sukkar)

*Indicates those members attending virtually by MS Teams

Matters Open to the Public and Press

Minute	Description	Action
41/23	**Apologies for Absence and Chair's Welcome**	

Minute	Description	Action

The Chair welcomed the Board members and attendees to the Great Western Hospitals NHS Foundation Trust Board meeting held in public. It was noted that Simon Wade was deputising in the absence of Kevin McNamara, Chief Executive.

Apologies were received as above.

Liam Coleman, Chair, wished to formally record thanks on behalf of the Board to Nick Bishop, Non-Executive Director, as he leaves the Trust on 30 June 2023. Nick was thanked for his support and strength to the Board over the past seven years and wise counsel offered to his peers.

42/23 **Declarations of Interest**
There were no declarations of interest.

43/23 **Minutes of the previous meeting (public)**
The minutes of the public meeting of the Board held on 4 May 2023 were adopted and agreed as a correct record, subject to the following amendments:

Minute No 13/23 – Improving Together Staff Stories - Amend on page 3, 4th paragraph to "….and *added that the BSW Acute Hospital Alliance had been selected as part of the first wave of NHS England's new Provider Collaboratives Innovators Scheme, which was recognition of our work done so far and the potential to do much more in the future."*

Minute No. 17/23 – IPR – 5th paragraph to amend the target to *"20%"*.

Minute No. 20/23 – Staff Survey Results 2022 – add at the end of the sentence in 2nd paragraph "*in place*."

44/23 **Outstanding actions of the Board (public)**
The Board received and considered the outstanding action list.

The Board **noted** the outstanding actions which had now been closed.

45/23 **Questions from the public to the Board relating to the work of the Trust**
There were no questions from the public to the Board.

46/23 **Care Reflection (Patient Story) – Services to support and facilitate improved pathways of care for patients**
Jill Kick, Head of Integrated Services & Community Therapy, Sarah Knight, Head of Patient Flow, and Tania Currie, Head of Patient Experience & Engagement, joined the meeting for this item.

The Board received a film which identified the work of two new services set up to support and facilitate improved pathways of care for patients – Home First and the Urgent Community Response Service. The film shared the experience of two patients who had benefitted from these services along with staff providing an explanation of the pathways, how these were facilitated and the benefits that had since been delivered.

Paul Lewis, Non-Executive Director, reflected on a case that he was personally aware of and assurance was provided on the processes that were now in place to

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ensure that patients were evaluated for discharge on an individual basis and from a primary care perspective.

The Board reflected on the story, which included the use of volunteer mobility workers with the Live Well Hub and how the Urgent Community Response Service was linked into primary care. The management of future demand on the services was also discussed and the ongoing support by the ICB to maintain these services.

The Board thanked Jill, Sarah and Tania for sharing this story and the considerable work undertaken to implement these services; particularly noting the success in the delivery of such services and the effect on patient experience.

The Board **noted** the care reflection.

47/23 **Chair's Report**

The Board received and considered the Chair's Board Report which highlighted activities and shared information on governance developments within the Trust and externally. The following additional points were noted:

- Regular meetings with the ICS Chairs continued which provided a useful forum for sharing information.
- The appraisal process for the Chair and Non-Executive Directors was outlined which this year would include a 360° review.

The Board **noted** the report.

48/23 **Chief Executive's Report**

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

Industrial action – An update on the pay deal offered by the Government to the National Staff Council was noted for staff under Agenda for Change to be paid in June 2023. However, a number of staff groups had voted against the offer, including the Society of Radiographers, and further industrial action was expected over the next six months. Further strike action by British Medical Association Junior Doctors was scheduled to take place for 72 hours from 14 to 17 June 2023. The Board Members were assured around the Trust's response planning which had commenced.

Robotic Surgery – The first robotic surgery at Great Western Hospital was carried out during May 2023 following the purchase of a surgical robot earlier in the year. The Trust was the first in the BSW to offer this service which would significantly improve the patient experience.

In response to a question asked by Nick Bishop, Non-Executive Director, on the competency of users of the surgical robot, Simon Wade, Chief Financial Officer, replied that an additional extensive training module had also been purchased from the supplier to ensure the success of its early implementation. In response to a second question on theatre utilisation time, Jon Westbrook, Chief Medical Officer, confirmed that an empty theatre had been dedicated to surgical robot usage and that this would be over and above normal activity. Jon Westbrook added that the

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surgical robot was essential for attracting future surgical consultant applicants to the Trust and would ensure that surgical services would be sustainable.

Patient Safety Incident Response Framework – The Patient Safety Incident Response Framework (PSIRF) had been published by NHS England in August 2022, which would replace the current Serious Incident Response Framework by Autumn this year and represented a significant shift in the way the NHS responded to patient safety incidents. Training on the new system was currently underway at the Trust.

In response to a question asked by Lizzie Abderrahim, Non-Executive Director, on additional resourcing implications around investigations to gain learning from incidents, Lisa Cheek, Chief Nurse, replied that a review of the metrics within the framework was currently being undertaken to understand how the model would be implemented into the organisation and that investment in training would be significant at every level. A briefing paper would be provided to the Quality & Safety Committee in the future once services had been mapped out.

New Carer Support Passport – A new Carer Support Passport had been introduced at the Trust, which had been designed to enable hospital staff to recognise carers more quickly, allowing them to be involved in discussions about the patient's care where appropriate and also documented agreed involvement in the care that would continue to be provided by the carer during the patient's hospital stay.

Decant begins for Integrated Front Door – Changes in patient pathways were to be implemented due to the ongoing construction work on the urgent and emergency care expansion. The Paediatric ED had moved into the children's area in the UTC along with Paediatric ED staff to continue their management of patients in this new location.

NHS@75 and marking the NHS' 75th birthday – The NHS Assembly's NHS@75 project had sought consensus on the future development of the NHS and those GWH staff who had completed this had been asked to share their responses to help inform work on the refresh of the Trust's strategy. A number of celebrations would be taking place nationally and the events taking place at GWH to celebrate the 75th anniversary of the NHS was outlined.

NHS England National Provider Collaborative Innovators Scheme launch – The Chief Executive attended the national launch of NHS England's Provider Collaborative Innovators Scheme in London recently, alongside the ICB, our AHA partners and clinical leaders. The Board was reminded that our Acute Hospital Alliance had been selected as the only South West representative in the first wave of the scheme.

Climate-friendly pain relief – This Trust recently became only the second NHS organisation in the country, and first in the South West, to install a Central Destruction Unit (CDU) to make Entonox carbon neutral and reduce our carbon footprint. The piped supply of nitrous oxide had also been decommissioned and this project had been made possible by obtaining funding from the Healthier Futures Action Fund via Greener NHS.

Staff Survey 2022 – Following the results of the 2022 NHS Staff Survey, a number of Trust-wide actions had been identified to help us respond to areas for

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improvement. Equity Data Walks were to take place to learn more about the experiences behind the data collected for discrimination from a manager or colleague in the last 12 months as told by 9% of staff. In response to 53% of staff who would recommend the Trust as a place to work, the new leadership behaviours framework was to be launched. Lizzie Abderrahim, Non-Executive Director, also informed the Board of her experience with joining a recent equity walk using the tea trolley and that it was a valuable opportunity to engage with staff and hear their views directly.

Pulse Staff Survey results – Recent survey results had shown that more staff than ever feel able to make improvements in their area of work, which reflected the growing confidence of teams to adopt the principles of our Improving Together way of working.

49/23 **Board Committee Assurance Reports**

Performance, Population & Place Committee Chair Overview

The Board received an overview of the detailed discussions held at the Performance, Population & Place Committee (PPPC) at its meeting on 24 May 2023 and the following was highlighted:

Non-Criteria to Reside – Significant progress had been made with non-criteria to reside and the Committee had acknowledged this achievement. The further 21% reduction since March 2023 had delivered a saving of 652 bed days.

Cancer – Progress on cancer performance was slower than planned due to challenges in capacity and expertise. A detailed action plan covering 'what by when' had been requested for the next quarterly report to provide a greater level of assurance.

Liam Coleman, Chair, asked if the outsourced contract provider to deliver a plastics service to GWH was still unresolved as the risk remained a challenge for the organisation. Claire Thompson, Chief Officer of Improvement & Partnerships, responded that mutual aid was in place as a solution and that another provider was being sought within the BSW.

Emergency Preparedness Resilience & Response Assurance (EPRR) Report – The Committee was fully supportive of the approach taken by the EPRR Steering Group to change our internal risk ratings from 'amber' to 'red' for the core standards for 'Shelter & Evacuation' and 'Lockdown Plans' as there had been no progress since the last assurance report and they were dependent on work from Health & Safety and the external contractor SAFE who oversee the Trust's security. The Committee debated that whilst there was no evidence to suggest that core standards were being breached due to internal actions taken, it had been agreed to take a cautious approach to the risk assurance level of Red and in terms of the risk appetite for it.

It was noted that the timescales for monitoring actions were incorrect on this report.

Helen Spice, Non-Executive Director, sought further assurance on the number of 'red' risk ratings within the report and could the Board be assured how the Trust was comparing to and progressing at the same rate as some of our colleagues in the system and more widely. Peter Hill, Non-Executive Director, was assured that the Trust was performing well and that the data received at PPPC and commentary

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within the report provided this assurance on how this Trust was performing within the South West. However, Peter Hill acknowledged that there was no level of visibility on relative performance at a national level in reports received at PPPC and that this could be brought out in future reports to show comparison. Liam Coleman added that datasets from the Region were received by Trusts on weekly basis to provide benchmarking detail. Claire Thompson, Chief Officer of Improvement & Partnerships, added that the NHS Oversight Framework, once published, would also provide a further set of metrics of benchmarking data.

The Board **agreed** that the dataset received from the Region be circulated to all Board Members as an example of the data being provided to Trusts and the context that sits behind the data, noting that this would be regularly reviewed by the Executives. It was also considered that national information could be added to pillar metrics and alert metrics to support that data in the IPR.
Action: Chief Operating Officer

The Board **noted** the report.

Quality & Safety Committee Chair Overview
The Board received an overview of the detailed discussions held at the Quality & Safety Committee (Q&SC) at its meeting on 18 May 2023 and the following was highlighted:

Total Harms – There had been a reduction in total harms from 302 to 249 but this had been mostly attributed to a reduction in Covid infections.

Claudia Paoloni, Non-Executive Director, commented that although metrics did not indicate overall improvement in performance, Q&SC could be assured that actions were being taken to drive improvement and evidence could be demonstrated that any deterioration in performance was acted upon immediately by operational teams.

Pressure Harms – There had been a slight reduction in the number of hospital acquired pressure harms but an increase in community acquired pressure harms. Further investigation had demonstrated a complexity of causation, particularly those patients on complex care packages and end of life pathways. New objective metrics had been introduced and that some wards had showed marked improvement with no pressure ulcers being reported alongside continued teaching and training. Assurance on progress was gained by Q&SC.

Hospital Acquired Infections – Following an increased incidence of *C.diff* which was identified predominantly to a surgical ward, a peer review from an external organisation had been undertaken which had resulted in some feedback regarding environmental factors and infection control behaviours. A formal report was awaited, but following focused measures taken, there had been no new cases for 28 days.

The Board noted the actions that had been taken to show improvement in hospital acquired infections and recorded thanks to the Chief Nurse, Chief Medical Officer and their teams on the action plans put in place to achieve this marked improvement.

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In response to a question asked by Peter Hill, Non-Executive Director, on how learning and continuous relearning was applied to the organisation, Lisa Cheek, Chief Nurse, provided assurance on the actions being taken within the organisation to continue to drive improvement and ensure that re-education and re-learning was ongoing to drive infection rates down, particularly within nursing as there was a very junior and new workforce. Lisa Cheek added that in terms of *C.diff* infection rates, this Trust compared favourably to its neighbouring trusts within the South West at the beginning of the year, apart from the period of increased incidence within one ward. However, a number of *C.diff* cases had since been reported across the organisation and also across the system and a piece of work with the ICB was underway to understand the factors behind this.

Mortality & Morbidity Q4 2022-23 & Annual Report – The annual and quarterly report was received which demonstrated that the Trust's HSMR and SHMI were within the expected range compared to hospital trusts nationally, but concerns remain around the accuracy of data due to the impact of clinical coding delays. The Chief Medical Officer was addressing the areas of development and actions that needed to be implemented to address both timely M&M reviews and clinical coding. A business case had been developed for a long term plan for in-house training and retention of staff, with a timeline for improvement.

Clinical Audit & Effectiveness Q4 2022-23 Report – At the end of 2022-23, all audits were on track, except for the National Asthma Audit, with 99.5% national audit rate and 100% delivered time on time for those. A business case had been submitted for funding to support undertaking the National Asthma Audit.

Rommel Ravanan, Associate Non-Executive Director, asked for further assurance on safe staffing compared to the results of the staff survey which reported that staff felt that there was not enough staff. Lisa Cheek responded that the Trust was not currently working within the national recommendation of 1:8 in terms of our staffing establishments. Nursing comments from the staff survey had been scrutinised, acknowledging the current Trust's ratio of 1:10, and that robust oversight and governance processes were in place to manage safe staffing on a daily basis. Actions were in place to meet the national guidance, with further investment in qualified staffing to reach the 1:8 ratio.

Lisa Cheek, Chief Nurse, reported on the new approach to the CQC inspection framework which was a single assessment framework with five domains. Key lines of enquiry were to be replaced by quality statements focusing on health inequalities, working with communities, listening to both patients and staff, and also how the Trust works across the system. An online portal for evidence had been introduced to enable evidence to be continuously submitted by our organisation and not just around inspections. The frequency of investigations may vary too in relation to the emergency framework. Work was underway with the CQC on how to implement the new framework.

It was **agreed** that the single assessment framework would be circulated to the Board Members for information. **Aug 2023**
Action: Chief Nurse

The Board **noted** the report.

Minute	Description	Action

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 meeting on 22 May 2023 and the following was highlighted:

Faried Chopdat, Non-Executive Director, wished to record thanks to the Executive and teams for the high quality reports to enable the Committee to pressure test those reports and good debate.

Board Assurance Framework – FIDC was satisfied overall with the strategic risks and relevant assurances, together with the process and reporting of the strategic risks in the BAF. One risk which related to the delivery of savings was to be reflected on further on the issues to achieve delivery.

Month 1 Finance position – This was the first time a Month 1 report had been received and was well received to provide early insight.

Risks & Mitigations within the Financial Plan – An update was provided to FIDC on critical risks identified in the delivery of the financial plan and mitigation actions, including enhanced monitoring and grip and control activities.

Improvement and Efficiency Plan Update – There were a number of actions in place for plans to be identified and aligned to address the financial plan and deliver savings.

Digital Strategy Plan – FIDC received and approved the Digital Strategy Plan and recommended that comments made by FIDC members should be reflected to ensure this plan was aligned with the overall Trust's strategy.

Lizzie Abderrahim, Non-Executive Director, asked for a better understanding of how the assurance ratings were reached in terms of actions to identify efficiency targets when historically this had been a challenge for the Trust. Faried Chopdat acknowledged that this was a continuous challenge for the Trust and that FIDC was constantly looking at different ways to address efficiency targets with the introduction of different initiatives, which included the delivery of targets across the ICS as a whole. There was to be focus on new governance arrangements for the delivery of cross divisional targets and cultural mindset shift to drive capability throughout the organisation.

The Board **noted** the report.

People & Culture Committee Chair Overview
The Board received an overview of the detailed discussions held at the Finance, Infrastructure & Digital Committee (FIDC) at its meeting on 22 May 2023. As a verbal report was provided at the March Board meeting, this report was for noting only.

The Board **noted** the report.

50/23 **Integrated Performance Report**
The Board received and considered the Integrated Performance Report (IPR) which provided commentary and progress on activity associated with key safety and quality indicators in March 2023.

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Lizzie Abderrahim, Non-Executive Director, welcomed the information provided in the EDI section which helped to inform the context.

Some of the new Non-Executive Directors on the Board asked about measures, methodology and commentary in the IPR but agreed to explore this further at the Improving Together induction session for the NEDs on 17 July. However, challenges to current IPR were welcomed as a fresh pair of eyes.

The Board **noted** the report.

51/23 **Charitable Funds Committee Assurance Report**

The Board received an overview of the detailed discussions held at the Charitable Funds Committee (CFC) at its meeting on 10 May 2023 and the following was highlighted:

Fundraising – Continued risks and uncertainty remain with the cost-of-living implications and actions were mitigate this. Capacity within the fundraising team remains also.

Financial Position – The position continues to be well controlled and there were no areas of concern to report.

Charitable Funds – Paul Lewis, Non-Executive Director, informed the Board that whilst there was limited funds available in the General Fund of approximately £30k, the divisional funds available amounted to £850k and CFC had expressed concern that these funds were not being spent. Paul Lewis reported that the CFC had requested that the divisions were provided with a pro forma and invited to attend CFC meetings on their proposals to spend the funds, both in terms of supporting patients, equipment and staff and also identify ongoing needs. This had been positively received by the divisions and would continue to be monitored by CFC. This approach was welcomed by the Board.

The Board **noted** the report.

52/23 **Safe Staffing 6-month review for Nursing & Midwifery**

The Board received and considered a report that provided the Board with assurance that wards and departments had been safely staffed in line with the National Quality Board guidance (2014) and Developing Workforce standards (2018).

This report had been robustly scrutinised by the Quality & Safety Committee.

The following was highlighted:

- The good processes in place to monitor safe staffing on a day-to-day basis and monthly reporting of rates and vacancies.
- Robust and improved processes around agency spending alongside the now implemented yearly establishment reviews.
- Actions in place to reach the 1:8 nurse to patient ratio as part of the 2023/24 business planning in line with national guidance.

Minute	Description	Action

- The AHP report provided detail to the 427wte AHPs in the Trust and the recruitment challenges faced. The international recruitment of AHPs continued to be successful and work was ongoing to increase the pipeline.
- The Trust had received a HSE Pastoral Award for its support to Internationally Educated Nurses.

Lizzie Abderrahim, Non-Executive Director, wished the Board to acknowledge that this Trust had taken the decision to continue with one Continuity of Care team to facilitate safe staffing levels across the service, to continue to provide focused care in areas of deprivation.

In response to a question asked by Will Smart, Non-Executive Director, on fill rates, Lisa Cheek agreed to include an overview of the metrics to evidence a robust and safe staffing model for the Trust to the NED induction.

The Board **noted** the report.

53/23 **Annual Report & Accounts 2022-23**

The Board was requested to delegate authority to the Audit, Risk & Assurance Committee to approve the final Annual Report & Accounts 2022-23 in order to meet the deadline of 30 June 2023.

RESOLVED:
The Board to delegate authority to the Audit, Risk & Assurance Committee to approve the final Annual Report & Accounts 2022-23 before the deadline of 30 June 2023.

54/23 **Annual Quality Account 2022-23**

The Board was requested to delegate authority to the Quality & Safety Committee to approve the Quality Account 2022-23 for publication on the Trust's website in order to meet the deadline of 30 June 2023.

RESOLVED:
The Board to delegate authority to the Quality & Safety Committee to approve the Quality Account 2022-23 for publication on the Trust's website before the deadline of 30 June 2023.

55/23 **Digital Strategic Plan**

The Board received and considered the new Digital Strategic Plan, which outlined a vision to be achieved through delivery of a range of programmes summarised under five priority areas: Access & Mobility, Infrastructure & Security, Applications, Use of Information and Digital Literacy, Support & Training. Where appropriate, the Trust would work closely with key partners including Acute Hospital Alliance peers and the wider ICS to reduce duplication, improve the delivery of services and the experience of both our population and staff.

The document also provided a summary of how the Strategic Plan responded to the Trust Strategy, with each programme of work seeking to improve four outcomes, these being Quality and Safety, Efficiency and Productivity, Resilience and Business Continuity and User Experience.

Minute	Description	Action

The Finance, Infrastructure & Digital Committee (FIDC) had approved the Strategic Plan, with requirements that the plan was continually reviewed and monitored to ensure that it was reviewed alongside the refresh of the Trust Strategy and annual business planning process.

It was noted that the report had also previously been received by the Trust Management Committee, and Non-Executive Directors by invitation.

The Board agreed that it would be essential for the Trust to have digital champions in the organisation to help drive the digital strategy and promote training for digital projects. Jon Westbrook, Chief Medical Officer, added that the Trust already had in place two Chief Clinical Information Officers and two Chief Information Nursing Officers. A Chief Clinical Information Officer had been appointed for the EPR programme across all three organisations involved in the project.

Jon Burwell, Chief Information Officer, explained that an action plan was in place around digital champions and he outlined the work already underway at Salisbury Hospital, and that this would also be applied to the EPR project to avoid duplication on engagement work.

Claire Lehman, Associate Non-Executive Director, asked how population health data could be utilised within our own organisation and also external partners, and to engage with the ICS to encourage further learning. Jon Burwell responded that modules had been built into the EPR full business case to enable patients to access their data which would support primary care.

Jon Burwell explained that plans were being mapped to develop an ICS data warehouse and that discussions were underway to determine how that business intelligence would then be presented. The implementation of EPR would help to develop this further. A national initiative was also in place for safe data environments and could be accessed for audit research, population health, etc. Claire Thompson, Chief Officer of Improvement & Partnerships, added that the Trust had been asked to join two safe data environments; Thames Valley as part of the Oxford rollout programme on an integrated care record and another in the South West.

RESOLVED:
The Board to approve the Digital Strategic Plan.

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.

56/23 **Ratification of Decisions made via Board Circular**
None.

57/23 **Research & Innovation Annual Report**
The Board received and noted the Research & Innovation Annual Report.

Minute	Description	Action

Jon Westbrook, Chief Medical Officer, stressed the importance of having a strong research and innovation programme in the Trust and there was good evidence of improvements in quality of standards in care. A number of considerable successes at GWH were outlined, which included cardiology and pacemakers, surge in vaccine trials, and a sterile preparation unit in Pharmacy to enable a number of cancer and oncology research projects to commence. Funding for clinician's time to develop their grant applications was being explored in collaboration with other institutions such as the University of Bath.

A clinical room and more office space to expand the unit had now also been secured within GWH.

The Board **noted** the report.

58/23 **Terms of Reference Annual Review**
The Board received and considered a report which invited the Board to refresh the Terms of Reference of the People & Culture Committee, Charitable Funds Committee, and Remuneration Committee.

RESOLVED:
The Board to approve the terms of reference.

59/23 **Urgent Public Business (if any)**
None.

60/23 **Date and Time of next meeting**
It was noted that the next meeting of the Board would be held on 3 August 2023 at 9.30 am, at the Double Tree by Hilton, Swindon.

The meeting finished at 13.05 hrs.

ACTIONS ARISING FROM MEETINGS OF THE TRUST BOARD (matters open to the public) – August 2023				
PPPC - Performance, Population and Place Committee, P&CC – People & Culture Committee, Q&SC - Quality & Safety Committee, RemCom - Remuneration Committee, FIDC – Finance, Infrastructure & Digital Committee, ARAC – Audit, Risk and Assurance Committee				
Date Raised	**Ref**	**Action**	**Lead**	**Comments/Progress**
1 June 2023	49/23	**Performance, People & Place Committee Chair Overview** Circulate for information a copy of the dataset received from the Region.	Chief Operation Officer	Completed.
1 June 2023	49/23	**Quality & Safety Committee Chair Overview** CQC single assessment framework to be circulated to Board members.	Chief Nurse	The Board received a presentation from CQC on the new CQC framework at the Board workshop on 6 July 2023.

Future Actions				
None				

Report Title	**Question for the Board**				
Meeting	**Trust Board Meeting**				
Date	**3 August 2023**	Part 1 (Public)	X	Part 2 (Private)]	
Accountable Lead	Caroline Coles, Company Secretary				
Report Author	Caroline Coles, Company Secretary				
Appendices	n/a				

Purpose							
Approve		**Receive**	x	**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 in respect of: process/outcome/other (please detail):							
Process & outcome							
Significant	X	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							
Assurance in respect of the process of obtaining and gaining response to questions to the Board.							

Report

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

This paper reports the question and response asked of the Board by a governor on 26 July 2023.

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

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	X			X	
Key Risks – risk number & description (Link to BAF / Risk Register)	n/a				**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Deputy Chief Nurse, Trust Board				
Next Steps	-				

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

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board are invited to consider if further action is required.	
Accountable Lead Signature	Caroline Coles
Date	26 July 2023

Question to the Board				
Topic	**Questioner**	**Question**	**Responder**	**Board Response**
Police Force attending mental health cases.	Pauline Cooke, Governor	The police force over the next 2 years will not be attending non urgent, non life threatening, mental health cases. This could manifest itself by no police attending hospital when a mental health patient is acting up lets say in ED. What will the hospital have to do to protect Staff and other patients. Has this already been brought to the Trusts attention and if so, are plans in place to safeguard both the patient and staff during an incident.	Luisa Goddard, Deputy Chief Nurse	This was discussed at the Mental Health Operational Group on 25 July 2023 which was attended by the police lead for Mental Health. Locally the police are working up plans to change practice but were committed to doing it in partnership with us, AWP and the ICB. We will continue partnership working and close collaboration to ensure there is as minimal impact as possible if this does come in. The ICB are leading a lot of work with mental health services which will also minimise the impact. The police are also still committed to attending when there is potential harm to the patient or others. We will continue to monitor closely through our operational group and in the Mental Health Governance Committee.

Report Title	**Experience of the Oxford Brookes University and Great Western Hospital Student Council**				
Meeting	**Board of Directors**				
Date	**3rd August 2023**	Part 1 (Public) [Added after submission]	x	Part 2 (Private) [Added after submission]	
Accountable Lead	Lisa Cheek				
Report Author	Luisa Goddard Deputy Chief Nurse and Student Council chairs				
Appendices					

Purpose

Approve		Receive		Note	X	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 in respect of: process/outcome/other (please detail):

Significant		Acceptable	X	Partial		No Assurance	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Report

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

A Student Council was set between the Oxford Brookes University (OBU) student nursing programme at the Swindon Campus and Great Western Hospitals NHS Trust in the Autumn of 2022.

The benefits of shared decision making forums (or councils) are well documented including empowering staff and ensuring an appropriate platform to have impact, 'a voice that counts'. It is also considered to be a developmental opportunity for those involved.

The OBU / GWH student council also achieves tangible outcomes / change due to direct and close link between the university and the Trust.

The council has a nominated 'Chair' (or co chairs), who are elected from within the membership, 'Sponsors' who will support the council to become established and provide coaching support and advice (OBU Programme Lead) and 'Enablers' (Chief Nurse / Deputy Chief Nurse).

The sponsors and enablers are invited to attend bi monthly but advice and support with projects between that if required.

Oxford Brookes University Swindon Campus educates the majority of student nurses who have placements with the Trust and once qualified go on to have a career with the Trust.

Nationally attrition rates for student nurses is at a record high and this is one initiative to help improve the experience of the Trust's students and ensure that they feel listened to and supported.

The attached slides are the benefits of the Student Council from one of the Co Chairs perspective.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	X	X	X	X	X
Links to Strategic Pillars & Strategic Risks – select one or more	★				
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
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?			X
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			X
Explanation of above analysis:			

Recommendation / Action Required

The Board/Committee/Group is requested to:

- **To note the experience of the Student Council Chairs**

Accountable Lead Signature	Lisa Shreeh
Date	27 July 2023

BENEFITS OF BEING ON THE STUDENT COUNCIL

A Students Perspective

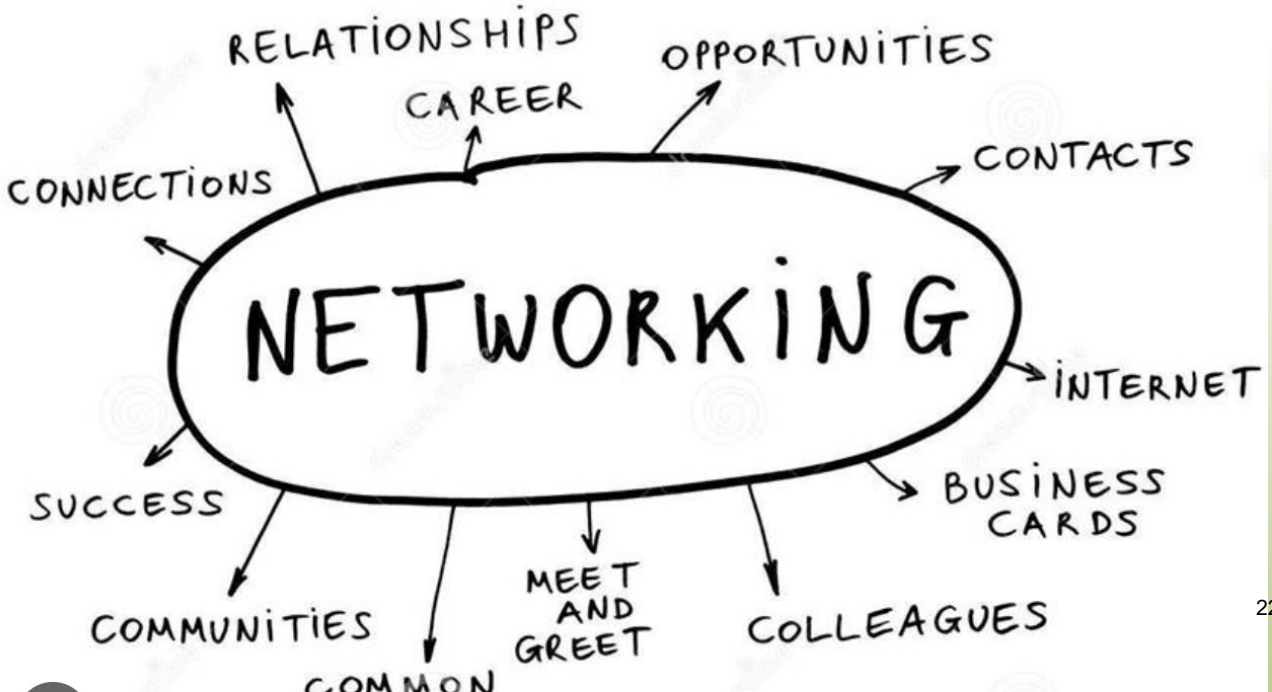
W. WANGARI MURIGU

ENHANCED LEADERSHIP SKILLS

Significant development of one’s leadership abilities. You'll have the opportunity to collaborate with fellow council members to address the needs and concerns of your peers, take charge and make decisions. These skills are valuable for future roles in healthcare management or nursing leadership positions.

IMPROVED COMMUNICATION AND ADVOCACY

Allows one to hone their communication skills. You'll interact with students, faculty, and administrators, representing the interests of your cohort. This experience can help you become an effective advocate for important issues in the nursing field, such as improved resources, student support, or curriculum enhancements.



NETWORKING OPPORTUNITIES

Joining the Student Council exposes you to a broader network of individuals within the university community. Collaboration with students from various cohorts, including nursing and other healthcare-related fields when joined with the Oxford students in addition to university faculty, university staff and Trust partners. This networking can lead to valuable connections, such as potential mentors, research opportunities, or partnerships for future projects. Like being here today is valuable.

PROFESSIONAL DEVELOPMENT

The Student Council often organizes events, offering opportunities for professional development. One can attend or even participate in organizing such activities, which can enhance your knowledge, skills, and understanding of the nursing profession. These experiences can contribute to your personal growth and help you stay updated with current trends and advancements in healthcare.

IMPACTFUL CONTRIBUTION

Access to a platform to make a meaningful impact on your nursing program and the overall student experience. You can actively participate in decision-making processes, voice concerns, propose improvements, and implement positive changes. Your contributions can shape the educational environment for future nursing students and help create a more inclusive, supportive, and engaging learning community.

WHAT COULD BE IMPROVED

Providing a wide range of co-curricular and extracurricular activities such as:

- Clubs, and/or sports teams,
- Volunteering opportunities,
- Cultural events.

These enhance student engagement by offering avenues for personal growth, skill development, and social interaction beyond the classroom.

Report Title	**Chair's Board Report**				
Meeting	**Trust Board**				
Date	**3 August 2023**	Part 1 (Public)	x	Part 2 (Private)]	
Accountable Lead	Liam Coleman, Chair				
Report Author	Caroline Coles, Company Secretary				
Appendices	Appendix 1 : Summary Board Safety Walks				

Purpose							
Approve		**Receive**		**Note**	x	**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 in respect of: process/outcome/other (please detail):							
Process							
Significant	x	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

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

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust and externally.

The report provides information in respect of:-

- Council of Governors
- Non-Executive Directors
- Strengthening Board Oversight
- Local Update
- Key Meeting Dates.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		x	x	x
Key Risks – risk number & description (Link to BAF / Risk Register)	-				**Risk Score**
	-				
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?			x
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			x
Explanation of above analysis:			

Recommendation / Action Required The Board/Committee/Group is requested to:	
The Board is requested to note the contents.	
Accountable Lead Signature	Liam Coleman, Chair
Date	24 July 2023

Chair's Board Report

This report provides the Board of Directors with a summary of key headlines and shares information on governance developments within the Trust and externally during June & July 2023.

1. Council of Governors

1.1 Joint Trust Board and Council of Governors Workshop – A joint Trust Board and Council of Governors workshop was held on 17 July 2023 when the Integrated Care System (ICS) was the topic of discussion which included a System and Place Overview with examples of how partnership working had benefitted patient care, these included diabetes care, enhancing care towards patients' homes, Home First and the Swindon Co-ordination Hub.

1.2 Deputy Lead Governor – Natalie Titcombe has been appointed as our new Deputy Lead Governor who replaces Pauline Cooke. The Board wishes to thank Pauline for her considerable contribution over the years as both Lead and Deputy Lead Governor.

1.3 Monthly Meeting with Lead Governors - The regular monthly meetings were held with the Lead Governors.

2. Non-Executive Directors

2.1 Senior Independent Director (SID) - The Trust Board, in consultation with the Council of Governors, approved the appointment of Paul Lewis as SID until the end of his term of office, 31 March 2024.

3. Strengthening Board Oversight & Development

3.1 Board Safety Visits - Attached as appendix 1 is the summary report of the Board safety walks held during January and June 2023.

The following visits were held in June and July 2023.

Date	Area	Board Member
26 June 2023	Community	Claudia Paoloni, NED, Bernie Morley, NED, and Lisa Cheek, Chief Nurse
29 June 2023	Mercury Ward	Lizzie Abderrahim, NED, and Simon Wade, Chief Financial Officer

26 July 2023	Woodpecker Ward	Liam Coleman, Chair, and Felicity Taylor-Drewe, Chief Operating Officer

3.2 Board Workshop - A Board workshop was held on 6 June 2023 on Hearing the Patient Voice. This included 2 external speakers; Sarah Balchin, Director of Community Engagement and Experience, Solent NHS Trust whose presentation was entitled *'Alongside Communities – the Solent approach to engagement and inclusion – our story',* and Chris Day, Director of Engagement, CQC whose presentation was on the new CQC Framework and what good patient involvement looks like.

4. Key Meetings during June & July 2023

Meetings	Purpose
Bi-monthly meeting with Chair/Deputy Chair/ Senior Independent Director	Regular meeting to update and discuss any topical issues
Bi-monthly meeting with Non-Executive Directors/Associate Non-Executive Directors	Regular meeting to update and discuss any topical issues
1-2-1 meeting with Chief Executive	Regular meeting
EPR Update	Monthly update meeting
Monthly Chair/Lead Governors' Meeting	Regular meeting to update and discuss any topical issues
BSW Chairs catch up	Regular meeting bringing together healthcare providers within the BSW ICS
Mental Health Governance Committee	Attendee of committee
Finance, Infrastructure & Digital Committee	Attended Board Committee as observer
Extraordinary Wiltshire Health & Care Board	Attended Board Committee as member
Voluntary Service Awards	Attended to present
NED/ANED Induction Meeting with Company Secretary	As part of new NED/ANED induction programme
NED/ANED Improving Together Induction Session	As part of new NED/ANED induction programme
Meeting with Regional Director	Meeting to discuss topical issues
Strategic Engagement Event between NHS Chairs, CEOs and NEDs	Engagement session arranged by ICB
Annual Joint Board & Council of Governors Workshop	As part of Board/Council of Governor annual meeting programme
NED appraisals	Annual review of performance

Appendix 1 - Board Safety Walk Arounds Summary Report for January to June 2023

Visit summary

Name of site	Date of Walk Around
Forest Ward	12th January 2023
Urgent Treatment centre	16th March 2023
Beech Ward	20th March 2023
Linnet Ward	26th April 2023
Jupiter Ward	24th May 2023

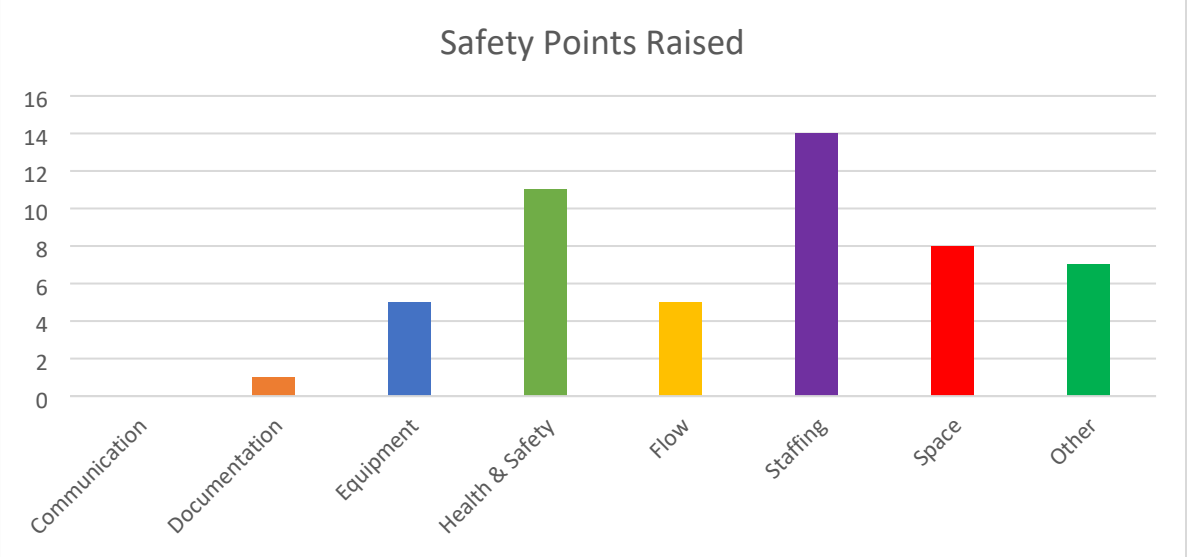
1. Summary of feedback

A themed review of the notes taken during each visit has been completed. The themes that were identified through visits in 2022 have been used to provide a basis for assessment against each of this year's visits.

The themes have been grouped into three main areas:

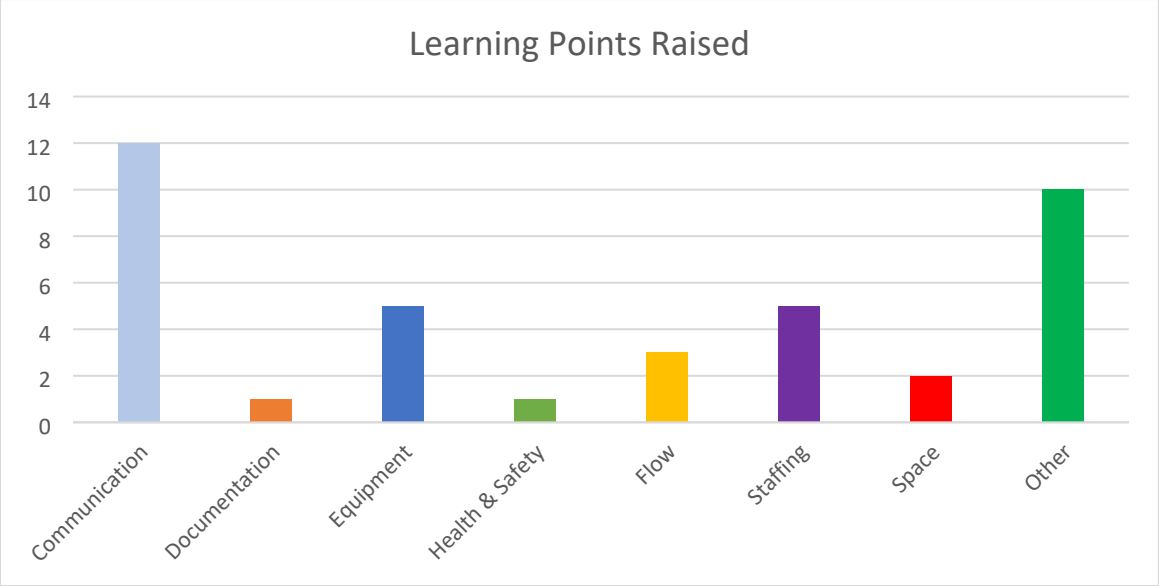
- Safety points raised
- Learning points raised
- Further discussion points raised.

The overall results for the five visits completed January to June 2023 show that staffing remains the highest area of concern.



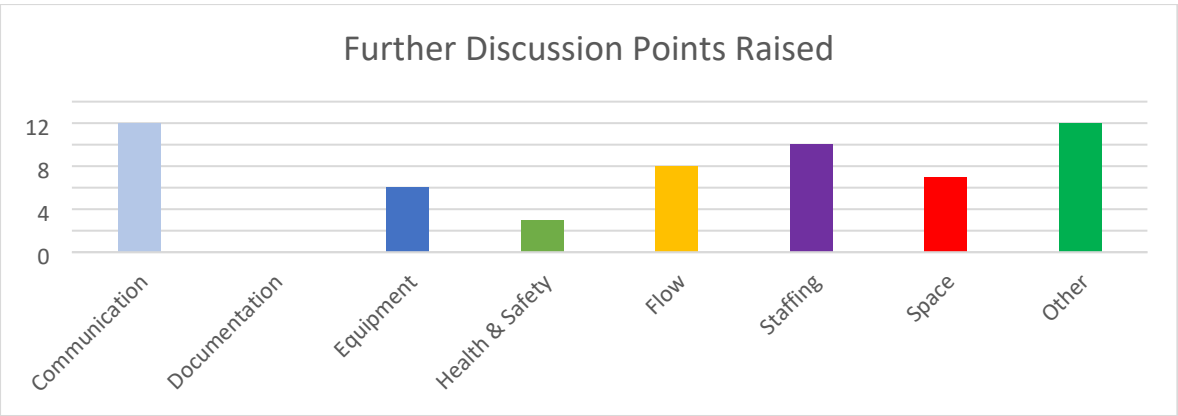
Below are some of the points raised in the visits in relation to staffing:

- There are currently some gaps in therapy provision which the team are planning to recruit for
- International nurses who currently require ward-based role prior to moving to specialist Areas can give some inconsistencies in staffing.
- Staff are often recruited and then want to work the night shift due to pay incentives; this makes it harder to staff during the day.



Below are some of the points raised in the visits in relation to learning:-

- Clear signage in main corridors and down in the Main Atrium for some wards.
- There were concerns with staff morale in 2022, this is now monitored, and staff do a daily 'Rate my shift' slip. The aim is for 75% of staff to rate their shift as average or above
- Due to multiple teams visiting the ward, nurses are not always able to join the ward rounds to ensure they relay all information back to a patient, so that the patient has a clear understanding of the reasons behind the decision made
- One ward identified that the phonelines are often busy so there is now a non-emergency email address where queries can be sent to and responded to within two working days This has been well received by family and friends, especially in the coordination of care.



Below are some of the points raised in the visits in relation to other:-

- Access to some training.
- The department now has a Breastfeeding/Baby Feeding room which provides mothers with a safe and private space
- There has been an increase in Friends & Family (F&F) positive responses, since going around with the tea trolley handing to patients and or assisting them if needed to complete. Fantastic outcome in February 23 with 96% of F&F responses saying they would recommend the ward as an area.

2. Conclusion

The feedback from the board safety visits has remained very positive, with excellent staff engagement before, during and after the visits. Clear actions have been agreed on the day and followed through afterwards to ensure completion.

Report Title	**Chief Executive's Report**				
Meeting	Trust Board				
Date	3 August 2023	**Part 1 (Public)**	**X**	**Part 2 (Private)**	
Accountable Lead	Chief Executive Officer				
Report Author	Kevin McNamara, Chief Executive Officer				
Appendices	N/A				

Purpose

Approve		**Receive**		**Note**	**X**	**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 in respect of: process/outcome/other (please detail):

Process

Significant	**x**	**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

The Chief Executive's report provides an overview of a broad range of current issues at the Trust themed around operations, quality, systems and strategy, and workforce, wellbeing and recognition.

Report

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

This report includes updates on:

- Industrial action
- Sulis Elective Orthopaedic Centre
- NHS England Long Term Workforce Plan
- NHS 75 celebrations
- Staff Excellence Awards
- Parliamentary Awards

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	X	**X**	**X**	**X**	**X**
Links to Strategic Pillars & Strategic Risks – select one or more	★				
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
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?	X		
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?	X		

The report refers to a visit by Swindon Borough Council's Cabinet. The new administration has tackling inequality as one of its three pledges, and this – along with our Trust's work in this area – was referred to during the visit.

Our Staff Excellence Awards are covered in the report – one of the award categories is championing equality, diversity and inclusion.

The report mentions our Trust receiving the Gold Award in the Ministry of Defence's Employer Recognition Scheme. This is the highest standard in the scheme, and was given in recognition of our commitment and work to support staff and patients who are reservists and veterans, forces families and other local people who have links to the Armed Forces.

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ **Note the report**	
Accountable Lead Signature	Kevin McNamara, Chief Executive
Date	27 July 2023

1. Operational updates

1.1. Industrial action

We continue to be impacted by industrial action as a result of the ongoing dispute between a number of Trade Unions and the Government.

Last month we saw five days of industrial action by British Medical Association Junior Doctors, followed very soon after by two days of strikes by Consultants.

During the junior doctors strike, 428 shifts were not covered. This equates to 63% of junior doctor shifts. There were 396 appointments and procedures cancelled.

During the consultants strike, 50 shifts were not covered. This was 18.2% of scheduled consultant shifts. There were 151 outpatients who had appointments and procedures cancelled.

Last month the Government offered junior doctors a 6% pay increase for 2023-24 based on a recommendation from the independent pay review panel. The Government said this was a final offer and no amount of strikes would make it reconsider the offer. The BMA indicted it will continue to strike.

Last week the BMA announced that Junior Doctors will strike for four days from 11-15 August.

Consultants have announced further dates for action on 24 and 25 August, which falls just before a Bank Holiday weekend which we know will be very busy.

For the first time at our Trust, we saw industrial action taken by members of the Society of Radiographers. Derogations were put in place during this strike, which meant that we were able to provide radiographic imaging services to cover emergency ‘life and limb’ situations. Our services operated at a Christmas Day level over the two days of strikes.

We have planned well for all of the industrial action to date, however these continue to impact upon our patients who have seen appointments and operations cancelled, and experienced longer waiting times.

We continue to hope for a resolution to the dispute between the unions and the Government at the earliest opportunity.

1.2. Business continuity incident in June

We declared a business continuity incident following two unplanned power outages on the same day.

Our IT team worked hard to get systems back up and running as quickly as possible, and staff were given advice about how to minimise the impact of any future electricity cuts.

Once the power was restored the same day we carried out a successful test of our generator the next morning.

Incidents of this nature cause unnecessary disruption for patients and additional work for our colleagues across the Trust. We will ensure Board has oversight of the learning through the Finance, Infrastructure, and Digital Committee.

1.3. Demand

In recent weeks we have been particularly busy with high attendances to the Emergency Department and Urgent Treatment Centre. The flow of patients through the hospital has been a challenge with high numbers of patients with no criteria to reside.

June represented our second busiest month on record.

Following a period of increased demand, we held two consecutive 'reset days' in July.

This enabled us to focus on a daily review in our coordination centre of patients with no criteria to reside, looking at which patients might be suitable for NHS@Home (our virtual ward), reviewing patients awaiting scans more frequently, and ensuring all appropriate patients receive a surgical review.

We have worked very closely with colleagues from both Wiltshire and Swindon councils to support with discharges.

2. Quality

2.1. Sulis

Board members will be aware that the Royal United Hospitals NHS Foundation Trust bought Circle Health Group's private hospital in Bath in June 2021. It is currently run via a Wholly Owned Subsidiary model, acting as an independent business.

Working together with our partners in the Acute Hospital Alliance we have secured approval from NHS England and £25m national funding to increase elective orthopaedic capacity at Sulis for patients at the RUH, our own Trust, and Salisbury along with the wider South West.

The Sulis Elective Orthopaedic Centre expansion will increase the number of operations performed at Sulis each year by around 3,750 cases.

Work will begin this autumn and is due to complete in June 2024.

2.2. Robotic surgery featured on regional TV

Having carried out our first procedures in May, our new surgical robot was featured on BBC Points West in June.

Surgical staff talked about the benefits the robot will bring to both staff and patients.

The robot is part of our investment in improving patient care, and along with delivering higher quality care, it will help us to recruit and retain the best surgeons.

3. Systems and Strategy

3.1. Long Term Workforce Plan published

The NHS Long Term Workforce Plan was published on 30 June.

It sets out projections for the NHS workforce with a focus on three areas:

- Recruit – grow the workforce
- Retain existing talent – embed the right culture and improve retention
- Reform – work and train differently

The plan sets out the NHS ambition to see:

- Staff shortfalls fall significantly by 2028.
- A workforce growth rate of between 2.6% and 2.9% a year resulting in a permanent NHS workforce of up to 2.3 million in 2036/37 compared to 1.4 million in 2021/22.
- Between 9% and 10.5% of staff recruited internationally in 15 years' time, compared to almost 25% at present.
- The rate of staff leaving the NHS to reduce from 9.1% in 2022, to between 7.4% and 8.2% by 2038

The plan is clear that there are multiple interdependencies that will influence its success, including infrastructure (the need for sufficient physical capacity for training expansion and need to sustained capital investment), funding for education, and investment in social care.

The plan will be updated every two years, and kept in line with the economic situation.

3.2. NHS75

We marked the 75th anniversary of the NHS on 5 July in a number of ways.

These included:

A new physical display was installed on the ground floor of Great Western Hospital depicting 75 staff members from the whole workforce.

The Trust produced a video exploring how Swindon's Great Western Railway Medical Fund provided inspiration for the National Health Service we have today, and we were also involved in a ceremony naming a new Great Western Railway train after Aneurin Bevan.

Our Great to Talk podcast series featured stories from a number of different staff in the run up to the anniversary.

There was considerable media interest in the anniversary and we spoke to local journalists about the challenges facing the NHS now and in to the future.

The Swindon Advertiser visited the hospital and gave out cakes to staff working here, and our staff also took these to the Orbital.

Across the hospital, staff brought patients together to take part in the NHS Big Tea, with cakes provided by Serco. Wards and departments were also encouraged to arrange local celebrations to mark the anniversary where possible.

A small number of staff attended national events including a service at Westminster Abbey and a Local NHS Champions' Reception at 10 Downing Street.

The Brighter Futures Superhero Run took place just after the anniversary and runners were asked to dress up as an NHS superhero.

3.3. Trust strategy engagement

This summer we will be testing our thinking on our vision, strategic pillars and our values, engaging with a range of staff, community groups, and other stakeholders.

Our Big Conversation will consider:

- What are our priority areas?
- How do these address the needs of our local communities?
- What kind of organisation do we want to be?
- What conditions do we need to thrive?
- How can everyone contribute?

The results of the engagement will help to inform the refresh of our Trust strategy.

3.4. Visit from Swindon Borough Council

Last month we hosted new Swindon Borough Council leader Jim Robbins and Cabinet members.

We took the opportunity to show the new administration our coordination centre and latest site developments.

We also discussed the overlap between some of work fulfilling our responsibilities as a large organisation in the local community and the council's three pledges to combat inequality, build a better Swindon and achieve Net Zero.

4. Workforce, wellbeing and recognition

4.1. Staff Excellence Awards

Around 360 staff attended our annual Staff Excellence Awards which recognised the achievements of colleagues from right across the Trust.

The 11 winners were:

- Championing ED&I Award: Patient Advice and Liaison Service
- GWH Rising Star Award: Eleanor Drew, Trainee Physiologist
- Hero Award: Beyond the call of duty: Stewart Chikukuza, Clinical Fellow
- Improving Patient Experience Award: Acute Rehab Physiotherapy
- Kindness Award: Claire Brice, Speech and Language Therapist
- Leading the GWH Way Award: Timea Novak, Consultant
- Wellbeing at Work Award: Leanne Kent, Staff Nurse
- Patient Choice Award: Anne Kendall, Consultant
- Lifetime Achievement Award: Sue Facey, Community Outreach Nurse
- Team of the Year: Communications Team
- Star of the Year: Amanda Smith, Senior Healthcare Support Worker

4.2. Star of the Month

Our latest STAR of the Month winners are:

Kirsty Nelson-Smith, Consultant, who was recognised for her work during the junior doctor industrial action to ensure consultants were organised to cover, so that patients could continue to receive the care they need.

Jason Brown, Senior Workforce Analyst, who built a complex but slick and operational agency management tool that is shared right across the organisation, with overwhelmingly positive feedback from staff.

4.3. Parliamentary Awards

Individuals and teams from our Trust were finalists in three categories of the national Parliamentary Awards.

The Swindon Integrated Care Alliance Coordination Centre was highly commended in the Excellence in Urgent and Emergency Care category.

Consultant Nurse Bev Breen was a finalist in the Nursing and Midwifery Award and recently retired Neonatal Nurse Toni Starr was a finalist in the Lifetime Achievement Award category.

4.4. Our Health Heroes

We had two winners in the national Our Health Heroes Awards in June. Our Trust charity Brighter Futures was recognised in the Best Healthcare Initiative by a UK Charity for their fundraising efforts for the Radiotherapy Appeal and Toni Starr, retired Neonatal Nurse, was recognised in the Lifetime Contribution category.

4.5. HSJ Awards – Home First and Shared Programme

HomeFirst was shortlisted in the ‘Best use of integrated care and partnership working’ category in the Health Service Journal Awards. This initiative, which launched at the end of last year, helps patients get home more quickly and reduces their length of stay in

hospital, sometimes by as long as a week. Multi-disciplinary team assesses patient in their own home during the first 72 hours after discharge – rather than waiting in hospital for this assessment to take place.

The **SHarED programme** supporting high impact users, involving several trusts including ours, was shortlisted in the Urgent and Emergency Care Safety Initiative of the Year' category of the awards.

4.6. Employer Recognition Scheme Gold award

We were given the Gold Award in the Ministry of Defence's Employer Recognition Scheme. This is the highest standard in the scheme, and was presented in recognition of our commitment and work to support staff and patients who are reservists and veterans, forces families and other local people who have links to the Armed Forces.

My thanks go to all the members of the Trust's Armed Forces Working Group for this award, which reflects our commitment to being a forces-friendly organisation.

Separately, a number of staff took part in the 2023 Military Challenge. They completed a series of physical and mental activities designed to test their team working, cognitive thinking, planning and resilience skills.

4.7. Marking Windrush Day

To celebrate the 75th anniversary of Windrush and the 75th anniversary of the NHS, we held our first ever Change the Narrative story-telling event.

Around 60 staff attended the event, which was held in the Academy and involved staff and volunteers bravely sharing their stories about migrating to the UK to work in the NHS.

4.8. Leadership conference

More than 150 staff attended our first Leadership Conference ('Putting great behaviours at the heart of our leadership').

Attendees heard from Professor Michael West, Senior Visiting Fellow at The King's Fund, who spoke about how to build successful teams who are compassionate, to support delivering excellent patient care.

At the session we launched our new leadership behaviours tool, and explored the behaviours we expect our leaders to demonstrate.

4.9. Nursing and Midwifery Conference

We held our first ever Nursing and Midwifery Conference earlier this month, with around 150 staff attending.

The event at Oxford Brookes University was opened by NHS England Regional Chief Nurse Sue Doheny, who spoke about the future of nursing and midwifery.

Paralympic tennis player Louise Hunt was among the other guest speakers, with other sessions looking at patient safety, learning, and looking after yourself and others.

4.10. Great West Fest

Our third annual staff family festival Great West Fest will take place on Saturday 2 September at Town Gardens in Old Town, Swindon. The line-up for the event has been announced and it features headliners Borrowed and Blue along with funfair rides for children, arts and crafts, circus skills and food vendors. The event is now fully booked.

Report Title	**Integrated Performance Report (IPR)**				
Meeting	**Trust Board**				
Date	**3rd August 2023**	Part 1 (Public)	x	Part 2 (Private)	
Accountable Lead	Felicity Taylor-Drewe, Chief Operating Officer Simon Wade, Chief Financial Officer Jude Gray, Director of HR (Human Resources) Lisa Cheek, Chief Nurse				
Report Author	Al Sheward – Deputy Chief Operating Officer Rayna McDonald – Deputy Chief Nurse Claire Warner – Associate Director of HR Operations John Ridler – Associate Director of Finance				
Appendices	Use of Resources: • Statement of Financial Position • Working Capital • Income & Expenditure – Variance Run Rate • SPC (Statistical Process Control) Chart – Pay				

Purpose

Approve		Receive		Note	x	Assurance	x
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 in respect of: process/outcome/other (please detail):

Significant		Acceptable	x	Partial		No Assurance	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Report

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

Our Performance

Key highlights from the report this month are:

OPERATIONAL PILLAR METRICS

Of the 6 Operational Pillar Metrics, there have been improvements in the Emergency Care Mean time with natural changes for UTC mean stay. There has been an increase for the 3rd month in a row for ED attendances. There is a worsening position for RTT, Cancer, ED attendances and NC2R pillar metrics.

Cancer 62 day - Cancer 62 day waiting times remain below standard. Deterioration for the second month has been seen in the Cancer Faster Diagnosis standard.

RTT (Referral to Treatment) 65 Week Waiters – June's performance shows the total number of patients waiting over 65 weeks at 640. This has continued to grow since March 2023. Total number of patients at risk of breaching 65 weeks by Dec 2023 is at 10,851 against a trajectory of 9,807. 10/20 specialties are behind plan. No patients above 78 weeks or 104 weeks were reported in June. There are no plans for any patients to be over 78 weeks in July 2023.

Emergency Care, Emergency Department Mean Stay – There has been no significant change to these Pillar Metrics although an improvement seen in ED Mean length of stay.
Emergency Care, Emergency Department & Urgent Treatment Centre Emergency Attendances. June saw another increase in the number of ED (Emergency Department) attendances.

I**npatient Spells, Number of Non-Criteria to reside (NC2R (Non-Criteria to Reside)) days.** The number of patients who remain in an Acute Hospital bed without a Criteria to Reside (NC2R) saw an increase in June 2023. The Trust is currently not delivering the 13% of NC2R against the bed base or the BSW 30% reduction.

OPERATIONAL BREAKTHROUGH OBJECTIVE

Clinically Ready to Proceed (CRTP) This group of patients includes Type 1 attendances. who saw an increase in the time from arrival to being CRTP. Mean time from ED to CRTP reduced in month.

Alerting Watch Metrics

Key alerting measures include, RTT, DM01 and Cancer. RTT shows deterioration in month whilst measures associated with DM01 & Cancer although not reporting in month, show deterioration in May 2023. Improvements have been seen in mays Cancer 31-day performance. Out of the 13-alerting metrics related to ED and Flow, 4 show signs of improvement.

Our Care

The Integrated Performance report (IPR) for Care present 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 achieve consistent positive response rates in excess of 86% from patient friends and family test.

There continues to be a decrease in the total number of harms down to 208 in month. This downward trajectory can be linked to a drop in the number of infection cases, E. Coli, and Covid being the main drivers. There has been a slight drop in the number of falls related harms in month, 110 and 111 in the previous month. There has been a very slight increase in the pressure harms in both the acute and community setting in month, but this has not affected the overall harms.
The number of Family and Friends positive responses has dropped slightly in month but remains on the internal target of 86%.

Breakthrough Objectives

Pressure harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough objective. For 2023-24 the following new targets have been agreed.

- Reduction in the number of pressure harms by 20% across the organisation in 2023/24 compared to 2022/23.
- Zero category 4 pressure ulcers across the organisation.
- Zero category 3 pressure ulcers in the acute setting.

June has seen an increase in both acute and community pressure related harms, with 40 in the community setting in month, affecting 34 patients. An increase of three harms from last month, and one additional patient. Rapid response visits have identified that 10% of the patients visited by their teams were identified as having severe frailty. A frailty scoring system has been implemented across Urgent Care response visits, with a plan to roll out across Community Nursing, to support risk assessment.

Alerting Watch Metrics

There has been a drop in the Trust complaint response rate in month to 74%, which is below the internal target of 80%.

Methicillin-resistant Staphylococcus Aureus (MRSA) and Methicillin Sensitive Staphylococcus Aureus (MSSA) data showing zero and three respectively for June, demonstrate good ongoing management in these areas.

Rates of all three reportable gram-negative bloodstream infections (E. coli, Klebsiella and Pseudomonas aeruginosa) have increased again in June. There is no obvious underlying theme, however, concerns around environmental cleanliness have been noted since the change to cleaning practices in April. The Trust already had higher rates than its peers, so cleaning will not be the only factor. Pipework and handwash basins that do not adhere to modern standards may be a contributing factor and Estates are looking into upgrading these.

Non-alerting Watch Metrics

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

- The total number of falls and rate per 1000 bed days has continued to decrease for the third consecutive month.
- Three Serious Incidents have been declared in month, all will be investigated under the Serious Incident Framework
- There has been a significant increase in the number of concerns in month, and a slight increase in the number of complaints.
- There have been no reported Methicillin-resistant Staphylococcus Aureus (MSRA) infections reported for the third month.
- Pseudomonas infections have risen again in month to 10.
- FFT overall response rate has seen dipped slight and is just under the internal response rate of 28%
- The emergency department have seen a slight decrease in both the overall response rate and positive response rates, with both now just below target.

Our People

This section of the report presents workforce performance measured against the pillars of the 'People Strategy' – Great workforce planning, opportunities, experience, employee development and leadership. Each area is measured with a KPI (Key Performance Indicators) indicator achievement score and self-assessment score based on progress in month.

Strategic Pillar Target from A3 goals:

To aim to be in the top 20% of Trusts for staff survey results and in the lower quartile for turnover within Model Hospital.
The Trust aims to improve our Staff Survey response rates year on year and increase the number of staff "recommending the Trust as a place to work"

Breakthrough Objectives

The Trust Breakthrough objective is to achieve a 5% improvement in the question "*I am able to make improvements happen in my area of work*" in the Staff Survey.
The Quarter 2 Pulse survey is launched on the 3rd July and is open until 31st July. An additional free-text question has been included in this survey as part of the "Great Place to Work Campaign" to collect information about why staff are proud to work for GWH. Results of the Q2 survey will be available from 8th August.

Alerting Watch Metrics

Sickness absence remains only slightly above KPI, however a further reduction in month from 3.8% to 3.66% in May 2023. Of this absence, 1.8% is long term absence and 1.9% is short term absence.

Non-Alerting Watch Metrics

Voluntary turnover for May 2023 continues to be below the KPI target of 11%, reporting at 10.5% and sustaining the reduction seen in April 2023.

Agency spend as a percentage of the total paybill has reduced in June 2023 to 3.41%, back below the Trust target of 4.5% and in line with the performance in April. Agency spend was in line with the Trust Plan in M3 with a small underspend of £1,244 and £115,000 year to date. Therefore, currently on plan to achieve a £3m reduction which associated risks.

HR Scorecard

Vacancy rate has reduced slightly in June (7.9%) which is due to a reduction of 53wte within the establishment. In June a new workforce establishment control has been implemented to ensure that the Trust maintains the workforce WTE plan and any increase and linked to activity and monitored via TMC. This has been included in the IPR slide for workforce.
The in-month time to hire has decreased slightly again in May to 47 days compared to 50.6 days in April for substantive staff. Bank Recruitment pipeline has undergone a 'data cleanse' and is a much-improved position reporting 28.60

Use of Resources

As at M3 the Trust is in a £4.6m deficit position which represents a £3.1m adverse variance to plan. Pay and non-pay pressures are driving the adverse variance.

NHSE stipulated for M3 that all providers should assume ERF is paid to them in line with plan for Q1. This is included in the above numbers and means that our position is £2m better than it would be if ERF remained directly linked to activity performance, ie our position would have been £5.1m worse than plan if we were reporting in line with plan assumptions.

For pay (£4.1m adverse YTD), £2.0m is driven by Medicine division. Of this, £1.2m is due to temporary staffing covering vacant posts across medical and nursing. The remaining £0.8m are costs covering industrial action. ICC division is £0.5m over budget due to temporary staffing spend covering medical/nursing vacancies in Cancer care, Community care and Sunflower ward, while Corporate is £0.3m adverse, also due to temporary staffing overspends on admin and nursing staff.

One of the key drivers of the non-pay (£4.4m adverse YTD) is the £0.5m shortfall on efficiency savings. A further £0.5m is due to clinical supplies, specifically in SWC and ICC, while depreciation is also £0.5m overspent. The remaining £2.9m overspend is the risk share system allocation.

The income variance (£5.4m favourable YTD) is driven by the release of year end accruals (£0.9m) and TVCA income in ICC (£0.8m). Additional elective, day case and outpatient income accounted for a further £4.0m, while RTA and overseas visitor income is £0.2m above plan. Fixed block income is £0.6m over plan. Private patient income is £0.1m over plan with residual other income of £0.3m. These are offset by an underperformance in elective income in SWC (driven by T&O and Urology) of £1.6m.

Efficiency savings were £0.3m ahead of target in month and are £0.6m behind plan on a YTD basis. The in-month improvement is mainly due to the recording of discharge lounge and CMDU savings in Medicine and a movement of schemes from amber to green status.

Link to CQC (Care Quality Commission) Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	x		**x**	**x**	**x**
Key Risks – risk number & description (Link to BAF (Board Assurance Framework) / Risk Register)					**Risk Score**
Consultation / Other Committee Review /	PPPC (Performance, Population & Place Committee) & Trust Management Committee				

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

Explanation of above analysis

Workforce

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

https://www.hee.nhs.uk/sites/default/files/documents/Pan-LondonDiscrimination%26RacismPrimaryCareSurvey_Final.pdf
https://lcp.uk.com/our-viewpoint/2023/04/burnt-out-or-something-more-examining-the-real-root-cause-of-nhs-workforce-challenges/
Workforce race inequalities and inlcusion in NHS providers (kingsfund.org.uk)

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	**Felicity Taylor-Drewe**
Date	27th July 2023

Great Western Hospitals
NHS Foundation Trust

Integrated Performance Report

July 2023

June 2023 & May 2023 data period

Improving together

Content & introduction

Great Western Hospitals NHS Foundation Trust

Section & purpose	Slides
Key indicators This is the NHS Oversight Framework indicators for 2022/23 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	5-11
Breakthrough objectives This provides a more detailed analysis of performance and risks related to the 4 key metrics for improvement: patients developing pressure ulcers; over 12 hour waits in the Emergency Department; patients awaiting discharge (NCTR) and staff survey results	12-15
Our Performance This includes key indicators and watch metrics related to our access performance, as assured by the Performance, Population & Place Committee	16-19
Our Care This includes key indicators and watch metrics related to our care of patients, as assured by the Quality & Safety Committee	20-22
Use of Resources This includes key indicators and watch metrics for finance as assured by the Finance, Digital & Infrastructure Committee, and is also subject to a separate board report	23
Our People This includes key indicators and watch metrics for our workforce, as assured by the People & Culture Committee	24-28
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.	29-41

Key Indicators

NHS
Great Western Hospitals
NHS Foundation Trust

Measure Name	Mean/Thres.	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Total patients waiting more than 52 weeks	2020 (Avg)	1,215	1,568	1,926	2,164	2,281	2,188	1,817	1,833	2,159	2,240	2,385	2,469
Total patients waiting more than 65 weeks for elective care	465 (Avg)	201	280	404	531	631	610	463	455	384	458	525	640
Total patients waiting more than 78weeks	37 (Nat)	34	35	44	40	45	68	62	56	2	1	1	0
Total patients waiting more than 104 weeks	0 (Nat)	0	0	0	0	1	0	0	0	0	0	0	0
Total elective activity undertaken compared with 2019/20 baseline	120% (Nat)	87.3%	100.3%	94.2%	86.1%	97.1%	82.1%	100.1%	99.3%	136.3%	92.7%	102.7%	82.8%
Elective activity vs plan	100%	87.9%	103.6%	88.5%	90.2%	98.5%	102.5%	100.3%	93.3%	99.9%	110.6%	104.7%	93.0%
Total diagnostic activity undertaken compared with 2019/20 baseline	120% (Nat)	87.9%	90.5%	101.9%	95.6%	105.2%	98.4%	100.2%	97.0%	138.6%	95.2%	102.6%	Reported one month behind
Percentage of patients who receive a diagnostic test within six weeks of referral	99% (Nat)	46.9%	43.9%	46.5%	50.4%	52.3%	48.0%	48.5%	54.2%	56.1%	50.4%	52.3%	Reported one month behind
Total Cancer patients waiting over 62 days	211 (Avg)	268	326	284	258	223	178	150	110	145	189	188	Reported one month behind
Proportion of patients meeting the faster cancer diagnosis standard	75% (Nat)	75.8%	73.7%	67.1%	64.7%	73.2%	78.2%	70.8%	77.8%	76.5%	73.6%	71.3%	Reported one month behind
Total patients treated for cancer compared with the same point in 2019/20 (first and subsequent)	100% (Nat)	58.6%	107.1%	106.2%	85.4%	123.3%	141.0%	118.8%	115.6%	80.4%	73.9%	157.3%	Reported one month behind
Outpatient follow-up activity levels compared with 2019/20 baseline	75% (Nat)	73.9%	94.5%	88.8%	79.7%	97.0%	86.9%	89.3%	91.8%	117.4%	86.1%	77.6%	72.7%
Proportion of ambulance arrivals delayed over 30 minutes	46.1% (Avg)	31.0%	42.9%	46.3%	49.9%	47.2%	60.1%	44.6%	47.8%	47.2%	46.1%	44.2%	46.1%
Proportion of Patients spending more that 12 Hours in an Emergency Department (Type 1 & 3)	2% (Nat)	6.5%	8.2%	8.4%	8.5%	8.2%	9.4%	8.9%	8.0%	8.0%	7.1%	6.7%	7.4%
Proportion of patients discharged from hospital to their usual place of residence	94.3% (Avg)	94.2%	93.9%	94.3%	94.2%	94.0%	93.8%	94.2%	94.6%	94.3%	94.4%	95.3%	94.6%
GWH - Percent Non-Criteria to Reside (NCtR) Bed Days	24% (Avg)	24.5%	24.0%	26.1%	26.7%	25.6%	24.6%	22.6%	22.7%	24.2%	21.9%	21.7%	23.4%
National Patient Safety Alerts not completed by deadline	0.1 (Avg)	0	1	0	0	0	0	0	0	0	0	0	0

Key Indicators

Great Western Hospitals NHS Foundation Trust

Measure Name	Mean/Thres.	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Overall CQC rating		Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Requires improvement
Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate (Per 100,000 bed days)	0 (Nat)	0	0	0	6	0	0	6	6	0	0	0	0
Clostridium difficile infection rate (Per 100,000 bed days)	26.5 (Avg)	11.7	17.3	41.7	17.3	41.3	5.7	5.7	31.9	57.2	34.7	Waiting for data	Reported one month behind
E. coli bloodstream infection rate (Per 100,000 bed days)	52.4 (Avg)	52.7	75.0	35.8	11.5	35.4	51.4	68.6	95.8	68.6	28.9	Waiting for data	Reported one month behind
CQC well-led rating		Good	Good	Good	Good	Good	Good	Good	Good	Good	Good	0	0
Proportion of staff in senior leadership roles who are from BME background	12% (Nat)	4.7%	5.9%	6.0%	6.5%	6.8%	6.8%	6.8%	6.6%	6.6%	6.3%	5.2%	5.2%
Proportion of staff in senior leadership roles who are women	62% (Nat)	69.1%	67.0%	66.3%	67.3%	67.5%	67.5%	68.2%	68.4%	67.5%	68.1%	58.6%	56.9%
Average hours lost to ambulance handover delays per day	50 (Avg)	30	51	61	66	60	49	67	53	47	32	34	54
Adult general and acute bed occupancy	95.6% (Avg)	95.3%	97.9%	95.9%	96.5%	95.9%	95.7%	96.0%	95.8%	95.5%	94.1%	94.7%	94.4%
Summary Hospital-level Mortality Indicator	1.00	0.90	0.93	0.95	0.98	1.00	1.02	1.04	1.06	1.08	1.11	1.12	1.12
Financial efficiency - variance from efficiency plan (£'000)	+/-	-289	-268	-247	190	-378	-338	-400	-238	281	-377	-384	334
Financial stability - variance from break-even (£'000)	+/-	-2068	-1848	-1938	-363	-1672	-1502	-1579	-1469	-1482	-2157	-2591	-144
Financial stability - variance from PLAN (£'000)	+/-	-326	-268	-408	1154	389	164	106	214	-18	-893	-2132	-223

Measure Name	Mean	2017	2018	2019	2020	2021	2022
Aggregate score for NHS staff survey questions that measure perception of leadership culture	6.8	6.8	6.8	7.1	6.9	6.5	6.7
Staff survey engagement theme score	6.9	6.9	6.9	7	7	6.7	6.7
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	0.6	59.6%	54.1%	60.4%	57.1%	56.1%	56.4%

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Total Harms

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

- Pressure harms
- Falls
- Hospital acquired infections (including Covid-19)
- Medication incidents
- Serious incidents
- Never Events

Pressure ulcers/harms acquired in our care (either as an inpatient or in the community), has been identified as the top contributor due to frequency and level of harm, therefore it has been developed as a Breakthrough Objective.

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

Patient Experience (FFT)

The Friends and Family Test is a national scheme which encourages patients to provide feedback about their experience of using our services. Patients are asked the question, Overall, how was your experience of our service? and have six options ranging from very good to very poor and don't know, there is also an area for free text comments, results are collated monthly.

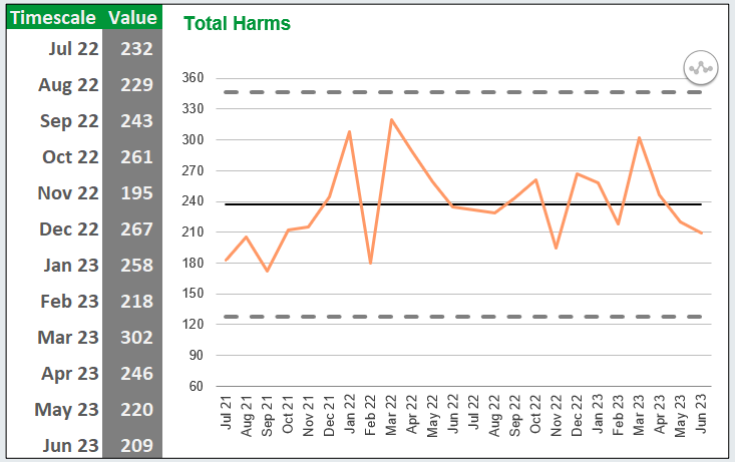
The FFT is mandated across all acute providers and therefore provides an opportunity to benchmark across the country. It is important to consider the proportion of patients completing the test and the overall positive score together, we have therefore added completion rates as watch metrics to our overall scorecard.

We have set ourselves a target of 86% for the combined positive response rate, this is based on the mean from 2021-22 plus 2%.

Total Harms

To achieve and sustain zero avoidable harm.

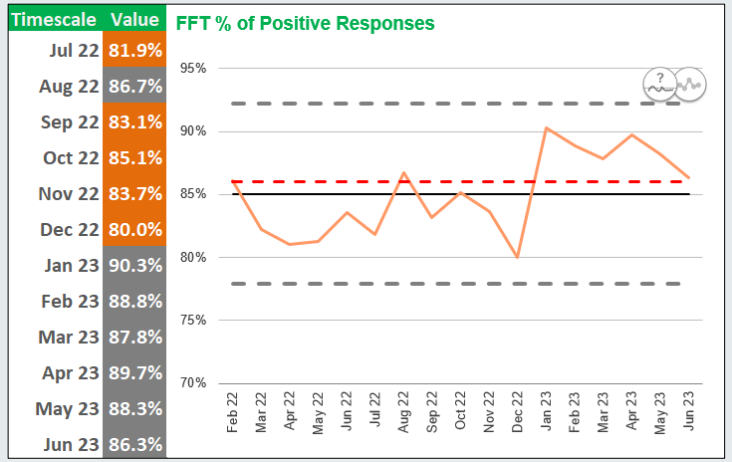
Timescale	Value
Jul 22	232
Aug 22	229
Sep 22	243
Oct 22	261
Nov 22	195
Dec 22	267
Jan 23	258
Feb 23	218
Mar 23	302
Apr 23	246
May 23	220
Jun 23	209



Patient Experience (Friends & Family Test)

To achieve consistent positive response rates in excess of 86% from patient friends and family test.

Timescale	Value
Jul 22	81.9%
Aug 22	86.7%
Sep 22	83.1%
Oct 22	85.1%
Nov 22	83.7%
Dec 22	80.0%
Jan 23	90.3%
Feb 23	88.8%
Mar 23	87.8%
Apr 23	89.7%
May 23	88.3%
Jun 23	86.3%



Counter Measures

The number of harms has decreased for a third consecutive month. Changes to COVID testing have reduced the overall numbers of hospital-acquired infections. Falls harms have remained stable and there has been a slight increase in pressure harms.

The number of hospital acquired infections has increased for *C. difficile* and for the gram-negative bloodstream infections. Rates of MSSA and MRSA have remained low and zero respectively. This supports a link with environmental cleanliness, since *C. diff* and gram-negative organisms are associated with colonisation of the environment. Serco have an action plan to improve standards, and this is being monitored at executive level.

For June there has been a slight decrease in the number of Family and Friends positive responses, but it still remains over the internal target of 86%.

- Following the launch of the Carers Support Passport last month we have seen a significant increase in the use of the passports.
- The new Changing Places facility within the children's unit is almost complete.
- All Health Care Support Workers are being encouraged to complete the care certificates. This will help to provide consistent standards of care.
- Same Day Emergency Care (SDEC) are using opportunities to promote family and friends including with those less likely to respond by text.

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.

In common with many other providers, the Trust has not consistently achieved the National Cancer Standards or Access standard for RTT. Nationally expectations are being reset around targets. Countermeasures for the deteriorations seen here are listed below

Cancer 62 Day
In May, there were 35.0 breaches in total, with 23.0 of these attributed to the Urology, Skin and Breast pathways. Skin and Breast have increased demand resulting in capacity challenges. We continue to see greater than normal breaches in Urology. Over half the breaches can be attributed to our capacity for TRUS Biopsies. Other breaches in Urology relate to patients needing time to consider which choice of treatment they would prefer.

RTT: Number of patients waiting over 65 weeks

The number of patients waiting over 65 weeks increased in month by 115 patients, to 640. This was driven by increases in Gastroenterology (+38), Oral Surgery (+34) and Paediatrics (+27). These increases have resulted in an adverse movement in the submitted trajectory by 140 patients. However, Neurology (-24), ENT (-4) and Plastic Surgery (-1) improved in month.

Internally, a stretch trajectory has been set for all patients who would be potentially waiting over 65 weeks at the end of March 2024 (the '65-week cohort') to be treated or discharged by the end of December 2023. This is ahead of the national expectation of March 2024 and supported by speciality trajectories.
In line with Improving Together methodology, for specialities adverse to their 65-week trajectory, deep dives are in place to understand top contributing reasons for the position to then identify rapid improvement actions.

Zero 78-week breaches were reported at the end of June 2023.

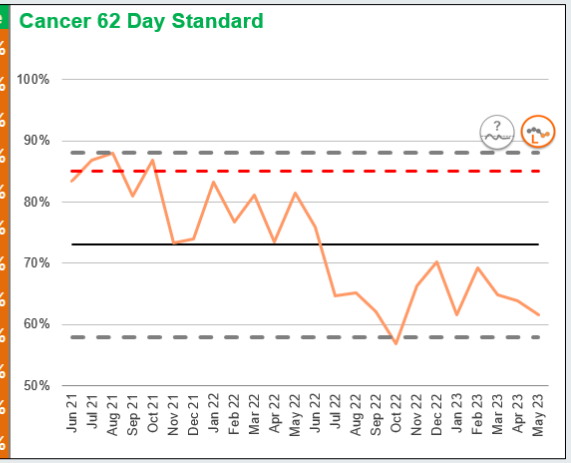
Felicity Taylor-Drewe
Chief Operating Officer

Service | Teamwork | Ambition | Respect

Cancer 62 Day

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

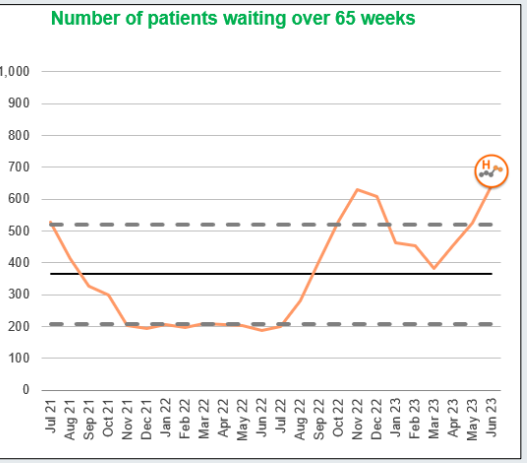
Timescale	Value
Jun 22	76.0%
Jul 22	64.7%
Aug 22	65.1%
Sep 22	62.0%
Oct 22	56.9%
Nov 22	66.4%
Dec 22	70.2%
Jan 23	61.6%
Feb 23	69.3%
Mar 23	64.8%
Apr 23	63.8%
May 23	61.5%



RTT: Number of patients waiting over 65 weeks

To eliminate over 65-week waiters by March 2024 supporting reduction in average waiting times.

Timescale	Value
Jul 22	201
Aug 22	280
Sep 22	404
Oct 22	531
Nov 22	631
Dec 22	610
Jan 23	463
Feb 23	455
Mar 23	384
Apr 23	458
May 23	525
Jun 23	640



Counter Measures

Risk: Capacity in Dermatology & Plastics is insufficient to see and treat patients.
Mitigation:
Plastics - Seeking further Mutual aid from OUH and Cotswold Surgical Partners. Plastic Consultants have agreed to see additional patients on a pay per patient basis. Monthly theatre lists have been implemented for ENT and Oral Surgery Consultants.
Dermatology – A Locum Consultant returned from long term leave in June, which will create greater capacity, however the clearing of the backlog may see an increase in breaches. We are using CSP for BCC patients that will reduce the number of patients being referred to the Plastics team.

Risk: Urology Pathway are often complex requiring multiple diagnostics, with multiple treatment options needing to be discussed at Tertiary centres before treatments can be planned. Patients requiring additional treatment following an incomplete TURBT procedure will breach due to recovery and planning time.
Mitigation: Pathway improvement manager is working with service to implement the best practice timed pathway which includes a Demand/Capacity review of TRUS biopsies. The Surgical team are undertaking LATP biopsy training with a view to reducing the demand on TRUS biopsies, this will start to have an impact from Q2..

Risk: Colorectal 2ww triage & Appointment post MDT.
Mitigation Service has direct oversight of the registrar rotas with Consultant input to allow triage to happen. Registrar clinics in place to aid outpatient capacity for first appointment and MDT slots are allocated to clinics.

Risk: Insufficient capacity to recover 65 week + breach position by March 2024
Mitigation:
- Patient level details/plans updated on weekly basis in line with recovery trajectory.
- Unfit patients/patient choice being managed in line with Trust Access Policy.
- Additional clinical capacity being provided across services for patients at risk of breaching the 65 week standard.

Risk: Impact on Elective capacity due to the proposed industrial action across multiple staff groups.
Mitigation:
- All elective activity on proposed strike days reviewed. Maximum clinical sessions running where staffing allows.
- Patient impact assessed and alternative sessions to be provided. Long waiting and cancer patients prioritised.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

Emergency Care – Emergency Department - Mean Stay

Patients are 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 in June ’23 was 410 minutes against the national standard of 240 minutes. June showed a significant improvement in the mean time in ED having reduced from 448 minutes in May. Flow in ED remained challenging, contributing to ambulance handover delays, although total time lost (30-60 mins) was again improved.

Emergency Care – Urgent Treatment Centre - Mean Stay

Patients are not delayed within the Urgent Treatment Centre (UTC). This is a marker of a service that is functioning as expected

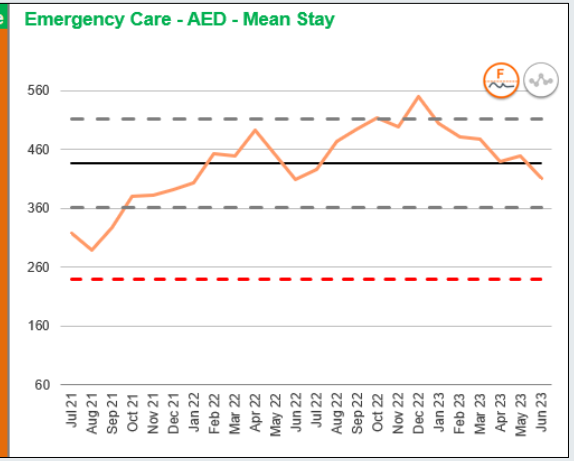
The total meantime wait for a patient in June 2023 was 162 minutes against the national standard of 240 minutes, demonstrating good flow through the service.

Felicity Taylor-Drewe
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.

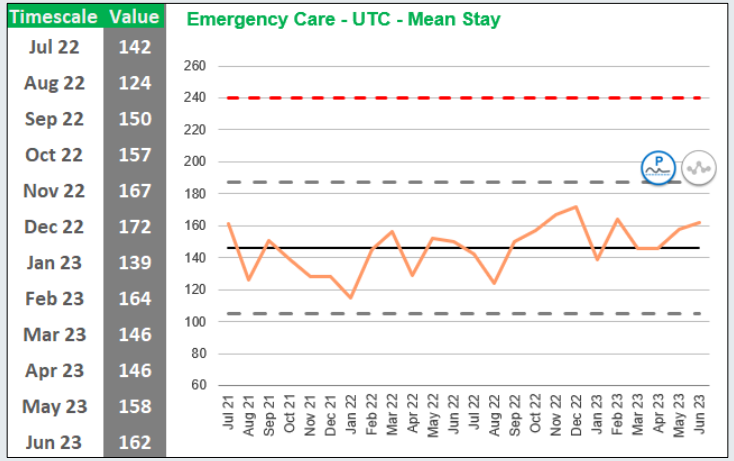
Timescale	Value
Jul 22	425
Aug 22	473
Sep 22	494
Oct 22	514
Nov 22	499
Dec 22	550
Jan 23	503
Feb 23	482
Mar 23	477
Apr 23	440
May 23	448
Jun 23	410



Emergency Care – Urgent Treatment Centre - Mean Stay

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

Timescale	Value
Jul 22	142
Aug 22	124
Sep 22	150
Oct 22	157
Nov 22	167
Dec 22	172
Jan 23	139
Feb 23	164
Mar 23	146
Apr 23	146
May 23	158
Jun 23	162



Counter Measures

- Weekend ED Paeds Consultant to be maintained with vacancy monies; improve quality of care and waiting times for children, whilst also supporting main ED staffing
- Pit-stop nursing maintained (challenging as now within 'normal' staffing numbers); provides clinical oversight of queue, starts assessments early & potential for simple treatments
- Support services input for admission avoidance & improved discharge - Co-ordination Centre, Flow and Community Teams
- Increased capacity for Triage of self-presenting patients (Triage cubicles x2), assessment of 'ED Majors' patients (6 bays) and provision for early ambulance assessment (Pitstop x1)

- Metric routinely meeting standard
- Roster change trial implemented for staff to increase staffing model mapped to key times of patient arrival – extension continues.
- Review of ACP staffing model and operational hours commencing to provide more reactive service.
- Single front door pathways between the Emergency Department and the Urgent Treatment Center are now in place alongside front door building work and new patient entrances.

Executive Summary

Great Western Hospitals NHS Foundation Trust

Emergency Department & Urgent Treatment Centre - Emergency Attendances

Emergency Attendances collects the total number of attendances in the Emergency Department (ED) & the Urgent Treatment Centre (UTC). May has seen a large increase in attendances to both ED & UTC.

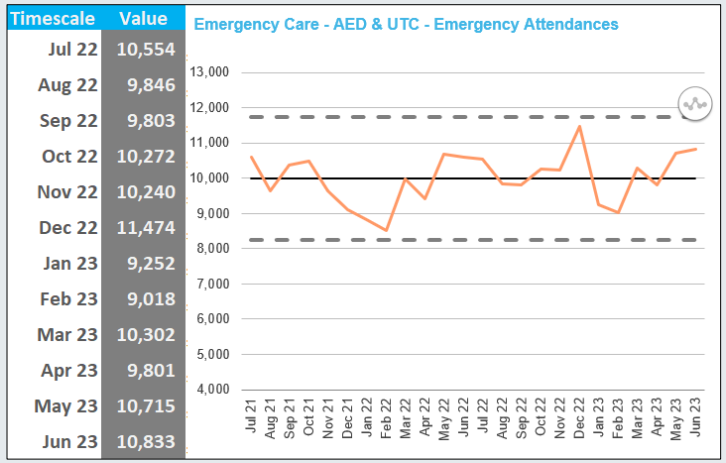
Attendances are up by 35 compared to the same time in 2022 and up by 422 compared to 2021.

ED & UTC combined saw 10,833 patients in June (ED 5433, UTC 5400), this is an increase on May numbers. There was a corresponding increase in the number of long stay patients >21 days with a levelling of NCTR bed days.

Emergency Care – Emergency Department & Urgent Treatment Centre - Emergency Attendances

To ensure patients are cared for in the appropriate setting

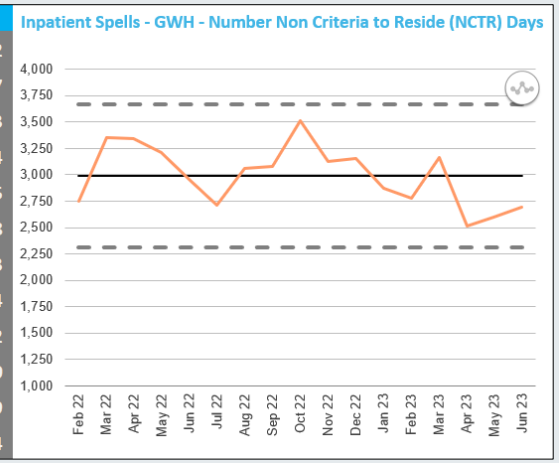
Timescale	Value
Jul 22	10,554
Aug 22	9,846
Sep 22	9,803
Oct 22	10,272
Nov 22	10,240
Dec 22	11,474
Jan 23	9,252
Feb 23	9,018
Mar 23	10,302
Apr 23	9,801
May 23	10,715
Jun 23	10,833



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

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

Timescale	Value
Jul 22	2,712
Aug 22	3,057
Sep 22	3,083
Oct 22	3,514
Nov 22	3,125
Dec 22	3,158
Jan 23	2,873
Feb 23	2,774
Mar 23	3,162
Apr 23	2,510
May 23	2,599
Jun 23	2,694



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

After several months of a declining NCTR, June has seen a noticeable increase in the number of patients who could be discharged and a larger was proportionally required social care and council support.

Counter Measures

- Reset NCTR escalation triggers for internal, local and system support .
- Develop an action plan to sustain delivery on holding only 13% of bed Occupancy as NCTR patients.
- Pre strike week ED attendance and admissions hugely increased
- Review learning from industrial actions- larger number of cases and longer waits for diagnostics & procedures, specialist reviews occurred where seniors where supporting ward cover.

- Wilshire council joining the discharge hub model commenced
- 7 day hub starts July 15th
- SBC recognised the reduced capacity in step down beds contributing to the NCTR and a review of all PW3 patients was undertaken– exploring a model for residential homes to support bridging gap to care home placements – Task and finish group commenced with ICA support.

Felicity Taylor-Drewe
Chief Operating Officer

Executive Summary

Great Western Hospitals NHS Foundation Trust

Voluntary Staff Turnover (rate)

The annual voluntary turnover rate provides us with a high-level overview of Trust health.

The NHS People Plan highlights the support and action needed to create an organisational culture where everyone feels they belong.

Workforce retention is a top priority across the NHS. High turnover rates are typically associated with increased recruitment and training costs, low morale and reduced performance levels.

The Trust has seen a continued improvement in the trend since July 2022. The voluntary turnover rate for May 2023 is unchanged from April and remains below the Trust KPI target of 11%. Stability of this metric will be driven by ongoing initiatives in the Trust Retention Plan 2022-25.

Staff Recommendation as a Place to Work

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 staff engagement score is seen as a key priority for the Trust. The Kings Fund reports there is now overwhelming evidence to show that engaged staff really do deliver better health care and higher levels of staff engagement (measured through the staff survey) have lower levels of patient mortality, make better use of resources and deliver better financial performance.

The Q2 Pulse Survey is currently in circulation with results available in August 2023.

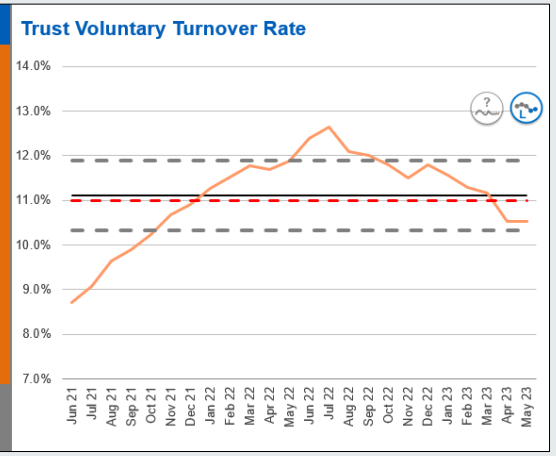
Jude Gray
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

Trust Voluntary Turnover Rate

To achieve and maintain a maximum voluntary turnover rate of 11%.

Timescale	Value
Jun 22	12.4%
Jul 22	12.6%
Aug 22	12.1%
Sep 22	12.0%
Oct 22	11.8%
Nov 22	11.5%
Dec 22	11.8%
Jan 23	11.6%
Feb 23	11.3%
Mar 23	11.2%
Apr 23	10.5%
May 23	10.5%



Staff % recommend the organisation as a place to work

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

Counter Measures

- The Trust-wide Retention Workshop is scheduled to meet again in July 2023, with increasing participation from teams across the Trust. The group will complete an A3 assessment to identify counter measures focussed on connecting retention initiatives with the workforce and improving uptake of support and opportunity for all colleagues.
- The third Great West Fest will be held on Saturday 2 September at Town Gardens, and offering tickets to even more staff, volunteers and families this year. The event features free children fun fair and live music acts.
- The Trust is proud to celebrate as of the 12th July 2023, achievement of the Armed Forces Gold Employer Recognition Award. This strengthens our partnership with supporting our armed service colleagues and their families.

- Q2 Pulse survey is live until 31 July 2023, with a current compliance rate of 11% (national average of 8%) . Data will be available on 8th August and will be used to inform the 'Great Place to Work' communication campaign.
- The 'Great Place to Work' campaign launched on the 10th July, to promote the Trust as a great workplace and showcasing our commitment to career progression, recognising staff achievements and prioritising health and wellbeing. Colleagues are encouraged to get involved through testimonials, career stories and an 'I'm proud to work here' video.
- A communication was shared with staff to promote the continued investment in safer staffing level, international recruitment and establishment increases and how this aligns with our commitment to delivery of the NHS Long Term plan.

Executive Summary

NHS
Great Western Hospitals
NHS Foundation Trust

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

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

Discrimination has been a longstanding issue in the NHS, the GWH NHS Staff Survey results highlights highlight that 19.8% of Ethnic and Minoritized staff have experience discrimination compared to 6.3% 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

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.

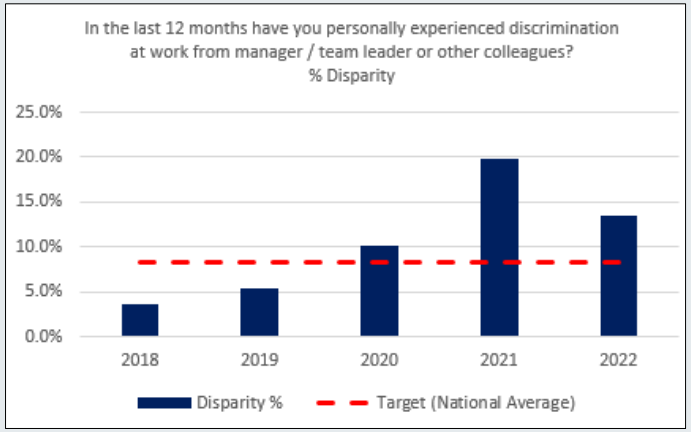
Discrimination is a systemic problem, if we are to make a marked difference, our response must be systemic too. Success will be borne from developing sustainable strategies based on education and support and by challenging behaviours that do not align with our STAR values. Our commitment to addressing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

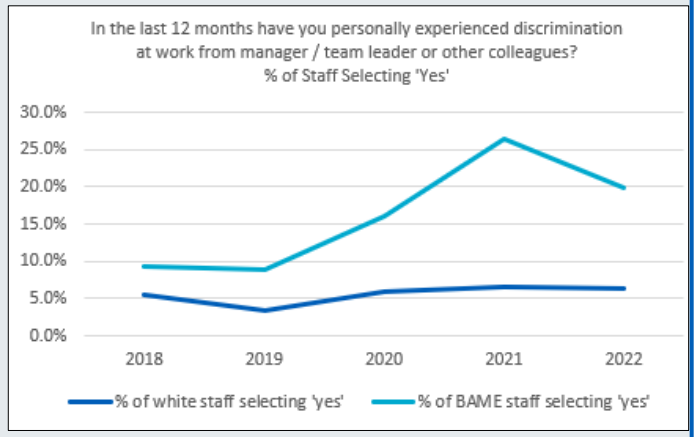
The Trust ambition is to reduce the disparity between white staff and BAME staff from 13.5% to 8.3% in line with the national average and be below the national average for all staff.

Jude Gray
Director of Human Resources (HR)

Service | Teamwork | Ambition | Respect

% 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 EDI Lead has visited several wards to talk to staff about their experience of discrimination in the Trust. The supporting survey closed early July, with over 90 responses. The results will be analysed and a report presented to the EDI Group in August, including proposed actions that will form part of the EDI action plan for 2023-24.
- An engagement event is planned for 18th July to improve cultural awareness between staff from the UK and our Internationally Educated Staff. This will mark the celebration of the 75th anniversary of the Empire Windrush's maiden voyage to the UK and the 75th year of the NHS. Past and present NHS staff from a Black, Asian Minority Ethnic background will be invited to share their stories with GWH Staff.
- Trust plans to launch an allyship programme continue. The pilot will launch during National Inclusion Week (last week of September) and a stall will be hosted by the EDI Lead and Race Equality Network Chairs in the Trust's Atrium on Tuesday 26 September.

Executive Summary

Great Western Hospitals NHS Foundation Trust

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

There has been a significant and growing financial deficit over the last 3 years at the Trust. Large financial deficits undermine the public trust in the NHS and put the financial viability of the organisation at risk.

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. Great Western Hospitals NHS Foundation Trust's Green 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 also for indirect emissions by 2045. In line with NHS targets, we are aiming to achieve an 80% reduction in our direct footprint by 2028-2032.

In lieu of our carbon footprint data from Greener NHS (anticipated for early Q3) this report focus is on electricity and gas consumption which forms a significant part of our direct carbon footprint.

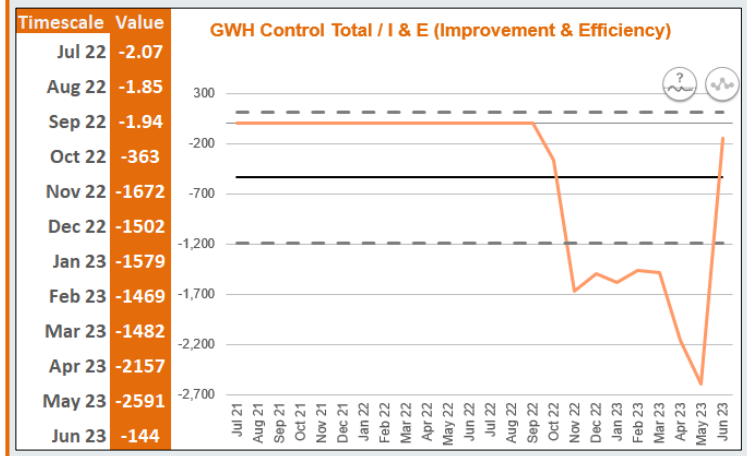
Over the coming years we will be focusing on the delivery of our Green Plan and ICS Green Plan which will be formally reported on annually and refreshed every 3 years.

Simon Wade
Chief Financial Officer

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

To achieve and sustain a break even financial position.

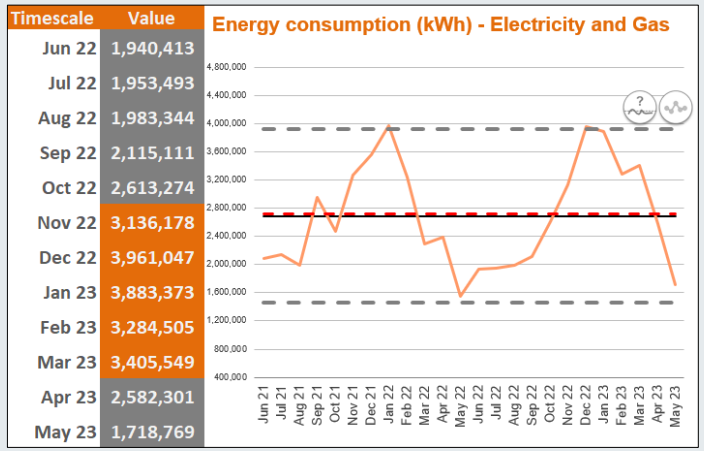
Timescale	Value
Jul 22	-2.07
Aug 22	-1.85
Sep 22	-1.94
Oct 22	-363
Nov 22	-1672
Dec 22	-1502
Jan 23	-1579
Feb 23	-1469
Mar 23	-1482
Apr 23	-2157
May 23	-2591
Jun 23	-144



Energy consumption (kWh) – Electricity & Gas

To achieve an organisational carbon neutral footprint.

Timescale	Value
Jun 22	1,940,413
Jul 22	1,953,493
Aug 22	1,983,344
Sep 22	2,115,111
Oct 22	2,613,274
Nov 22	3,136,178
Dec 22	3,961,047
Jan 23	3,883,373
Feb 23	3,284,505
Mar 23	3,405,549
Apr 23	2,582,301
May 23	1,718,769



Counter Measures

- As at M3 the Trust is in a £4.6m deficit position which is £3.1m adverse variance to plan. Pay and non-pay pressures are driving this.
- NHSE stipulated for M3 that all providers should assume ERF is paid to them in line with plan for Q1. This is included in the above numbers and means that our position is £2m better than it would be if ERF remained directly linked to activity performance, ie our position would have been £5.1m worse than plan if we were reporting in line with plan assumptions.
- Efficiency savings were £0.3m ahead of target in month and are £0.6m behind plan on a YTD basis. There are £15.2m of identified schemes but only £4.5m (27%) of this total is fully developed. There is an unidentified gap of £1.5m to the overall Trust savings target of £16.7m.
- Countermeasures have been put in place through the efficiency programme, including:
  - Focus on actions to reduce run rate
  - Cross-divisional schemes such as Better Buying and Medicines Optimisation
  - Enhanced workforce controls
  - Agency control measures

•The board approved Green Plan has been published with targets and action plan agreed.

•Capital funding for sustainability projects has been agreed and work is underway on reducing emissions from nitrous oxide and entonox at GWH.

•GWH is the ICS Green Plan chapter lead for reducing emissions from Medical Gases.

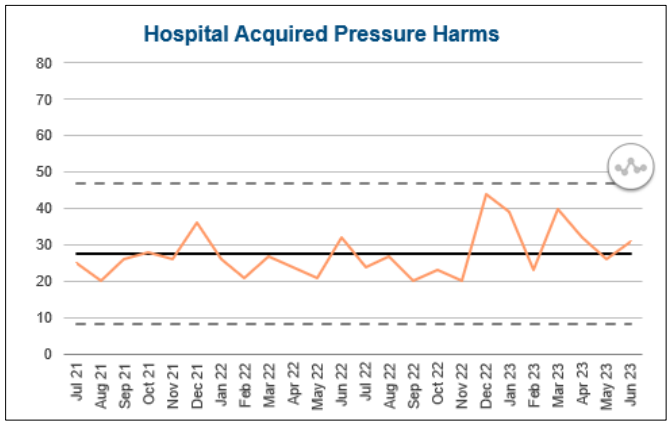
2023/24 Breakthrough Objectives

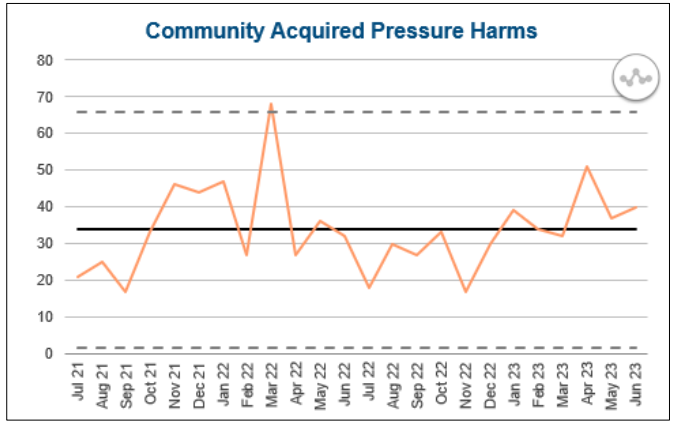
Reduction of Pressure Harms

NHS Great Western Hospitals NHS Foundation Trust

Total Pressure Harms

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
42	57	47	56	37	74	78	57	72	83	63	71





Common cause – no significant change

Understanding the Data

The number in the charts above represents the number of pressure harms that patients have developed whilst in hospital or under the care of a community nursing team. The number reflects the total number of harms not total number of patients i.e., one patient may have two or more pressure harms.

All pressure related harms are reported and then clinically validated to determine if they were acquired whilst under the care of GWH.

Tissue viability is the overarching term that describes the speciality that primarily considers all aspects of skin and soft tissue wounds.

We are driving this measure because...

We know that pressure damage is an avoidable cause of harm to patients and believe that through using the evidence-based improvement methodology we can make a significant difference to patients.

Regular measurement is required to ensure front line teams and divisions identify themes and those actions required for improvement of pressure related harms. This will help reduce the level of pressure related harm and improve staff knowledge and skills in caring for our patients.

Performance

Overall, there has been an increase in the number of pressure harms reported.

There were 31 (26 May) hospital-acquired pressure harms during June.

- This is a slight increase compared to last month (26).
- Ward Managers and Matrons are attending a masterclass on pressure ulcer prevention on 19th July.
- The Acute TVN lead is working with the Academy to review education packages.
- Datix working group is reviewing investigation and reporting processes to improve the timeliness of learning and theme identification.
- aSSKINg trial beginning on four wards w/c 10th July.

In the community setting there were 40 (37 May) pressure harms acquired during June. This is a slight increase from the previous month.

- A frailty scoring system has been implemented across Urgent Care response visits, with a plan to roll out across Community Nursing, in order to support risk assessment.
- 'Learning from incidents' a Tissue Viability board is at the entrance to Orbital- highlighting risks and required responses to harm.
- Tissue Viability education has been delivered at Oxford Brooks to trainee Nursing Associates focusing on identification of risks and harm due to pressure.
- Equipment stores achieved 100% of emergency requests for pressure relieving equipment within the required timescales.

Risks

The continuing high caseloads for Tissue Viability and Community Nursing in addition to the difficulties in recruiting to establishment in the Community Nursing services can impact the ability to provide high quality pressure ulcer prevention management, specialist review and assessment and as a result pressure ulcer rates may increase.

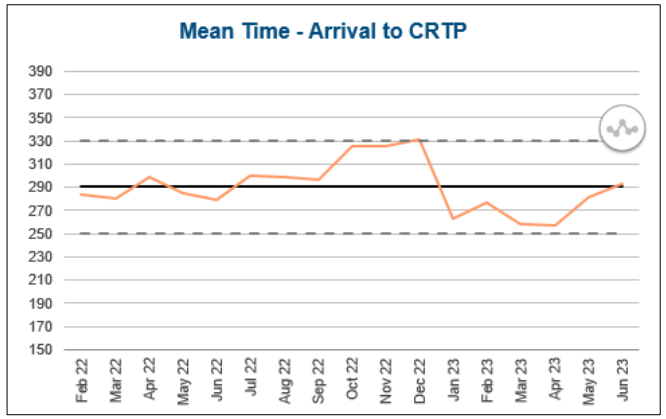
2023/24 Breakthrough Objectives

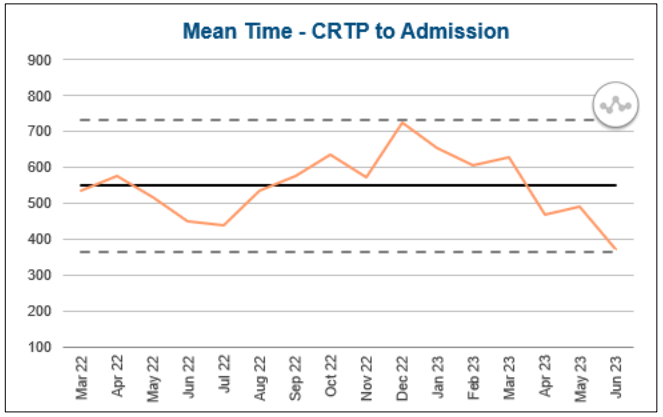
Emergency Attendances - Clinically Ready to Proceed (Admitted)

Great Western Hospitals NHS Foundation Trust

Mean time in ED (Minutes)

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Pre CRTP	300	299	297	326	326	332	263	277	259	258	281	293
Post CRTP	438	536	575	636	572	725	654	608	629	467	492	373





Common cause – no significant change

Understanding the Data

The patient cohort for the data is only type 1 patients who are admitted into the Trust (excludes type 3 patients or any patients discharged). More work to be done to include discharged patients with CRTP.

The graphs show the mean-time waiting from arrival to clinically ready to proceed and post clinically ready to proceed.

On average 65-70% (mean time) of the patients in ED who are 'clinically ready to proceed' are awaiting beds within the hospital. This figure has remained consistent for many months.

April data highlights that on average patients are waiting less time in for a bed in ED compared to previous month.

We are driving this measure because...

The metric Clinically Ready to Proceed is part of the UEC Bundle that is part of the proposed Clinically Led Review of NHS Access Standards.

CRTP is a milestone that separates out the overall Pillar Metric of 'mean time in ED'. Pre CRTP shows the time taken for patients to be triaged, seen and diagnosed. Post CRTP would indicate the time taken for patients to wait for a bed to be available.

Performance

- Mean time in ED from arrival to clinically ready to proceed (CRTP) increased in month to 293 in June (from 281 in May) showing patients waited slightly longer to be triaged, seen and diagnosed.
- Mean time in ED from CRTP to admission reduced in month from to 373 in June indicating patients spending less time in ED awaiting admission.

Risks

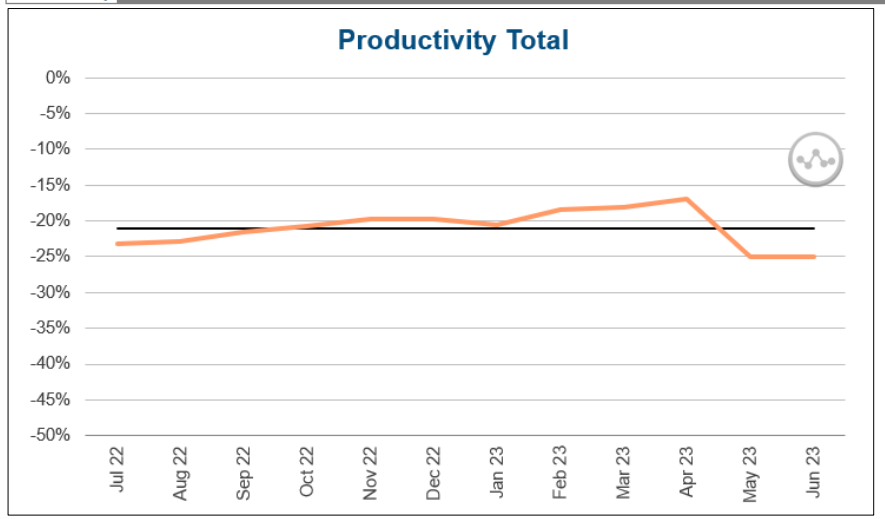
Physical and pathway reconfiguration required for WFP programme will see slightly reduced bed numbers across the ED footprint.

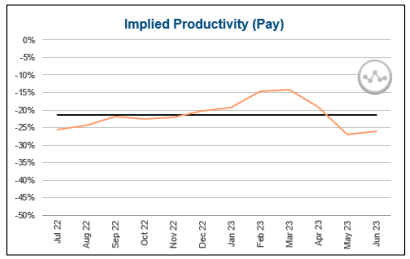
2023/24 Breakthrough Objectives

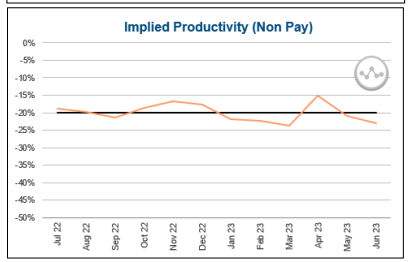
Great Western Hospitals NHS Foundation Trust

Productivity

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Total	-23%	-23%	-21%	-21%	-20%	-20%	-21%	-18%	-18%	-17%	-25%	-25%
Pay	-25%	-24%	-22%	-23%	-22%	-20%	-19%	-15%	-14%	-19%	-27%	-26%
Non Pay	-19%	-20%	-21%	-19%	-17%	-18%	-22%	-22%	-24%	-15%	-21%	-23%







Common cause – no significant change

Understanding the Data

The graphs show a metric made up of weighted activity growth and cost (adjusted for inflation) as a change from 2019/20 levels to give implied productivity. This is currently negative meaning we are less productive than 2019/20 levels - so either weighted activity being delivered is lower or the costs of delivering that activity are higher than in 2019/20. This is shown for pay and non-pay.

We are driving this measure because...

Productivity is reduced when compared to 2019/20 levels leading to longer delays in treatment (activity) and increase in costs. Elective recovery rates are lower than planned and the 2023/24 plan has been set with a target level of activity and productivity stretch

Risks

There have been several risks outlined as part of the A3 for productivity (refer to fishbone diagram)
These included risks such as Divisions lacking capacity to engage in data/findings and sickness and work pressures impacting workforce to deliver on increased productivity stretch in the Trust activity plans.

Performance & Countermeasure

Implied Productivity in total has maintained at an overall total **–25%** for Month 3 (this is a 7% deterioration from the 18% at the end of 2022/23).

This still reflects being off track with our activity and financial plan due to higher pay pressures such as industrial action impact. As this measure continues to be against 2019/20 cost change this is measuring the increased cost from 2019/20 levels. The pay productivity will return to +6% at the end of the 2023/24 plan if planned cost and efficiency levels this year are also delivered.

The Non-Pay productivity movement has also worsened slightly in Month 3 due to the financial position and costs being off plan that are needed to achieve the plan productivity levels. Similar to Pay, the Non-Pay is expected to return to –19% by March 2024 if the plan for the year is recovered in the remaining nine months of the year.

The CIVICA project has been implemented to allow the full range of outputs to be realised – full project deliverables are by August 2023 with Aurum opportunities being presented. Data quality tolerance needs to be reviewed for areas such as coding and information breakdown.

The outputs will allow more key divisional stratified data to also be presented and for key questions to be asked around activity, workforce and quality.

The aim is to produce productivity data, trends and information that can enable intelligence and action plans across divisions in areas such as variation in treatment cost. A Division engagement plan will be put in place when outcomes are fully available, embedding into improvement groups etc. as standing items for review and updates.

2023/24 Breakthrough Objectives

Great Western Hospitals NHS Foundation Trust

Staff Survey - I am able to make improvements happen in my area of work

2018	2019	2020	2021	2022 Q1	2022 Q2	2022 Q4	2022	2023 Q1
49.40%	56.70%	54.50%	49.30%	50.31%	51.10%	52.72%	51.90%	57.20%

Domain	Our Leadership
Metric Focus	Driver
Threshold	
Value	Percentage
Improvement Direction	Higher is Better

Understanding the Data

The data shows the percentage of staff positively responding that they feel able to make improvements happen in their area of work.

These results are predominantly a measure of engagement and service improvement. It is important to know if staff feel able to provide the care and service they aspire to give.

We are driving this measure because...

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

The result of this survey could help how staff feel about making improvements happen in their workplace.

Performance

- Divisions continue commitment to delivery of counter measures in this are. The Trust OD lead is supporting with listening forums in Meldon Ward and General Medical staff to understand drivers of low performance and support interventions.
- The monthly Staff Survey working group has introduced a standing agenda item of shared learning, further to successful presentations by Speech & Language Therapy team and Cancer Services.
- Pulse Survey for Q2 have been launched and results expected at the end of August.
- Great Place to Work Campaign has been launched.
- Planning underway for 23/24 staff survey launch at the end of September.

Risks

- Whilst continuing the 'inch wide, mile deep' focus on question 3F, there are broader opportunities for improvement which are outlined in the divisional Staff Survey presentations which require focus.

- Divisional teams continue improving together training in different timescales, therefore the risk is that less improvement actions could be made in areas who are yet to go through training.

Our Performance

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-23	Apr-23	May-23	Jun-23	Trend
RTT	No. of >=18 weeks waiters		H	16051	16723	16141	16891	
	No. of >=52 weeks waiters		H	2159	2240	2385	2469	
DM01	No. of patients on DM01 waitlist		H	11441	11680	12263	One month behind	
	DM01 performance %	99% (Nat)	F	56.1%	50.4%	52.3%	One month behind	
	DM01 6 week wait breaches		H	5018	5796	5848	One month behind	
Cancer	% Cancer 62 day performance	85% (Nat)	F	64.8%	63.8%	61.5%	One month behind	
	% Cancer 31 day performance	96% (Nat)	F	85.5%	88.7%	91.9%	One month behind	
	% Cancer 2 week wait	93% (Nat)	F	89.2%	79.2%	67.2%	One month behind	

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

Performance & Counter Measure

June's DM01 validated performance is showing a slight variance from the 52.3% performance in May to 52.2%. The number of patients on the waiting list has increased slightly to 12,491 and the number of 6-week breach has increased to 5969. 2 Pads in Radiology continue to be fully utilised with one supporting the CDC and activity numbers continue to remain high. The teams continue to deliver scans within 2 weeks for cancer referrals and anticipate a continued recovering picture for the routine patients, which at present is in line with trajectory. Ultrasound still remains the largest issue, but a recovery plan is due to start in August. ERF Funding is being used for mobile MRI for 6 months until the end of September, and CT 3 days a week for 6 months until the end of September will be funded by the TVCA. Activity is also ongoing to bring mobile Endoscopy on site with a target date of the 24th July, supporting the CDC project.

31 Day decision to treat to treatment standard is heavily impacted by the capacity issues in the Skin pathway with 91% of the breaches being accounted for by this service. WLI activity is being used to help manage demand. A locum returns in June, providing additional capacity. Additional capacity in Plastics is being sourced through private partner (CSP in Wootton Bassett) and through any available mutual aid from OUH.

65.7% of the 62-day breaches were with the Skin, Urology & Colorectal Pathway.

Cancer waiting times for first appointment remain below standard with an increase in demand and the impact on clinic cancelations as a result of the industrial action. The Colorectal Pathway is having the greatest impact on all of the 2ww standard with 27.2% of all of the breaches.

In May, 73% (93) of the 28-day breaches were for across 4 tumour sites (Colorectal, Urology, ENT & Gynae)

Counter Measure - Work is underway with the TVCA to implement the Best Practice Timed Pathways across all 5 (Lower GI, Urology, Gynae, Upper GI & Head & Neck) of these Pathways.

We continue to work with the OUH Plastics team for extra capacity, however, there is a clear deficit in capacity within Plastics that will impact the cancer pathway is unable to be mitigated further without significant staffing and / or investment. This is subject to a strategic service review.

The weekly Elective Access Meetings continues to support improvement work through monitoring of counter measures, identifying support and mutual aid options and review of individual patients within pathways to move on in pathway if required.

Additional capacity for LATP biopsy within the Prostate pathway will come on-line from June 23 when further consultants complete their training. This will help alleviate some of the capacity issues within Radiology for TRUS biopsy (LATP is gold standard procedure for biopsy, and should be used in place of TRUS)

Our Performance

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-23	Apr-23	May-23	Jun-23	Trend
ED	A&E (ED & UTC) Emergency Care 4 Hour Performance %	95% (Nat)	F	77.2%	75.7%	74.8%	73.8%	
	AED (Type 01) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	F	58.4%	54.9%	55.0%	54.2%	
	AED (Type 01) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	F	16.0%	14.5%	13.6%	14.8%	
	A&E Arrival to Departure Percentage over 12 Hours (Type 1 & Type 3)	2% (Nat)	F	8.0%	7.1%	6.7%	7.4%	
	A&E Arrival to Departure over 12 Hours (Admitted Patients)	2% (Nat)	F	33.6%	27.7%	27.5%	31.0%	
	Percentage of Ambulance Handover Over 15 Minute Waits	SPC	H	71%	67%	70%	72%	
	Number of Ambulance Handover 30 Minute Waits	SPC	H	725	590	713	736	
	Percentage of Ambulance Handover s Over 30 Minutes	SPC	H	47.2%	37.6%	44.2%	46.1%	
	Percentage of Ambulance Handovers Over 60 Minutes	SPC	H	30.9%	19.4%	23.7%	28.9%	
Flow	Admitted - Average Length of Stay in Department (mins)	SPC	H	887	725	772	666	
	Non - Admitted - Average Length of Stay in Department (mins)	SPC	H	302	299	292	284	
	Number of Stranded Patients (over 14 days)	SPC	H	136	136	134	127	
	Number of Super Stranded Patients (over 21 days)	SPC	H	81	80	85	77	

Performance & Counter Measure

ED performance has demonstrated continued improvement across most areas compared to previous months, despite increased attendances. This is an indicator of the implemented measures across the 'Front Door' and support across the organisation.

Relevant teams are looking at improvement measures across the 'Front Door' , pre-hospital and post discharge with measures to improve flow & discharge rates.

Work continues with various data streams internal and external, identifying which is not accurate and looking to improve and streamline all reporting

- Total % over 12 hours has increased from 13.5% to 14.7%.
- % over 12 hours admitted increased; 36.% compared to 33% last month.
- % over 12 hours non admitted has remained stable at 4%
- % of patients admitted decreased remains at 33%

Counter measures remain in place within the Breakthrough objective slides.

Risks

Pressure to maintain flow and bed availability with increasing demand, thereby with a potential to impact elective activity. This is mitigated by our ongoing Seasonal Planning and work with system partners.

Physical and pathway reconfiguration required for WFP programme works creating IFD project. Working with key stakeholders to mitigate potential Impact on capacity

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

Our Performance

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-23	Apr-23	May-23	Jun-23
RTT	No. of >=78 weeks waiters	SPC	L	2	1	1	0
Cancer	No. of referrals received	SPC		1979	1518	1844	One month behind
ED	UTC (Type 03) - Percentage Arrival to Departure within 4 Hours	95% (Nat)	?	95.6%	95.7%	93.9%	93.6%
	UTC (Type 03) - Percentage Arrival to Departure over 12 Hours	2% (Nat)	P	0.1%	0.0%	0.1%	0.0%
	Total ED Type 1 Attendances (all arrival methods)	SPC		5104	4809	5250	5433
	A&E Arrival Triage % Within 15 Minutes Arrival by Ambulance	SPC	H	69.6%	66.8%	63.8%	69.0%
	Type 1 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		47.3%	50.2%	43.7%	47.0%
	Type 3 - Triage Performance (% Triaged within 15 Minutes of Arrival)	SPC		44.6%	44.2%	38.5%	42.6%
	A&E (ED & UTC) Median Arrival to Departure in Minutes	240 (Int)	P	178	180	192	198
	Emergency Care - AED - Median Stay	240 (Int)	?	237	238	239	239

Performance & Counter Measure

ED Type 3 performance continues to meet the threshold values.

Cancer referrals remain above pre covid levels, resulting in capacity issues in a number of sites. The services are providing WLI activity to support where possible, though cancer performance is adversely affected where this is insufficient.

Risks

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

Our Performance

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-23	Apr-23	May-23	Jun-23
ED	Emergency Care - UTC - Median Stay	240 (Int)	P	140	139	151	158
	Total Number of Ambulance Handovers	SPC	L	1535	1571	1613	1598
	Total Hours Ambulance Handover Waits (over 15mins)	SPC		1443.00	951.30	1057.00	1628.78
	Number of Ambulance Handover Over 15 Minute Waits	SPC		1097	1051	1127	1152
Flow	Number of Ambulance Handover Over 60 Minutes Waits	SPC		475	304	382	462
Flow	Admitted - Average Length of Stay in Department (mins)	SPC		887	725	772	666
	Non - Admitted - Average Length of Stay in Department (mins)	SPC		302	299	292	284
	Elective Patients Average Length of Stay (Days)	SPC		3	3	3	3
	Non-Elective Patients Average Length of Stay (Days)	SPC		5	5	5	5
	Number of Stranded Patients (over 14 days)	SPC		136	136	134	127

Performance & Counter Measure

ED Type 3 performance continues to meet the threshold values.

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 Care

Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Mar-23	Apr-23	May-23	Jun-23	Trend
Concerns and Complaints	Trust overall complaint response rate	80% (Int)	?	75%	75%	84%	74%	
	Clostridium difficile (C. diff) infections (cumulative)	11.5 (Nat)		49	6	16	25	
IP&C	Escherichia coli (E. coli) infections (cumulative)	16.5 (Nat)		108	5	18	24	
	Pseudomonas infections (cumulative)	3.5 (Nat)		15	5	7	10	
	Klebsiella infections (cumulative)	5.5 (Nat)		26	4	7	8	
	Maternity Response Rate	18% (Int)		18%	17%	19%	17%	

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 complaint response rate has dipped in month and is now below the internal target. There is targeted work to support were this is linked to a single Division. This includes Triumvirate engagement to improve processes. To support complainants and ensure feedback and clear lines of communication, there are Trust wide weekly caseload reviews.

The rate of *C. difficile infection* continues to be above that of 2022/23. The ICB are conducting an in-depth review of all cases across BSW to look for common factors underlying this, as it is not specific to GWH. All samples are sent for ribotyping to help identify transmission within healthcare, with no links found so far. Antibiotic prescribing is reviewed in all healthcare-associated cases and, in the majority, has been found to be appropriate. We are also seeing higher numbers of patients found to be colonised with *C. diff* (15 in June compared with 6 in April and 5 in May), suggesting that prevalence of the bacterium is increasing locally.

Rates of all three reportable gram-negative bloodstream infections (*E. coli, Klebsiella* and *Pseudomonas aeruginosa*) remain higher than previously. A contributing factor may be changes to cleaning practices in April, which have led to concerns about cleaning standards. These have been escalated to executive level and Serco have provided an action plan, against which progress is being monitored. The Trust already had higher rates than its peers, so cleaning will not be the only factor. Pipework and handwash basins that do not adhere to modern standards may be a contributing factor and Estates are looking into upgrading these.

Maternity response rates have dropped just below target in the month of June. To support achieving improvement, the service send a text message to all patients, cards are also available at service level and the area is also supported with volunteers.

Risks

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Mar-23	Apr-23	May-23	Jun-23
Harm	No. of serious incidents reported in month	SPC		6	6	5	3
	Falls rate per 1000 bed days	SPC		6.4	6	5.6	5.8
	No. of Falls in month	SPC		127	116	111	110
	No. falls with moderate harm or above	SPC		7	2	0	3
	Medication incidents with moderate harm	SPC	L	2	2	2	2
Concerns and Complaints	No. of concerns received	SPC		190	109	107	139
	No. of complaints received	SPC		46	29	45	47
	Number of reopened complaints	SPC		3	2	2	2
IP&C	Methicillin-resistant Staphylococcus Aureus (MRSA) infection (cumulative)	0 (Nat)		3	0	0	0
	Methicillin Sensitive Staphylococcus Aureus (MSSA) infections (cumulative)	5.5 (Int)		32	1	1	3
	Covid – no. of hospital acquired	SPC		63	17	11	4

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

There are a total of 23 on-going Serious Incidents (SI), with three reported in month.

The number of concerns and complaints has risen in month, but the number of reopened complaints has remained table. A trial is underway of an interactive therapeutic Virtual Reality (VR) headset to support children undergoing procedures. The device assists with relaxation, distraction, pain relief and mental health crisis. An evaluation of the trial will take place prior to agreement of charitable funding. This follows the previous care reflection, Sophies Legacy, taken to trust board.

PALS team were extremely pleased to win the Championing Equality, Diversity, and Inclusion award at the Staff Excellence Awards.

The numbers of patient falls has decreased slightly in month, but the number with moderate harm and above has risen to three, zero in the previous month. The Health Care Support Workers (HCSW) induction training has been updated to include a practical visual impairment simulation activity.

The National Reconditioning games ran from October 22 to April 23. Information was submitted for 13 medals in total, coming 2nd in the Southwest.

Rates of both MRSA and MSSA have remained low. COVID numbers have continued to decline, though the cyclical nature of COVID waves suggests we may see a rise in July. Air scrubber rollout continues.

Risks

Our Care

Non-Alerting Watch Metrics

Plan Area	Measure Name	Target	SPC Improv. Icon	Mar-23	Apr-23	May-23	Jun-23
Safer Staffing	Safer Staffing – average fill rate RN (%)	85% (Nat)		96.6%	96.7%	99.6%	95.6%
	Safer Staffing – average fill rate HCA (%)	85% (Nat)		109.8%	111.1%	115.1%	105.7%
FFT	Overall response rate (%)	28% (Int)		25.5%	30.6%	27.9%	27%
	Positive response (%)	86% (Int)		88%	90%	88%	86%
	ED & UTC Response Rate	21% (Int)	H	20%	22%	21%	20%
	ED & UTC Positive Responses	79% (Int)		81%	82%	80%	76%
	Inpatients Response Rate	26% (Int)	H	26%	34%	29%	26%
	Inpatients Positive Responses	85% (Int)		86%	89%	88%	85%
	Daycases Response Rate	25% (Int)		26%	26%	24%	23%
	Daycases Positive Responses	97% (Int)	H	95%	96%	95%	96%
	Outpatients Positive Responses	98% (Int)	H	96%	98%	99%	98%

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 Measures

Safe Staffing fill rates remain consistent with previous months.

There has been a slight decrease in both the response rate and positive response rate across most areas. The Trust overall response rate has remained stable achieving the internal target of 86%.

Several initiatives have been undertaken in June to enhance the experience of patients and their families including;

- Following a previous accessibility review. It has been agreed that several doors across the Trust are being improved to enable easier access. This will include some doors with automatic holds and others with are button engaging.
- There is ongoing work to improve standards around personalised care. Senior staff are supporting with role modelling of the core care checklist. There is now a nail care video available on the HCSW intranet page which supports a new competency, training, and standardised nail care products.
- A new assessment is being added to Nervecentre to ensure cultural and religious personal care requirements are understood and met and bi-weekly mouthcare trolley dashes are ongoing across wards to raise awareness.
- There have been a number of improvements and developments made to improve patient experience in Same day Emergency Care, including improvements to the environment by adding a radio in the waiting and treatment rooms, a recycling waste box, a rotation of display board information and a snack and drinks table in the waiting area.

Risks

Use of Resources

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-23	Apr-23	May-23	Jun-23
Use of Resources	Capital Expenditure (£'000)	SPC		12940	0	761	2386
	Pay (£'000)	SPC		46425	23931	25949	25830
	Non Pay (£'000)	SPC		14984	15273	15528	16488

Performance & Counter Measure

Capital spend has increased in month as Way Forward Programme spend is now coming through.

Pay costs are a £0.1m decrease from M2; substantive costs were in line with prior month. Bank/locum costs increased by £0.2m due to industrial action, and agency decreased by £0.2m due to lower medical agency usage in Medicine. Reducing agency spend is a priority for the efficiency programme

Non-Pay are a £1.0m increase split across all divisions; SWC saw TVCA plastics costs increase by £0.2m (offset by income); Medicine costs increased by £0.3m due to clinical supply usage and Corporate increased by £0.3m due to additional NHS Property rental costs. Central accruals for seasonal costs accounted for £0.2m

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.

Risks

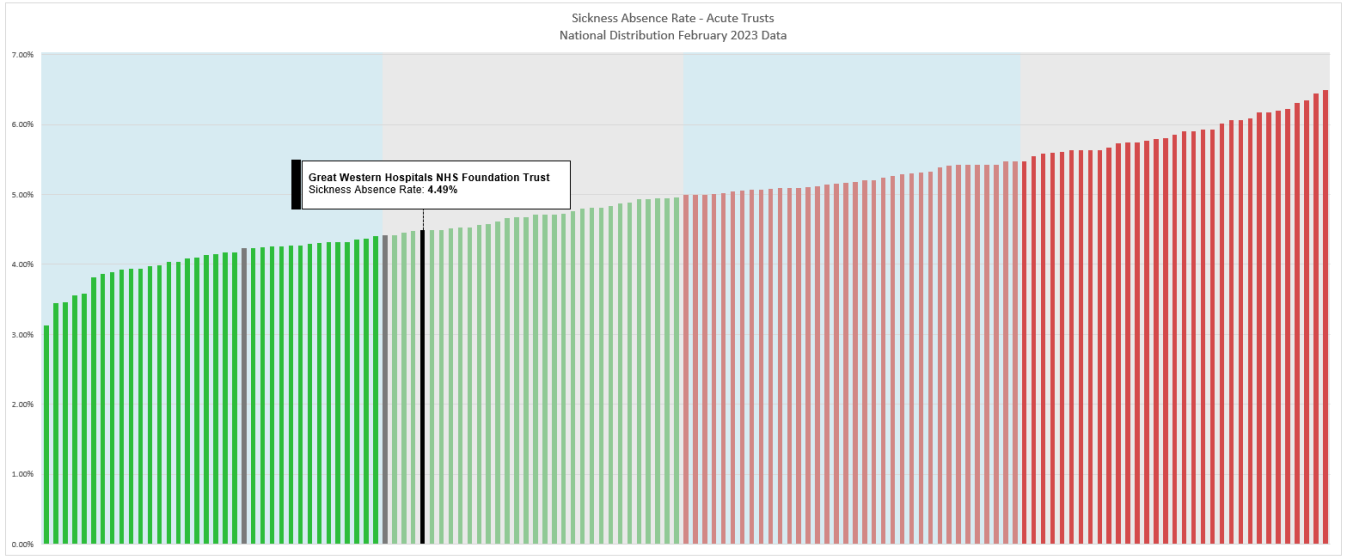
The Trust started the year with a £16.67m cash releasing efficiency plan, which includes a £2.98m carry over from 22/23. As at Month 3, the programme is £0.6m under plan, which has improved from a £0.9m YTD underperformance in M2. Medicine have recorded £0.6m of the £1.2m in-month savings, with SWC and ICC overperforming against the in-month plan. Out of the £16.67m target £15.2m is identified, an increase of £0.8m from M2. £4.5m is fully developed, up from £3.1m in M2. Divisions and supporting services must work to turn the remaining schemes flagged as opportunities into deliverable savings, as well as identifying schemes for the £3.4m currently flagging as unidentified.

Our People

Great Western Hospitals NHS Foundation Trust

Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-23	Apr-23	May-23	Jun-23	Trend
Workforce	Trust sickness absence rate	3.5% (Int)	F	4.6%	3.8%	3.7%	One month behind	



Performance & Counter Measure

- Sickness absence has decreased further in May 2023 from 3.8% to 3.66%. Short term sickness continues as the highest driver of absence, with 1.9% of sickness being short term and 1.8% being long term for May.
- National benchmarking data for February 2023 (NHS Digital) shows an decrease in the national sickness level, reducing from 5.3% to 5.0%. Absence for the entire South West region is marginally below the national position at 4.9% for January 2023, and for this period the GWH absence rate is 4.49%. As the data is several months behind it is expected that further improvements will be reported based on our May 2023 data.

Risks

- Increase sickness rate as per national trend during winter.

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

Our People

Great Western Hospitals NHS Foundation Trust

Non Alerting Watch Metrics

Plan Area	Measure Name	Target /SPC Target Icon	SPC Improv. Icon	Mar-23	Apr-23	May-23	Jun-23	Trend
Workforce	% of leavers within 1st year of employment	31.2% (Int)		24.7%	36.4%	29.5%	One month behind	

Plan Area	Metric	Target /SPC Target Icon	2017	2018	2019	2020	2021	2022	2023 Q1
Workforce	Staff Survey response rates	44% (Nat)	46.5%	43.6%	40.0%	53.4%	39.5%	58.7%	22.8%
	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%	Not in Quarterly Survey

Performance & Counter Measure

- The % of leavers within 1st year of employment has decreased in May 2023 to 29.5%. A review of the leavers in underway and will be reporting in July's IPR. A review of rolling 12 months data maybe more informative then monthly changes will be also completed.
- Staff Survey response rates and Health and Wellbeing Question can only be measure annually and currently delivering within target.

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 People

Workforce Scorecard

NHS
Great Western Hospitals
NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend Vs	
																	Last Month	Jun-22
W	Vacancy Rate	%	7.00%	6.94%	7.48%	6.70%	6.31%	6.56%	5.97%	6.23%	7.43%	6.40%	5.30%	7.52%	8.06%	7.94%	↓	↑
W	Vacancy Rate	WTE	-	358.52	386.57	347.09	328.65	343.04	313.11	329.52	392.94	335.02	276.66	401.58	437.89	431.29		
W	All Nursing Vacancy	%	7.00%	5.27%	5.62%	4.88%	5.58%	5.95%	5.27%	5.62%	6.51%	5.20%	3.65%	4.50%	4.95%	5.38%	↑	↑
W	All Nursing Vacancy (Reg & Unreg)	WTE	-	131.68	140.23	122.71	141.28	151.92	135.61	146.64	170.25	135.53	94.47	117.71	132.11	143.74		
W	All Registered Nursing Vacancy	WTE	-	119.04	130.70	121.67	113.32	102.85	87.51	91.41	92.65	77.18	43.38	84.20	97.00	107.48		
W	B5 Nursing Vacancy (exc. Corp & inc. Pre-Reg)	WTE	-	53.91	63.29	55.96	50.49	51.28	43.73	54.94	47.18	36.73	27.43	27.90	44.94	53.47		
W	B2-4 Nursing Vacancy (exc. Pre-Reg)	WTE	-	12.64	9.53	1.04	27.96	49.07	48.10	55.23	77.60	58.35	51.09	33.51	35.11	36.26		
W	Medical Vacancy	%	7.00%	8.94%	9.57%	6.53%	3.64%	5.73%	5.80%	5.43%	5.61%	8.49%	6.86%	9.35%	10.14%	9.93%	↓	↑
W	Medical Vacancy	WTE	-	62.75	67.19	45.84	25.59	40.26	40.74	38.33	39.16	59.19	47.86	67.29	74.56	73.05		
W	STT/AHP Vacancy	%	7.00%	7.44%	8.94%	8.25%	7.57%	6.89%	6.09%	6.54%	6.97%	6.29%	7.66%	11.10%	12.48%	12.69%	↑	↑
W	STT/AHP Vacancy	WTE	-	61.57	74.04	68.37	62.72	57.10	50.49	54.28	57.85	51.64	63.84	94.86	107.82	110.17		
W	SMA Vacancy	%	7.00%	8.98%	9.21%	9.66%	8.68%	8.21%	7.55%	7.88%	10.97%	7.96%	6.37%	10.62%	10.60%	9.01%	↓	↑
W	SMA Vacancy	WTE	-	102.52	105.11	110.17	99.06	93.76	86.27	90.27	125.68	88.66	70.50	121.73	123.41	104.33		
W	Recruitment Time to Hire - Trust Sub	Days	46.00	67.90	62.00	61.10	74.70	63.70	74.30	72.30	91.30	50.90	54.50	52.90	50.60	47.60	↓	↓
W	Recruitment Time to Hire - Trust Bank	Days	46.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	117.90	127.80	118.00	58.50	26.90	↓	↑
	Workforce Utilisation																	
W	Establishment WTE	WTE	-	5,168.30	5,167.69	5,183.80	5,204.80	5,226.19	5,248.35	5,289.43	5,289.16	5,236.02	5,224.47	5,337.41	5,434.85	5,433.60		
W	Budgeted vs Worked WTE Variance	WTE	-	91.14	138.16	191.33	121.30	71.71	184.20	87.52	51.09	109.88	237.86	31.62	45.85	51.23		
W	Actual Worked vs Budgeted %	%	-	1.76%	2.67%	3.69%	2.33%	1.37%	3.51%	1.65%	0.97%	2.10%	4.55%	0.59%	0.84%	0.94%		
W	Total Workforce Cost £	£	-	£22.36M	£21.78M	£21.98M	£27.41M	£23.43M	£24.05M	£23.64M	£22.93M	£24.66M	£23.73M	£23.85M	£23.98M	£25.73M		
W	Agency Spend as % of Total Spend	%	4.50%	6.36%	4.18%	6.23%	5.65%	6.53%	6.17%	5.97%	5.60%	4.98%	5.35%	3.41%	5.55%	3.41%	↓	↓
W	Agency Spend £	£	-	£1.42M	£0.91M	£1.37M	£1.55M	£1.53M	£1.48M	£1.41M	£1.28M	£1.23M	£1.27M	£0.81M	£1.33M	£0.88M		
W	Agency Target £	£		-	-	-	-	-	-	-	-	-	-	£1.21M	£1.04M	£0.88M		
W	Agency Spend vs Target £	£ Diff	£0.00M	-	-	-	-	-	-	-	-	-	-	-£0.40M	£0.29M	£0.00M	↓	↓
W	Agency WTE	WTE	-	117.85	121.32	134.43	137.51	127.69	113.12	109.26	102.88	90.00	106.82	90.76	105.02	96.40		
W	Bank WTE	WTE	-	304.96	377.97	375.45	285.71	258.31	354.47	278.67	310.93	323.25	377.11	303.84	351.68	355.36		
W	Registered Nursing Bank Fill	%	45.00%	47.09%	44.52%	37.70%	46.59%	48.32%	53.80%	43.60%	52.86%	55.30%	54.71%	57.70%	57.90%	54.99%	↓	↑
W	Unregistered Nursing Bank Fill	%	70.00%	75.59%	72.53%	69.81%	72.94%	66.26%	70.85%	62.98%	74.32%	71.78%	77.63%	83.58%	81.51%	80.82%	↓	↑

Our People

Workforce Scorecard

Great Western Hospitals NHS Foundation Trust

Type	Metric	Unit/Measure	Target	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend Vs Last Month	Trend Vs Jun-22
	Retention																	
W	All Turnover %	%	13.00%	15.46%	15.90%	15.00%	14.87%	14.69%	14.52%	14.90%	14.84%	14.42%	14.48%	13.79%	13.88%	-	↑	↓
W	Voluntary Turnover %	%	11.00%	12.38%	12.64%	12.07%	12.00%	11.78%	11.54%	11.84%	11.57%	11.25%	11.16%	10.54%	10.52%	-	↓	↓
W	Number of Leavers	Headcount	-	80	78	48	63	57	54	68	72	43	79	33	61	-		
W	Number of RN Leavers	Headcount	-	17.00	16.00	11.00	15.00	8.00	6.00	14.00	15.00	8.00	17.00	7.00	14.00	-		
W	Registered Nursing Vol Turnover	%	-	10.36%	10.38%	9.95%	9.85%	9.45%	8.86%	8.69%	8.42%	7.89%	7.72%	6.95%	6.72%	-		
W	Number of Unreg Nursing Leavers	Headcount	-	22.00	13.00	15.00	15.00	17.00	17.00	19.00	15.00	12.00	12.00	8.00	12.00	-		
W	Unregistered Nursing Vol Turnover	%	-	15.37%	15.76%	15.10%	15.24%	15.67%	15.57%	16.27%	16.63%	16.47%	15.85%	15.36%	15.08%	-		
W	Leavers within 1st Year of Employment	%	-	28.75%	29.49%	22.92%	20.63%	28.07%	29.63%	20.59%	23.61%	30.23%	24.05%	36.36%	29.51%	-		
W	Number of starters	Headcount	-	68	55	98	103	103	83	56	107	72	77	75	65	-		
	Absence																	
D	Sickness Absence % Rolling 12 Month	%	3.50%	4.90%	5.27%	5.14%	5.06%	5.11%	5.08%	5.17%	5.14%	5.08%	5.03%	4.93%	4.84%	-	↓	↓
D	Sickness Absence %	%	3.50%	5.13%	6.01%	4.73%	4.77%	5.34%	4.87%	5.79%	4.90%	4.52%	4.60%	3.83%	3.66%	-	↓	↓
W	Long Term Sickness %	%	2.00%	2.70%	2.67%	2.70%	2.52%	2.36%	2.36%	2.49%	2.52%	2.22%	2.24%	2.10%	1.79%	-	↓	↓
W	Short Term Sickness %	%	1.50%	2.43%	3.34%	2.03%	2.24%	2.99%	2.51%	3.30%	2.38%	2.30%	2.35%	1.72%	1.87%	-	↑	↓
W	Sickness Absence Cost £	£	-	£670.8k	£833.3k	£636.9k	£626.5k	£757.0k	£646.3k	£744.7k	£686.8k	£575.4k	£675.3k	£546.9k	£574.4k	-		
W	WTE Days Lost	WTE	-	7,222.9	8,669.9	6,823.7	6,688.1	7,846.0	7,055.2	8,721.5	7,358.2	6,109.2	6,960.2	5,648.5	5,612.7	-		
	Learning & Development																	
W	Mandatory Training Compliance %	%	85.00%	87.85%	87.71%	86.66%	87.18%	85.76%	86.38%	86.38%	86.61%	86.79%	87.69%	89.20%	90.27%	89.81%	↓	↑
W	Role Essential MT %	%	85.00%	89.61%	89.61%	88.53%	89.25%	87.97%	88.74%	88.92%	89.06%	89.03%	89.66%	90.92%	91.59%	91.37%	↓	↑
W	CQC Safe MT %	%	85.00%	86.15%	85.86%	84.85%	85.17%	83.60%	84.08%	83.89%	84.18%	84.54%	85.71%	87.48%	88.95%	88.25%	↓	↑
W	Bank-Only Mandatory Training Compliance %	%	85.00%	-	-	-	-	-	-	-	-	-	-	59.32%	64.39%	73.18%	↑	↓
W	Appraisal Compliance %	%	85.00%	74.55%	75.56%	75.75%	75.04%	76.32%	79.31%	81.43%	81.16%	83.33%	82.25%	83.11%	82.18%	83.86%	↑	↑
W	Non Medical Appraisal Compliance %	%	85.00%	77.85%	77.91%	78.12%	78.03%	77.94%	78.88%	81.08%	80.60%	82.33%	80.68%	82.46%	81.38%	82.76%	↑	↑
W	Medical Appraisal Compliance %	%	85.00%	50.37%	58.38%	58.41%	53.44%	64.63%	82.84%	84.13%	85.44%	91.07%	93.90%	87.90%	88.00%	91.81%	↑	↑
	Demographics																	
W	Staff in Leadership Roles %	%	-	3.31%	3.29%	3.14%	3.21%	3.31%	3.19%	3.16%	3.20%	3.26%	3.26%	3.44%	3.45%	3.43%		
W	Staff in Leadership Roles WTE	WTE	-	194.00	192.00	185.00	191.00	197.00	192.00	191.00	192.00	196.00	197.00	207.00	210.00	209.00		
W	% of Leadership Roles who are Female	%	-	65.46%	65.63%	67.03%	66.49%	67.01%	67.71%	67.54%	68.23%	68.37%	67.51%	68.12%	68.57%	67.46%		
W	% of Leadership Roles who from BME	%	-	5.67%	5.73%	5.95%	6.28%	6.60%	5.73%	5.76%	6.77%	6.63%	6.60%	6.28%	6.67%	6.70%		
W	Male % of Workforce	%	-	17.71%	17.63%	17.48%	17.67%	17.51%	17.43%	17.43%	17.55%	17.50%	17.71%	17.63%	17.75%	17.83%		
W	Female % of Workforce	%	-	82.29%	82.37%	82.52%	82.33%	82.49%	82.57%	82.57%	82.45%	82.50%	82.29%	82.37%	82.25%	82.17%		
W	BME % of Workforce	%	-	20.71%	20.87%	21.11%	21.30%	21.53%	21.89%	21.99%	22.54%	22.75%	23.24%	23.60%	24.22%	24.19%		
W	White % of Workforce	%	-	70.17%	70.22%	70.00%	69.69%	69.60%	69.32%	69.14%	68.74%	68.71%	68.25%	68.07%	67.43%	67.29%		

Our People

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Workforce Scorecard - Workforce Planning

Variances		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Establishment	*Plan*	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46	5391.46
	Actual	5337.41	5486.23	5433.60									
	Variance	-54.05	+94.77	+42.14									
Workforce (Staff in Post)	*Plan*	4917.66	4942.06	4958.27	4973.06	4996.74	5018.76	5041.25	5057.46	5066.09	5064.08	5064.98	5067.30
	Actual	4935.83	4996.96	5002.31									
	Variance	+18.17	+54.90	+44.04									
Bank WTE	*Plan*	271.91	322.50	262.43	246.62	240.30	300.37	303.53	262.43	278.24	208.68	227.65	237.13
	Actual	303.84	351.68	355.36									
	Variance	+31.93	+29.18	+92.93									
Agency WTE	*Plan*	104.12	123.49	100.49	94.43	92.01	115.01	116.23	100.49	106.54	79.90	87.17	90.80
	Actual	90.76	105.02	96.40									
	Variance	-13.36	-18.47	-4.09									

Key

Outside of tolerance
Within tolerance
in excess of plan
less than plan

Performance & Counter Measure

- Variance in funded Establishment against plan has recovered against the reported position for M2. Adjustments have been made for Disinvestment of Exec. Escalations posts that were on hold (-7WTE) across Corporate Services as well as adjusted Baseline, ongoing for Division of Medicine.
- The accelerated recruitment activity (particularly around Health Care Support Workers) has actualised in M3 due to start dates within the month of June, further increasing the Staff in Post for M3, however this is slowing down and therefore a refocus on recruitment new starters in underway with a target of 90 new starter per month.

Risks & Mitigations

- Any proposals to change establishment at the Workforce Review Meetings start formally week commencing 10th July, the initial phases of which have provided indication of future changes due within the next quarter (circa +7 WTE, within tolerance).
- Nursing controls for agency spend, include decreased usage benefits and a specific working group for Mental Health Nursing is in place to reduce both the cost and the usage.
- Quarterly review of tolerance levels have been completed and remain at 4.67% (+/-25 WTE).

Appendices

Explaining the IPR

Improving
together

Explaining the IPR

Great Western Hospitals NHS Foundation Trust

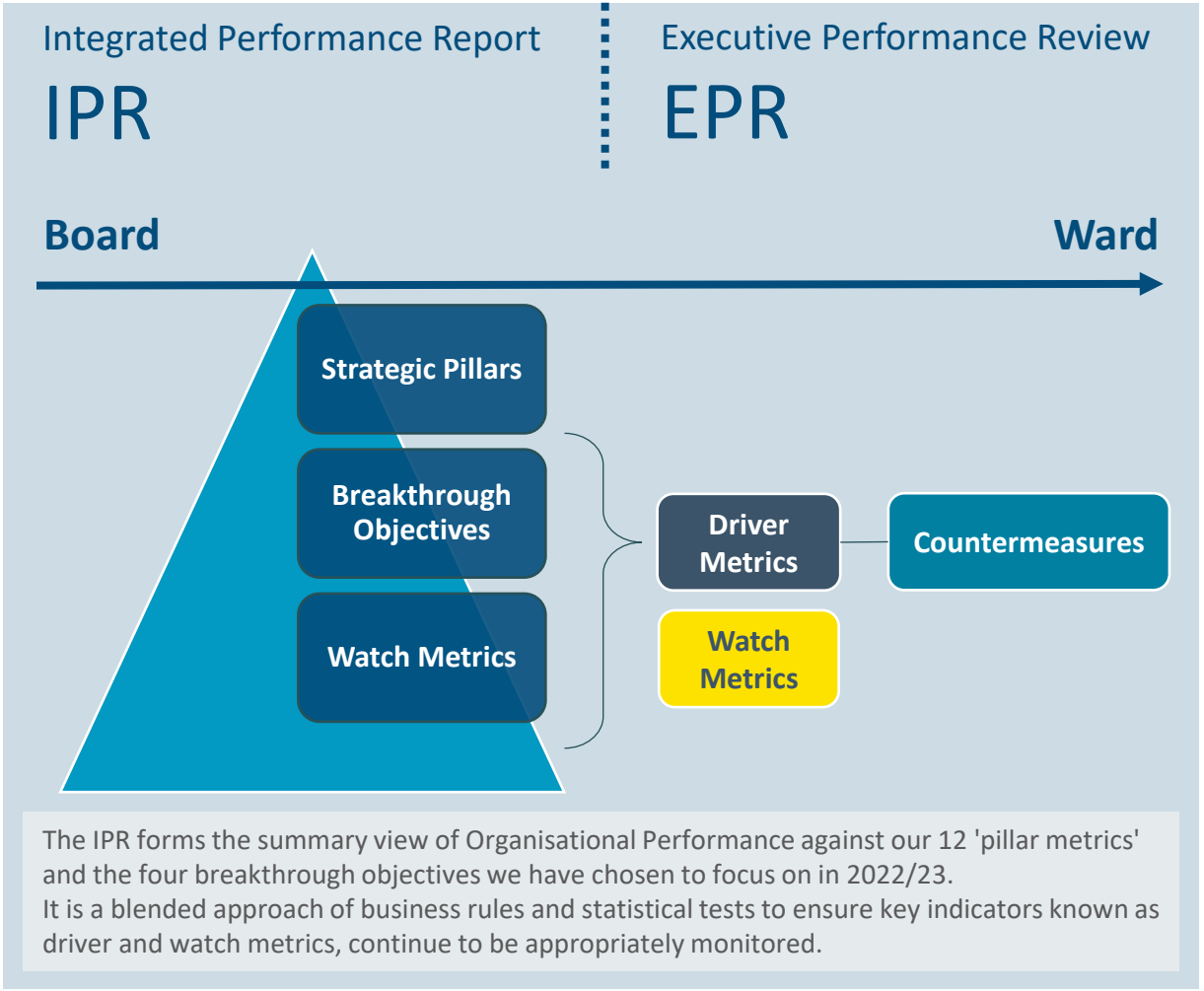
To turn our strategic themes (pillars) into real improvements, we're focusing on four key objectives that contribute to these themes for the next year.

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

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

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

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



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

Our vision & strategic focus

Great Western Hospitals NHS Foundation Trust

Our Vision

We will deliver great joined up services for local people at home, in the community and in hospital, helping them to lead independent and healthier lives.

Our four strategic pillars

- Outstanding patient care and a focus on quality improvement in all that we do
- Staff and volunteers feeling valued and involved in helping improve quality of care for patients
- Improving the quality of patient care by joining up acute and community services in Swindon and through partnerships with other providers
- Using our funding wisely to give us a stronger foundation to support sustainable improvements in quality of patient care

Strategic Planning Framework

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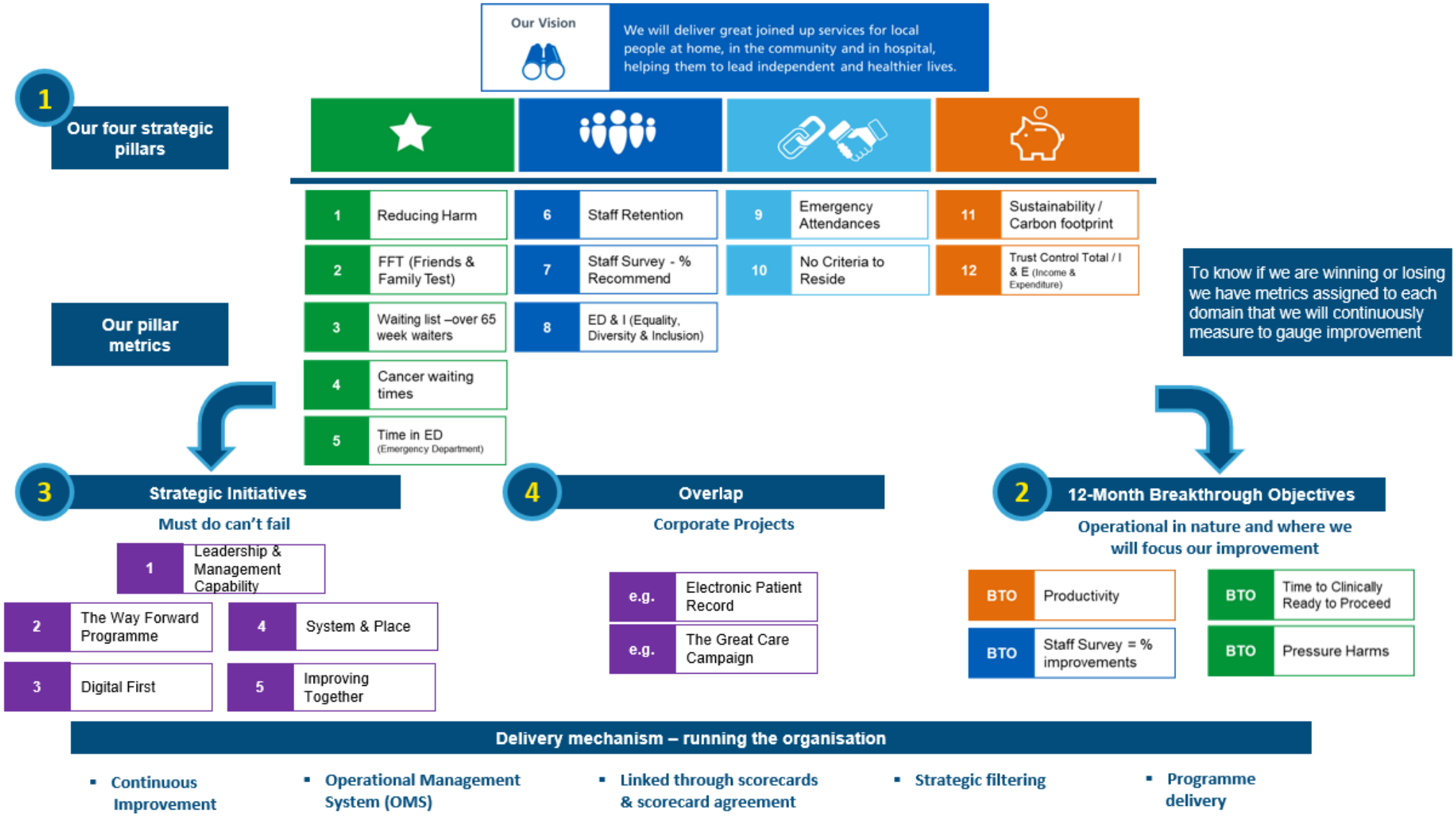
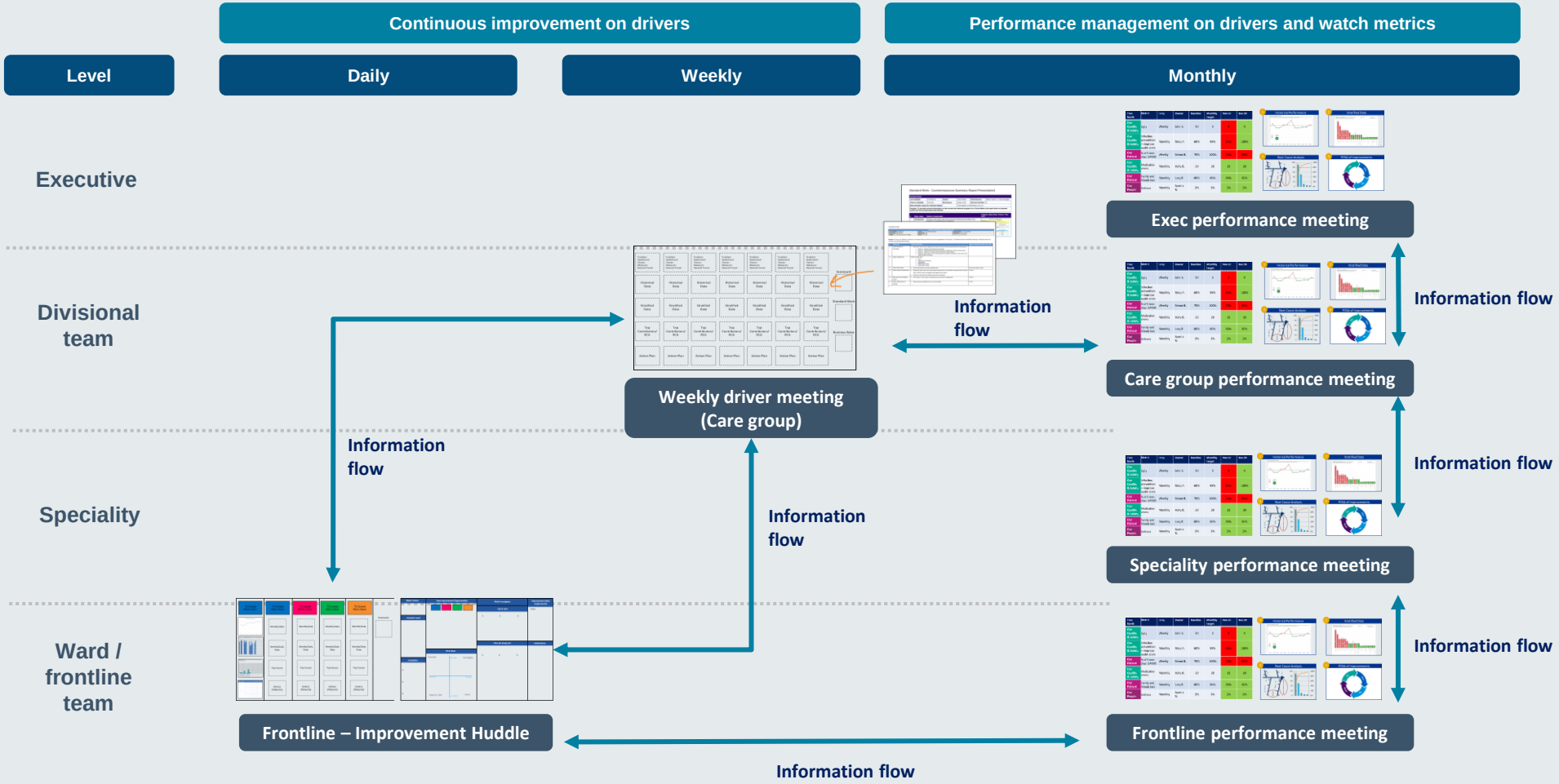


Ward to Board Meeting Blueprint

Great Western Hospitals NHS Foundation Trust



Building a culture of continuous improvement

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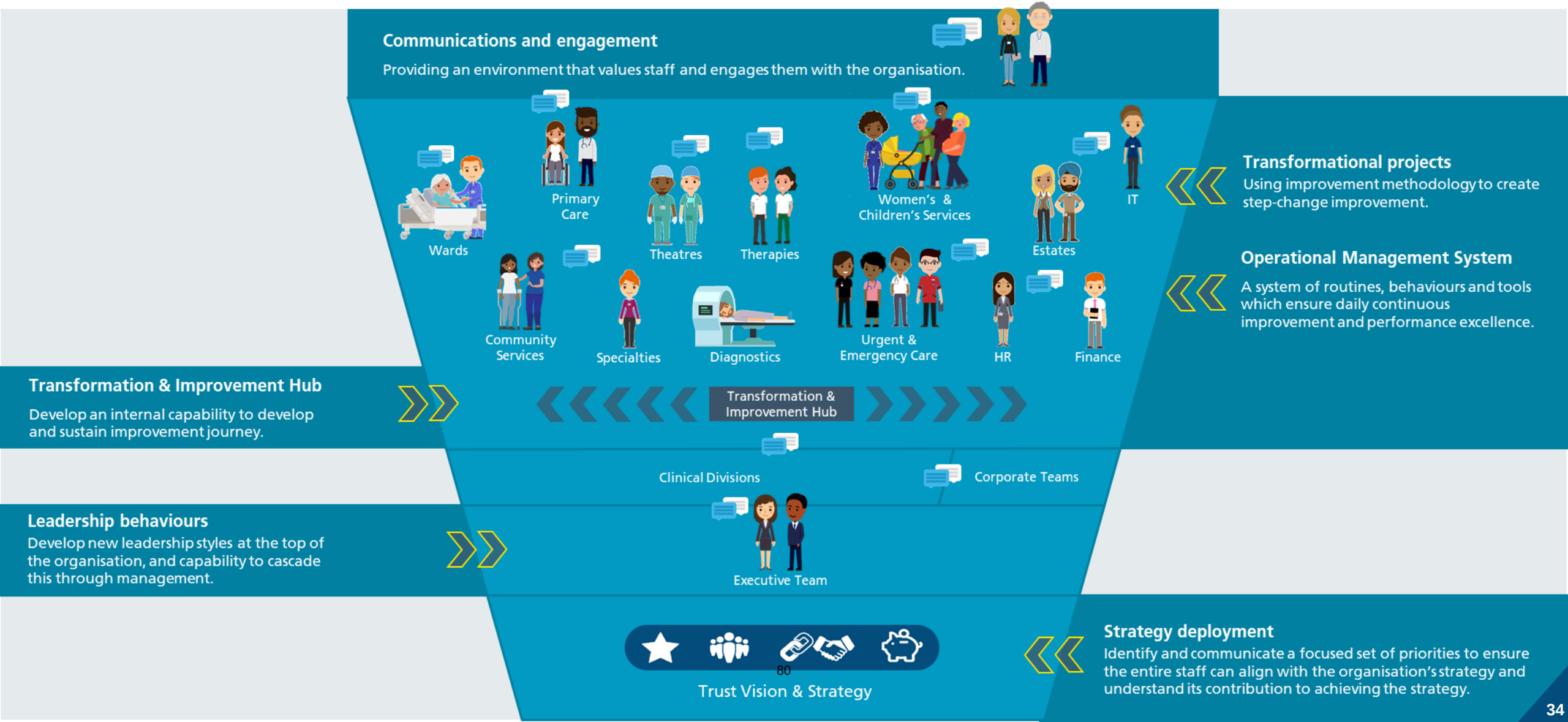


SPC supporting business rules

Great Western Hospitals NHS Foundation Trust

What is statistical process control (SPC)?

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

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

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

Key Facts about an SPC Chart

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

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

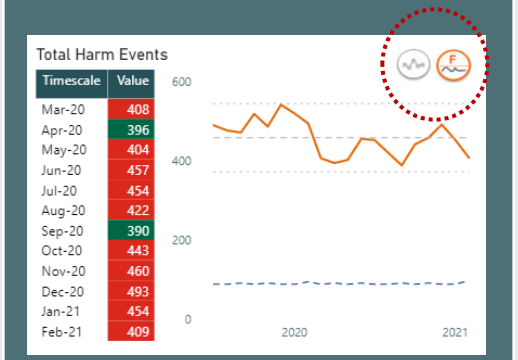
It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and **Common Cause** (i.e. no significant change.

NHS Improvement SPC icons:

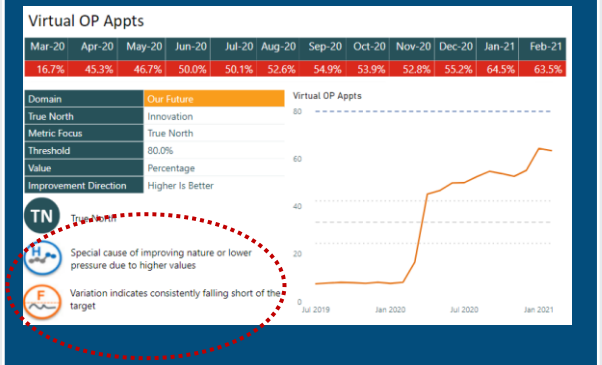
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

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NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Agreed Terms

Great Western Hospitals NHS Foundation Trust

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

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Performance, Population & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		28th June 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance, and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance, but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - Emergency Access	R	A	Continues to be high level of attendance. Busiest month so far this year with demand increasing further in June with a near record 560 patients attending in one day. It was, therefore, pleasing to note that mean waiting times remained at approximately 7.5 hours from it's previous high of 9+ hours. 12 hour waits improved slightly from 4.5% to 13.5%. The committee will receive information regarding the median. The committee received a very informative presentation on the Clinically Ready to Proceed (CRTP) work (new breakthrough objective). PPPC will monitor progress in this area.	Monitor Actions	July 2023

Integrated Performance Report – Elective Access - RTT	R	A	Good performance against the 104 and 78 week standard. Steady progress against the 23/24 65-week target. The committee remained concerned regarding the increasing number of 52+ week waiters and noted the increase in the number of patients now on the waiting list. A review by specialty has been undertaken with Gastroenterology shown to be the most challenging.	Monitor Actions	July 2023
Integrated Performance Report – Elective Access – DM01	R	A	The committee was informed of longest waiters reducing, however, the percentage of patients receiving diagnostics within 6 weeks had plateaued at around the 50+%. PPPC was assured that all cancer referrals had their scans within 2 weeks. The committee will receive a more in-depth report and presentation at it's next meeting.	Monitor Actions	July 2023
Integrated Performance Report – Cancer	R	A	No significant change since last month's in-depth report (see May report). A further update on improvement plans and workforce issues will be received in August.	Monitor Actions	Jul/Aug 2023
NHS Oversight Framework			GWH remains in 'segment 2' of the NHS Oversight Framework for Q4 2022/23, noting risks around the risks for the segmentation position as: - Ambulance handover & 12 hour waits (indications are these indicators will not form part of the 23/24 oversight framework) - Elective diagnostics (particularly ultrasound / endoscopy / sleep studies) - Financial position (efficiencies and expenditure rate)	Monitor Actions	Jul/Aug 2023

Issues Referred to another Committee –	
Topic:	**Committee:**

Great Western Hospitals NHS Foundation Trust

Board Committee Assurance Report

Performance, Population & Place Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Peter Hill	Peter Hill		26th July 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

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Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Integrated Performance Report - Emergency Access	R	A	The Committee acknowledged the pressure the service remains under, with attendances in June the second highest on record. Staff continue to strive to improve performance with average (mean) waiting times reducing from 9+ hours to less than 7 hours for the first time this year (median wait time 4 hours) 74% of patients were seen within 4 hours and the clinically ready to proceed (CRTP) time halving in the last 6 months falling from 12 hours from decision to admit, down to 6 hours. Regrettably, 15% of patients waited over 12 hours to be seen and the number of ambulance handovers being delayed by over 1 hour increased to 462 in month (from 382 in May). The Trust is viewed having the fourth best performance in the South West.	Monitor Actions	August 2023

Integrated Performance Report – Elective Access - RTT	R	A	The Trust continues to perform well against the 78-week standard being one of the three trusts in the South West achieving the KPI. However, there was an increase in the over 65-week waiters, especially in Gastroenterology. The Trust is using the improving together methodology to encourage service improvements and the Committee heard of some examples where this is having a positive impact. The number of 52-week waiters have double in the past 12 months. The Committee noted the impact of the recent strike action on this and other KPI's.	Monitor Actions	August 2023
Integrated Performance Report – Elective Access – DM01	R	A	The PPPC received a presentation regarding the diagnostic improvement plan with a particular focus on the recruitment campaign in Radiology. Performance overall remains a concern, however the team remain confident of meeting the 6-week waiting time trajectory by the end of quarter four. The letter from NHSE highlighting their concerns over aspects of BSW and GWH's performance was noted.	Monitor Actions	August 2023
Integrated Performance Report – Cancer	R	A	The service continues to struggle against the waiting time targets, although remains one of the South West's best performances in this area. The Committee heard of improvements planned for the diagnostic pathway in Urology with the introduction of LATP biopsies. The Committee also noted return of the Locum Dermatologists who will target long waiters albeit for only four months. The service continues to work on longer term solutions.	Monitor Actions	August 2023
Theatres Improvement Programme	A	A	The PPPC received a presentation from the Head of Theatre Services, this included examples of good progress, along with plans to improve theatre session utilisation and increase deficiency. The recent strike action had impacted on theatre session cancellations.	Monitor Actions	August 2023
Health Inequalities Quarterly Update			The PPPC received this report from the Chief Officer for Improvement and Partnership. Although the Committee felt it was too soon to apply a RAG rating, it wished to record how encouraged it was by the initial data collection on health inequalities in relation to waiting lists and by the various initiatives outlined in the report e.g the midwifery team supporting refugees and migrant families. The Committee will monitor progress going forward.	Monitor Actions	August 2023

Issues Referred to another Committee –	
Topic:	**Committee:**

Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Claudia Paoloni	Dr Claudia Paoloni		22 June 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF Numbers	

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Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR Pillar Metric: Total Harms	A	A	There has continued to be a decrease in the total number of harms from 249 to 220 in month attributed to a second consecutive drop in the number of falls and pressure harms. There were five serious incidents in month, slightly reduced from the previous month and are being investigated.		
IPR Pillar Metric: Friends & Family Test	A	A	The positive responses remain stable and above the internal target of 86%. Of note, an accessibility review has been undertaken following patient/visitor concerns about access within the main building and rehabilitation unit and a further fire assessment is also awaited. There has been a focus in the Emergency Department to support patients with disabilities and cognitive impairment with a well received initiative "Little Bags of Calm".		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR Breakthrough Objective: Pressure Harms	A	A	There has been a reduction in the number of pressure harms reported and there were zero category 4 harms and one category 3 harm reported. The reduction in harms has occurred in both the acute and community settings. In the acute setting, clear improvements have been seen where dedicated work has been undertaken using A3 methodology and an example of this can be seen with the targeted work on the Trauma Ward which had zero harm and zero category 3/4 harms. The Improving Together approach continues to drive further improvements to ensure that these results are maintained and other areas improved.		
IPR Alerting Watch Metric: Hospital Acquired Infections	R	A	Continued high levels of infections across the organisation remain a concern to the Committee, noting sustained raised *C.difficile* with no underlying themes being identified to explain this. The rates of other Gram-negative bloodstream infections (*E.coli, Klebsiella and Pseudomonas*) have also increased. There is a potential link of these infections rates with a change in environmental cleaning services provision which happened in April. The Committee, however, is assured that the concerns have been identified and escalated and that actions are being taken to address these elevated infection rates. Further monitoring has also been increased and the Infection Prevention & Control Team has engaged on a system-wide collaboration to identify any common themes as it appears there is a system wide increase in infections.		
Maternity Performance Report	A	G	The Committee was assured by the metrics in the report. Whilst it was noted that the midwife to birth ratios had reflected an increase in demand in the service, the escalation plan was effectively implemented such that 1:1 care for all families was ultimately delivered. Following a report to prevent future deaths from the NMC to all hospital trusts, a review of the local provision of skill mix of midwives attending home births is being undertaken. The areas of concern being around some midwives attending home births with limited experience in this birth setting or midwives in attendance with high experience in acute settings and unable to support midwives with limited experience overall. The Committee was assured that there was an action plan by the team to create a home birth		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			team which will require some recruitment and involve the Community Midwife Practice Educator. The Committee has asked for an update in six months, whilst recognising that this continues to be a risk for our organisation. Progress has been made against the Ockenden report which shows an increase in the number of actions being rated 'green' and reduction in 'red' outstanding actions.	Update on the action plan to be provided in six months' time	December 2023
Infection Prevention & Control Annual Report 2022/23	R	A	The Infection Prevention & Control Annual Report 2022/23 was received which was a well-structured and detailed report. The Committee was assured that this report reflected the current status of GWH's relatively high infection rates for the South West Region but there was strong leadership and a realistic action plan to address this. The Committee could see the significant changes and improvements since the appointment of Graham Pike, Associate Director of Nursing & IPC, and good progress has been made against last year's IPC improvement plan. There has been increased IPC team visibility, improved timeliness of investigations and a more rapid response to managing outbreaks and containment. The introduction of air scrubbers has proven to be successful. Whilst difficulties in recruitment into the Microbiology Department have been identified, an external review has been undertaken and we are awaiting the full report with recommendations on how to address this. The report also highlights that there is a national increase in some infections, which the Committee takes into account in considering its level of assurance into the actions being taken by the department. The Committee noted that IPC improvement plan for 2023/24, which identifies and addresses the fact that IPC practices still require improvement across the Trust. The improvement plan will focus on one key topic per quarter to ensure success and there are plans to undertake an infection control risk assessment of all clinical areas to identify their suitability for their function and with respect the relative infection control risks.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Quality Account 2022/23	Not Rated	Not Rated	The Committee approved the annual Quality Account.		
Safe Staffing	A	A	Overall average fill rates for nurses/midwives and HCSW for April and May 2023 were above 90%. The Internationally Educated Nurse recruitment programme continues to be successful and funding is secured until December 2023. However, there are registered nurse vacancies on key wards such as Saturn and the Acute Medical Unit. Bespoke recruitment and retention plans are in place for these areas. Nursing industrial action in April also had a negative effect on nurse staffing provision and additional costs. Areas of concern remain the AMU and within the community nursing space. Recruitment plans are in place.		

Issues Referred to another Committee	
Topic	Committee

Board Committee Assurance Report

Quality & Safety Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Dr Claudia Paoloni	Dr Claudia Paoloni		20 July 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	BAF Numbers	

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Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR Pillar Metric: Total Harms	A	A	There has been a further decrease in the total number of harms down to 208 in month, with a continued decrease in the number of falls rate for the fourth consecutive month and no incidences of MRSA reported now for the fourth month. There were three serious incidents in month, all being investigated under the serious incident framework. This is a reduced number of incidents compared to the previous month.		
IPR Pillar Metric: Friends & Family Test	A	A	There has been a slight reduction in positive responses but it still remains on the internal target of 86%.		
IPR Breakthrough Objective: Pressure Harms	A	A	There has been a slight increase in the number of pressure harms both in the acute and community settings, but there have been no category 3 or 4 harms reported in any areas where focused work has been undertaken,		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			giving reassurance that the approach is correct and effective but will take time to embed in all areas. There are high caseloads which add pressure to the Tissue Viability and Community Nursing Teams to manage.		
IPR Alerting Watch Metric: Hospital Acquired Infections	R	A	Concerns remains around the levels of Gram Negative bloodstream infections and also the rate of *C.difficile* infection continues to be higher than 2022/23. However, this does appear to the in line with the System suggesting that the prevalence of *C.difficile* is increasing locally in the System area. Of concern are the Gram Negative infections that may have been impacted by a change in cleaning practices in April with a new Serco cleaning contract. However, our rates were higher than peers prior to this contract suggesting that other factors are contributing to the infection rates. It has been identified that pipework and handwash basins require upgrading and this may also be a contributing factor. In view of the concern around this, the Committee has requested that it receives a report in August from the Lead Matron on the action plan in collaboration with Serco and for Estates to attend to report an action plan in changing the required estate components that may be contributing to the higher Pseudomonas infection rates.	Action plans to be received from the Lead Matron/Serco and Estates	August 2023
Maternity Performance Report	A	G	The Committee was assured by the metrics in the report. Whilst it was noted that the midwife to birth ratios had reflected an increase in demand in the service, the escalation plan was effectively implemented such that 1:1 care for all families was ultimately delivered. Of seven incidents that were graded as moderate harm or above for perinatal services in June, three were downgraded following multi-disciplinary reviews, one is undergoing an internal review, one is subject to RIDDOR reporting and one has been referred to an external review. Further progress has been made against the Ockenden report with actions being upgraded in June.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			Regarding the CNST Year 5 (Maternity Incentive Scheme), a preliminary action plan has been developed to achieve compliance. Our current position stands that it is projected that we should meet full compliance although two risk areas have been identified for this around a completion of a business case detailing financial impact of medical workforce requirements and a risk around Saving Babies Lives Care Bundle Version 3. Regarding the Saving Babies Lives Care Bundle risk, limitations in ultrasound scanning capacity has been recognised as an area of vulnerability.		
Q1 2023/24 Maternity & Neonatal Quality & Safety Report	A	A	It has been noted that in Q1 we have seen an increase in the rate of inductions of labour which is performed for many reasons, but is being reviewed to ensure that the appropriate pathways are being followed and to justify this induction rate. There has also been an increase in the stillbirth rate per 1000 births although this is also a national occurrence. The Patient Safety Team have identified a theme from incident reporting concerned with medication prescribing and administration. We are assured that this will be tackled through a new process of Medicine huddles. Another theme identified was the non-labelling of babies following birth but this is being managed through improved handover measures with focus on positive patient identification and the use of 'Welcome to the Ward' Champions.		
Perinatal Mortality Review Tool Q1 2023/24	G	B	100% compliance across all measures and the system remains embedded.		
Three year delivery plan for Maternity & Neonatal Services	A	G	We received a briefing on the Three Year Delivery Plan which identified six areas of improvement: • Recruitment and retention • Implementation of the Patient Safety Incident Review Framework (PSIRF)		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			• Equity, diversity, and inclusion • Service user engagement and feedback • Reporting structure and data sources • Perinatal culture and leadership A key area of risk identified a full implementation of Saving Babies Lives Care Bundle SBL as mentioned previously and progress of actions will be reported 6-monthly through the Quality & Safety Committee.		
National Neonatal Audit Project (NNAP) GWH results	Not Rated	Not Rated	We received the GWH results on the National Neonatal Audit Project which clearly demonstrated the successes within GWH and the South West. In our management of premature babies and associated infant mortality rates, improvements have been made in how GWH manages extreme pre-term birth (less than 27 weeks) and we now correctly refer to our tertiary centres in a timely manner. Also to note was our success in administering appropriate therapies to enhance premature baby outcomes including the use of magnesium, steroids and optimal cord management of these vulnerable babies. We exceed national rates in many areas around the management of our neonates and our mortality rates for babies less than 32 weeks are well below the national average.		
Mortality Report	R	A	We received the quarterly Mortality report which identified continued issues around the number of structured judgement reviews (SJR) completed and their quality. Also of note was the time taken to complete these which took on average four months to complete. Whilst it is recognised that issues around coding contributed to this, timely response is being addressed through the introduction of a new web-based SJR pro-forma which was implemented at the end of May allowing easy access and ensuring a standardisation of report. The Committee sought assurance around learning from these reports and the attendance and engagement at mortality meetings.		
Emergency Department Dashboard	A	A	The Emergency Department saw over 400 more attendances across ED and UTC in April and May compared to March. May was the highest		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
			monthly attendance for a year which has impacted triage times and increased length of stay and waits within those areas. ED Major chairs also showed approximately 1000 more patients compared to Q4. Patient questionnaires shows some areas of improvement but some issues remain around pain management and comfort factors. The SHINE checklist have shown some areas of improvement but also a deterioration in others, such as initial vital signs measurements; but this seems to be reflection of surges in attendances impacting on staffing capacity. The SHINE checklist has now been rolled out onto the NerveCentre and work is being done around quality huddles and a daily check and challenge. Further work around triaging within the Major chairs is underway, as well as more work on the current patient questionnaire.		
Tendables Matrons' Audit and Ward Accreditation Update	Not Rated	Not Rated	An update was presented on an audit programme that is being undertaken across the organisation as a quality assurance tool to incentivise high standards of care and to reduce variation within our practice. A ward accreditation framework has also been introduced against which wards will be assessed and rated. How this will be reported in the future to the Quality & Safety Committee is under review to ensure that assurance around the right areas can be maintained.		
15+ Risk Report	R	A	There is one 15+ risk associated to quality and safety around the use of Major chairs in ED resulting in delayed patient timely triage intervention/ treatment or discharges. The Committee has requested a timeline and action plan on the de-escalation process down from the current score of 20 to the target score of 4.		Oct 2023
Board Safety Visits	Not Rated	Not Rated	An update on the board safety visits was received and it was noted that these visits are receiving positive clinical team feedback.		

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Safe Staffing	A	A	Overall average fill rates for nurses/midwives and HCSW for June 2023 were above 90% but slightly lower than the previous two months. The Committee congratulated the team on the success of the HCSWs which have shown no vacancies consistently for three months, whilst recognising there appears to be a high turnover in this group in the first year which is being reviewed for a possible causation.		
Electronic Discharge Summaries	Not Rated	Not Rated	Concerns remain that only partial assurance can be gained around our ability to deliver electronic discharge summaries in a comprehensive manner. To address generating appropriate electronic discharge summaries (EDS), a Task and Finish Group was created and identified a possibility for the development of an alternative platform to generate EDS from our existing systems. As this requires digital input, the Task and Finish Group has been expanded to involve an IT team and the Committee will receive an action plan at the next report to make progress around the EDS.	Action plan to be received	October 2023
Responsible Officer Annual Report	Not Rated	Not Rated	Receive the Responsible Officer annual report which showed good progress on rates of appraisal and revalidation.		

Issues Referred to another Committee	
Topic	**Committee**

Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**
Meeting Date	26 June 2023
Committee Chair	Faried Chopdat
Link to Strategic Objective	Pillar 4: Use of Resources
Link to Board Assurance Framework	BAF 4 S6 & S7
Improving Together Pillar Metrics	GWH Control Total / I&E
	Sustainability / Carbon Footprint
Improving Together Breakthrough Objective	Productivity

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. Month 2 Finance	Limited Assurance	x
2. Improvement & Efficiency Plan	Limited Assurance	x
3. Internal Recovery Plan	Receive	x
4. Way Forward Programme – Expansion Land Development Update	Receive	x
5. EPR Full Business Case	Approve	✓
6. AHA EPR Procurement Recommendation Report	Approve	x
7. Estates & Facilities Risk Register	Adequate Assurance	x
8. Infrastructure Projects Authority PFI Health Checklist Report	Adequate Assurance	x
9. Procurement Recommendation Report: Cath Lab	Approve	✓
10. Image Sharing Strategic Outline Case	Approve	x
11. Standing Financial Instruction	Receive	x
12. Node Room Air Conditioning Works	Approve	x
13. BAF Strategic Risks – review emerging risks	Approve	x
14. Committee Assurance Reports	Receive	x

POINTS OF ESCALATION	**Month 2 Finance Position**: The Trust is in a £4.7m deficit representing a £2.9m adverse variance to the plan – pay (£2.1m adverse YTD is due to additional accrued pay award for Months 1 and 2 of £1.3m and undelivered pay efficiencies of £0.7m) and non-pay pressures (£2.2m adverse YTD due to due to depreciation above plan and the Trust's share of the system risk allocation for 2023/24 of £1.5m are driving the negative variance). The full-year forecast is currently to be in line with the plan. However, if the YTD average run rate continued with no further efficiency identified and no growth in activity, the Trust would finish with a c.£28m deficit to plan. This highlights the risk around the current spending and activity levels and the shortfall in the efficiency savings target. The Trust continues to face significant challenges to its finance position and acknowledges management's focus and remediation plans to address those matters within the Trust's control.
	Improvement & Efficiency: The Trust started the year with a £16.67m cash-releasing efficiency plan, which includes a £2.98m carryover from 2022/23. As of Month 2, the programme is £0.9m under the plan. Medicine is the key driver, with no delivery reported against its YTD plan of £0.7m. Out of the £16.67m target, £14.49m is identified, with £2.8m unidentified. Divisions and supporting services must work to turn the £10.77m of plans and opportunities into deliverable schemes while focusing on generating new schemes to reduce the unidentified target. Only 18% (£3.1m) of the £16.67m target is on track; £12.3m is classified as amber or red. The Committee acknowledges that the focus must be on moving these schemes to delivery and developing new schemes to remove the unidentified target and mitigate the non-delivery of other schemes.
	EPR Full Business Case & EPR Recommendation Report: The full EPR business case was presented to the Committee for discussion and challenge. The Committee was appraised of the case for change, the preferred bidder, contractual negotiation, governance and benefits and risks, and the implementation plan. The Committee approved the Full Business Case and recommended this for discussion and approval at the Board.
KEY AREAS TO NOTE	**Financial Recovery Programme Update** – In addition to the work undertaken on the CIP, a programme has been initiated to focus on assisting the Divisions and Corporate Services to identify further CIP schemes and embed delivery of schemes identified from Red/Amber statuses to Green.
	Business Cases: Several business cases, and procurement reports was presented and constructively challenged, and pressure tested by the Committee. We were satisfied that due process was undertaken, and appropriate solutions were proposed to progress to the next stage.

BOARD ASSURANCE FRAMEWORK & RISKS	**Finance & Way Forward Risk Reporting:** The Committee noted that Finance's risk management process and reporting, including that of the Way Forward Program, is adequate and effective. Whilst we were reassured that the scoring of risks aligned with the Risk Management Policy, we requested management to reflect on the scoring of risk 872 as the delivery of the savings plan of £16.8m is the most significant risk of the financial position in FY23/24. Following the Committee's challenge, Risk 872 was upgraded from a risk score of 15 to 20 as £6.1m shortfall in efficiency delivery had still not been identified and the CIP delivery was under-achieving.
	Board Assurance Framework: The Committee reflects on the discussions held during the meeting and considers the identifying strategic risks for Board Assurance purposes.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**Nursing Agency Spend:** Whilst there is a lot to do here, we noted some early wins and improvements in nursing agency spending following focus and grip and control processes in place to address this challenge.
REFERRALS TO OTHER BOARD COMMITTEES	No items were noted for referral to other Board Committees.

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
	Substantial Assurance: There are clear actions and timescales. All actions are on track. There are no gaps in assurance
	Adequate Assurance There Is evidence of good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control and manage.
	Limited Assurance: There is partial clarity on the matter to be addressed; some progress has been made but there remain several outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated, or managed.
	No assurance: The report cannot clearly articulate the matter or issue; something has arisen at the Committee for which there is little, or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.

Board Committee Assurance Report

Committee	**Finance, Infrastructure & Digital Committee**
Meeting Date	24 July 2023
Committee Chair	Faried Chopdat
Link to Strategic Objective	Pillar 4: Use of Resources
Link to Board Assurance Framework	BAF 4 S6 & S7
Improving Together Pillar Metrics	GWH Control Total / I&E
	Sustainability / Carbon Footprint
Improving Together Breakthrough Objective	Productivity

Items received by the Committee	Level of Assurance	Board Action Required? Yes ✓ or No x
1. BSW Finance Protocol	Receive	x
2. Month 3 Finance	Limited Assurance	✓ (Risk ⇧)
3. CIP Programme	Limited Assurance	✓ (Risk ⇧)
4. Costing Assurance Update	Adequate Assurance	x
5. Way Forward Programme	Receive	x
6. Digital Risk Register	Adequate Assurance	x
7. EPR Programme	Limited Assurance	x
8. IT Infrastructure – Quarterly Update	Adequate Assurance	x
9. Cyber Security – Quarterly Update	Adequate Assurance	x
10. PFI – 6 monthly reports, including lifecycle, decant & Best Practice	Adequate Assurance	x
11. ERIC Report – Annual Update	Adequate Assurance	x
12. Power Outage – Lessons Learnt	Limited Assurance	x
13. Fleet EV Charging Policy	Approve	x
14. ICS Suppliers & Representatives Code of Conduct	Approve	x

POINTS OF ESCALATION	**Month 3 Finance Position**: At M3, the Trust is in a £4.6m deficit position, representing a £3.1m adverse variance to plan. Pay and non-pay pressures are driving the unfavourable variance. NHSE stipulated for M3 that all providers should assume ERF is paid to them in line with the plan for Q1. This is included in the above numbers and means that our position is c.£2m better than it would be if ERF remained directly linked to activity performance, i.e., the situation would have been c.£5.1m worse than plan if we were reporting in line with plan assumptions. On the current run rate plus known changes, we have a risk of c.£18.7m deficit. The primary reasons for this potential overspending would be a shortfall in efficiency delivery, alongside continued overspending on temporary staffing and industrial action.
	Improvement & Efficiency: At M3, £2.90m of CIP savings were delivered year to date (£1.23m delivery in M2), which is £334k above the monthly plan. This represents an improvement from M2 reporting, which was £0.9m behind schedule year to date. The identified level of 2023/24 efficiencies have improved from £14.49m in M2 to £15.20m in M3 against the £16.67m target, and there has been a significant shift from amber/red-rated schemes to green-rated schemes. The frequency of the Improvement Sub-Committee has been increased to fortnightly to focus on detailed plan workup and delivery, increasing oversight. During M4, the Committee is assured of plans to focus on expenditure analysis and benchmarking to review run-rate trends and identify mitigating actions.
KEY AREAS TO NOTE	**BSW Finance Protocol Enactment:** The BSW system submitted a balanced financial plan during the 2023/24 annual national planning round containing several risks shared across providers. In addition to these risks, there has been significant industrial action within the NHS, further increasing the risk of delivering a balanced financial plan. As a result, the BSW system was off schedule in Months 1 and 2. A change in NHSE guidance obligated the system to enact the financial protocols intended to enhance the financial control in the system and support the delivery of the balanced plan across the NHS in 2023/24. From a GWH perspective, whilst the efficiency programme delivery has not been at the required levels to date, significant progress has been made in reducing agency spending and restricting run rate increases in the year. The additional support that will come following the enactment of the protocols can be positive and will help further delivery.
	EPR Programme – Whilst substantial progress has been made regarding the Full Business Case, Procurement and Contract activities, and employing critical resources to the programme, the Committee highlights the risk that the programme is subject to approval by NHSE and therefore has noted this as partially assured.
	Power Outage Lessons Learnt - The Committee requested that a lesson learnt exercise be undertaken to establish the root cause of the Power Outage and any lessons that may be gleaned to ensure continued operations because of any future disruption. The Committee received an update; however, there are several gaps that both the Infrastructure and IT/Digital teams need to follow up on to provide a comprehensive view and assurance to the Committee.

BOARD ASSURANCE FRAMEWORK & RISKS	**Digital/IT Risks**: The Committee received the quarterly update of the Digital/IT risks following a refresh of the approach to risk management. Overall, 65 risks have been identified and are overseen by Digital Governance Committee, reflecting a better overall picture of the Trust for cyber and infrastructure. The revised approach will require embedding and will be assured through Digital Steering Group. Overall, the Committee acknowledged the improvements in risk reporting for Digital/IT.
CELEBRATING OUTSTANDING PRACTICE AND INNOVATION	**Finance & CIP Reports:** The monthly finance and CIP reporting has improved significantly in quality providing salient insights to the Committee. **General:** The Committee acknowledges the efforts that execs and their teams apply to due process to ensure that appropriate focus and constructive challenge are in place on matters of tremendous significance.
REFERRALS TO OTHER BOARD COMMITTEES	No items were noted for referral to other Board Committees.

Key to lead committee assurance ratings Assurance provides 'confidence / evidence/certainty that "what needs to be happening is happening in practice - 'Do we really know what we think we know?	
	Substantial Assurance: There are clear actions and timescales. All actions are on track. There are no gaps in assurance
	Adequate Assurance There Is evidence of good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control and manage.
	Limited Assurance: There is partial clarity on the matter to be addressed; some progress has been made but there remain several outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated, or managed.
	No assurance: The report cannot clearly articulate the matter or issue; something has arisen at the Committee for which there is little, or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.

Board Committee Assurance Report

People & Culture Committee – April 2023			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Paul Lewis	**Paul Lewis**		**30th June 2023**
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?			

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR – Staff Survey (Recommend Place To Work)	A	A	The Q1 Pulse Survey results (58.4%) show a 5.1% improvement from the 2022 annual staff survery result which is very encouraging. The Trust is launching a "great place to work' campaign on 10th July and Divisions are supporting this with employee testimonials to showcase GWH as a great employer.	Review progress at the next meeting.	August 2023
IPR – Staff Survey (I am able to make improvements happen in my area of work)	G	A	The Q1 Pulse Survery results show an improvement to 57.20% compared to 51.90% in 2022. Plans are in place for the top performing teams to share their learning with Divisional leads at the monthly staff survey working group. The first regular review for Divisions started at this Committee meeting in June 2023 with Surgery, Women & Children – see below.	Review progress at the next meeting.	August 2023

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
IPR – Voluntary Staff Turnover Rate	A	A	The Trust has seen a continued improvement since July 2022 and the rate for April 2023 was below the Trust KPI target of 11% which is very encouraging. Further plans such as the Retention Workshop, Staff Excellence Awards and the Stay Conversation initiative should help further improve our position. Our turnover rates with leavers within the 1st year of employment has increased month on month and was over target for April and so further analysis and actions will be taken to address this.	Review progress at the next meeting.	August 2023
IPR – EDI Disparity Ratio	A	A	The Trust ambition is to reduce the disparity between white staff and BAME colleagues from 13.5% to 8.3% in line with the national average. Engagement and workshops are now taking place alongside other plans such as the EDI lead tea trolley visits, the Inclusion Recruitment champion pilot and input and feedback from the EDI group. The Trust will also be launching an allyship programme in September.	Review progress at the next meeting.	August 2023

Staff Survery - Surgery, Women & Children Department	A	A	The Surgery, Women & Children Department presented their update which included a detailed action plan. There was positive feedback about the content and structure of the plans, but there remains some concerns about how well the actions will be delivered and embedded to make the improvements needed given some of the challenges in this area. The Committee have asked for a verbal update at the next meeting from the Deputy Chief People Officer to retain visibility and oversight of their progress.	Review progress at the next meeting.	August 2023
Annual Flu Report	B	B	We celebrated the results of this programme where GWH are leading the way in the South West. The team learnt and adapted their approach throughout this campaign and provided the dual administration of both Flu and Covid vaccinations. The report summarised an impressive number of key achievements, but also identified learning and opportunities to improve further. We were very proud to evaluate and record this as our first 'Blue-Blue' assurance rating!	N/A	
Resourcing Strategy	A	A	There was very positive support for the Resourcing Strategy. The Committee raised some questions and challenges about engaging our Generation Z population (possibly through on line focus groups) to ensure our recruitment and resourcing plans for 'zoomers' are tailored appropriately and robust to attract and retain them in the future.	N/A	

Issues Referred to another Committee	
Topic	**Committee**
None	N/A

Board Committee Assurance Report

Audit, Risk & Assurance Committee			
Accountable Non-Executive Director	**Presented by**		**Meeting Date**
Helen Spice	Helen Spice		23 June 2023
Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y/N	BAF Numbers	

The key headlines / issues and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'Assurance level' column below
Not assured	**Red – there are significant gaps in assurance and we are not assured as to the adequacy of current action plans. If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"**
Limited	**Amber – there are gaps in assurance but we are assured appropriate action plans are in place to address these**
Significant	**Green – there are no gaps in assurance / high level of confidence in delivery of existing mechanisms/objectives**
Full	**Blue – Delivered and fully embedded**

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
BDO Internal Audit Annual Report 2022/23	G	A	The BDO Internal Audit Annual Report for 2022/23 provided an overall moderate assurance opinion and confirmed that no major weaknesses were identified in the internal control system for the areas reviewed. The Committee noted that there had been some challenging reviews during 2022/23 but recognised that the internal audit plan had focused on areas where challenges were expected.		
Internal Audit – Consultant Job Planning	A	A	The Consultant Job Planning Report was rated moderate assurance for design and limited assurance for operational effectiveness. The Trust has a robust job planning process and policy and an electronic job planning system. However, at the time of the review implementation of the policies it was not evident that job plan were completed or objectives set. The Trust asked for a repeat audit in 12 months and this report will be referred to the Quality and Safety Committee.	Repeat audit to be undertaken in 12 months. Report to be referred to Quality & Safety Committee.	June 2024

Key Issue	Assurance Level		Committee Update	Next Action (s)	Timescale
	Risk	Actions			
Internal Audit – Data Security and Protection Toolkit	G	A	The Committee noted that there is overall moderate assurance over the design and operational effectiveness of the Trust's data security and protection controls and confidence in the return to be submitted is high.		
Internal Audit – Cost Improvement Programme	A	A	The Cost Improvement Programme Report was rated moderate assurance for design and moderate assurance for operational effectiveness. The Committee are aware that the CIP target was not achieved in 2022/23. It was noted that work needs to be done to improve ownership within the Divisions and Corporate Services. The Committee noted that the governance process for 2023/24 has been enhanced.		
Counter Fraud Annual Report and Counter Fraud Functional Standard Return	N/A	N/A	The Committee noted that the Counter Fraud Functional Standard Return for 2022/23 was submitted within the deadline and all areas were rated green.		
Annual Report and Accounts 2022/23	N/A	N/A	The Committee received and considered the Annual Report and Accounts for 2022/23. Deloitte confirmed that they still have a few minor areas of work to complete but are envisaging issuing an unmodified audit opinion. Their work on Value for Money is ongoing but they have not identified any areas of significant weakness. The Committee noted this improvement from the prior year. The Committee approved the Annual Report and Accounts for 2022/23 and the letter of representation subject to the finalisation of the remaining work.		
Losses and Compensations Q4 2022/23	N/A	N/A	The Committee approved the Loses and Compensations report for Q4 2022/23.		

Issues Referred to another Committee	
Topic	**Committee**
Internal Audit Report – Consultant Job Planning	Quality and Safety

Report Title	**Three Year Maternity & Neonatal Single Delivery Plan**				
Meeting	**Trust Board**				
Date	**3rd August 2023**	Part 1 (Public)	X	Part 2 (Private)	
Accountable Lead	Lisa Cheek – Chief Nurse				
Report Author	Lisa Marshall, Kat Simpson & Laura Little				
Appendices	None				

Purpose

Approve		Receive	X	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 in respect of: process/outcome/other (please detail):

Significant		Acceptable	X	Partial		No Assurance	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Assurance given around the strategy for the following 12 months in embedding the objectives of the Three Year Delivery Plan for Maternity and Neonatal Services.

Report

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

A summary presentation of the themes detailed in Three Year Maternity & Neonatal Delivery Plan including key highlights for celebration and the GWH strategy for achievement of full compliance.

Link to CQC Domain – select one or more	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
	X	X	X	X	X
Links to Strategic Pillars & Strategic Risks – select one or more	★				
	X		X	X	X
					Risk Score
Key Risks – risk number & description (Link to BAF / Risk Register)	612- There is a risk that GWH will fail to identify babies at risk in pregnancy because of inadequate ultrasound infrastructure in the Antenatal Clinic and Delivery Suite, resulting in poor patient outcomes and patient experience.				6
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	The Quality information will be reviewed by the Executive Committee and Divisional Governance meetings.				
Next Steps	Key actions will be taken forward through individual services and improvement groups.				

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

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

Explanation of above analysis:

Equality, Diversity, and Inclusion are woven throughout all four themes both for service users and the GWH workforce. Strategies are outlined to,

- Reduce workforce inequalities to ensure a representative and inclusion workforce
- Continued prioritisation of service user engagement when designing and planning the delivery of maternity & neonatal services

Recommendation / Action Required

The Board/Committee/Group is requested to:

- **Understand the initial self-assessment against the Three Year Maternity & Neonatal Delivery Plan and their impact on the development of the perinatal strategy to make care safer, more personalised and more equitable.**

Accountable Lead Signature	
Date	27 July 2023

NHS
Great Western Hospitals
NHS Foundation Trust

Three Year Maternity & Neonatal Single Delivery Plan

Lisa Marshall	Director of Midwifery and Neonatal Services
Kat Simpson	Head of Midwifery and Neonatal Services
Laura Little	Project Co-Ordinator for Maternity & Neonatal Services

Three Year Single Delivery Plan for Maternity & Neonatal Services

Great Western Hospitals NHS Foundation Trust

On 30th March 2023 NHS England published its three-year delivery plan for maternity and neonatal services. The plan sets out a series of actions for Trusts, Integrated Care Boards and NHS England with the aim:

to make care safer, more personalised and more equitable.

There are clear objectives which define the responsibility for Trusts, Integrated Care Boards and NHS England across four themes:

- Listening to women and families with compassion
- Supporting the workforce
- Developing and sustaining a culture of safety
- Meeting and improving standards and structures.

The initial strategy for Great Western Hospitals will focus on identified areas of improvement which include:

- Recruitment and retention
- Implementation of the Patient Safety Incident Review Framework (PSIRF)
- Equity, diversity and inclusion
- Service user engagement and feedback
- Reporting structure and data sources
- Perinatal culture and leadership.

Summary of Theme Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Theme One : Listening to Women & Families With Compassion

GWH Self Assessment (May 2023)		
0	6	1

Objective One : Care that is personalised	GWH Self Assessment RAG & Commentary (May 2023)
1.5a : Empower maternity and neonatal staff to deliver personalised care by providing the time, training, tools, and information, to deliver the ambitions above.	
1.5b : Monitor the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings.	
1.5c : Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022.	
1.5d : Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.	

Objective Two : Improve equity for mothers and babies	GWH Self Assessment RAG & Commentary (May 2023)
1.10a : Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.	
1.10b : Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. This data should be used to make changes to services and pathways to address any inequity or inequalities identified, to improve care.	

Objective Three : Work with service users to improve care	GWH Self Assessment RAG & Commentary (May 2023)
1.21a : Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.	

Aim of Theme One:

- All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
- During 2023/24, Integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
- From 2023/24, Integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

Key Highlight for Celebration:

- Established Continuity of Carer team in place with positive service user feedback, focussed on the most vulnerable families

Strategy for Achievement of Full Compliance:

- BFI Gold accreditation planned for May 2024
- Continued co-production with the Maternity and Neonatal Voices Partnership
- Effective utilisation of available funding to implement an EDI lead midwife/nurse for the service
- Continued prioritisation of service user engagement through our Maternity and Neonatal Voice Partnership (MNVP) when designing and planning the delivery of maternity and neonatal services.

Summary of Theme Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Theme Two : Growing, Retaining & Supporting Our Workforce

GWH Self Assessment (May 2023)		
0	7	5

Objective Four : Grow Our Workforce	GWH Self Assessment RAG & Commentary (May 2023)
2.6a : Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.	
2.6b : Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.	
2.6c : Provide administrative support to free up pressured clinical time.	

Objective Five : Value & Retain Our Workforce	GWH Self Assessment RAG & Commentary (May 2023)
2.12a : Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan	
2.12b : Implement equity and equality plan actions to reduce workforce inequalities	
2.12c : Create an anti-racist workplace, including for example, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource.	
2.12d : Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey	
2.12e : Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.	
2.12f : Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce	

Objective Six : Invest In Skills	GWH Self Assessment RAG & Commentary (May 2023)
2.17a : Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.	
2.17b : Ensure junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.	
2.17c : Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums	

Aim of Theme Two:

- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability

Key Highlight for Celebration:

- Established preceptorship program in place
- Education provision mapped to Core Competency Framework
- Recruitment and retention plan in place to support alternative routes to midwifery including return to practice and apprenticeship program

Strategy for Achievement of Full Compliance :

- The provision of anti-racism training to all staff, and implementation of an equity and equality plan to reduce workforce inequalities in conjunction with the Trust strategy to ensure a representative and inclusive workforce.
- Appointment of a cultural ambassador for the perinatal services
- Continued focus on succession planning pathways and medical workforce job plans.

Summary of Theme Detail & Ongoing Work Towards Compliance

Great Western Hospitals NHS Foundation Trust

Theme Three : Developing & Sustaining A Culture of Safety, Learning & Support

GWH Self Assessment (May 2023)		
0	10	6

Objective Seven : Develop A Positive Safety Culture	GWH Self Assessment RAG & Commentary (May 2023)
3.5a : Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. This includes time to engage stakeholders, including MNVP leads	
3.5b : Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.	
3.5c : At board level, regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy	
3.5d : Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit	
3.5e : Ensure all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways	

Objective Eight : Learning and Improving	GWH Self Assessment RAG & Commentary (May 2023)
3.11a : Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of duty of candour and a single point of contact for ongoing dialogue with the trust.	
3.11b : Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.	
3.11c : Respond effectively and openly to patient safety incidents using PSIRF.	
3.11d : Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.	
3.11e : Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.	
3.11f : Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).	

Objective Nine : Support and Oversight	GWH Self Assessment RAG & Commentary (May 2023)
3.16a : Maintain an ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.	
3.16b : Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard	
3.16c : Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.	
3.16d : Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.	
3.16e : At board level, listen to and act on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the FTSU guide and improvement tool.	

Aims for Theme Three:

- Throughout 2023, effectively implement the NHS-wide "PSIRF" approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Key Highlights for Celebration:

- Established communication process for families involved in care reviews and complaints which focuses on understanding their experience
- Safety Champion model embedded within the service where staff voices and concerns are heard
- Freedom to Speak Up Guardians in place

Strategy for Achievement of Full Compliance :

- Implementation of the Patient Safety Incident Response Framework (PSIRF) which sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety
- Increased MNVP involvement in compliant responses
- The maternity and neonatal quadrumvirate are participating in The Maternity Transformation Programme's (MTP) Perinatal Culture and Leadership Programme

Summary of Theme Detail & Ongoing Work Towards Compliance

NHS Great Western Hospitals

Theme Four : Standards & Structures that Underpin Safer, More Personalised & More Equitable Care

GWH Self Assessment (May 2023)		
1	2	6

Objective Ten : Standards to Ensure Best Practice	GWH Self Assessment RAG & Commentary (May 2023)
4.6a : Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025	
4.6b : Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.	
4.6c : Ensure staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance.	
4.6d : Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans	

Objective Eleven : Data To Inform Learning	GWH Self Assessment RAG & Commentary (May 2023)
4.11a : Review available data to draw out themes and trends and identify and promptly address areas of concern including consideration of the impact of inequalities	
4.11b : Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.	

Objective Twelve : Make Better Use of Digital Technology in Maternity & Neonatal Services	GWH Self Assessment RAG & Commentary (May 2023)
4.16a : Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England what good looks like framework.	
4.16b : Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the digital maternity record standard and the maternity services data set and can be updated to meet maternity and neonatal module specifications as they develop.	
4.16c : Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.	

Aim of Theme Four:

- Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new "MEWS" and "NEWTT-2" tools by 2025.
- In 2023, NHS England's new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
- By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

Key Highlights for Celebration:

- Effective governance and monitoring processes with engagement and shared learning across the system and region
- Digital strategy and roadmap in place that outlines the vision for full digitalisation of the perinatal service

Strategy for Achievement of Full Compliance :

- The revised Saving Babies Lives care bundle will require a significant increase in the ultrasound capacity for the maternity provision.
- This is recognised via the Trust risk register as an area of vulnerability with business planning underway to establish a strategy for implementation

NHS
Great Western Hospitals
NHS Foundation Trust

Three Year Maternity & Neonatal Single Delivery Plan

Report Title	**Standing Financial Instructions, Scheme of Delegation and Powers Reserved to the Board Review**				
Meeting	**Trust Board**				
Date	**3 August 2023**	Part 1 (Public)	x	Part 2 (Private)	
Accountable Lead	Simon Wade, Chief Financial Officer				
Report Author	Johanna Bogle, Deputy Chief Financial Officer				
Appendices	Appendix 1 – Proposed SFIs Appendix 2 – Proposed SoD Appendix 3 – Proposed Summary SFIs				

Purpose							
Approve	**X**	**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 in respect of process/outcome/other (please detail):							
Significant		**Acceptable**	**x**	**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:							

Report

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

A review of the Standing Financial Instructions (SFIs) and Scheme of Delegation (SofD) has been undertaken.

The SFIs have been reviewed based on the SFI's for RUH, to ensure there is consistency within the BSW system.

Revisions have been proposed to the Scheme of Delegation financial limits which aim to ensure that the budget holders in the lower levels of the Trust's hierarchy have greater accountability.

There are no amendments proposed to the Scheme of Reservation (Trust Board) (previously Powers Reserved for the Board) since the last review in February 2022, except for change of titles.

The Finance, Infrastructure & Digital Committee considered the SFIs & SofD and recommended that the Board approve the proposals.

Link to CQC Domain	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**
					x
Links to Strategic Pillars & Strategic Risks	★				
					x

Key Risks – risk number & description (Link to BAF / Risk Register)	-	**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Trust Management Committee March 2023 Audit, Risk k& Assurance Committee June 2023 Finance, Infrastructure & Digital Committee June 2023	
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?		x	
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			x
Explanation of above analysis:			

Recommendation / Action Required	
The Board is requested to approve the Standing Financial Instructions, Scheme of Delegation and Powers Reserved to the Board.	
Accountable Lead Signature	
Date	13 June 2023

Introduction

The Standing Financial Instructions (SFIs) of the Trust are due to be reviewed every two years. This piece of work was completed in March 2023 and involved leads from finance, corporate governance, and procurement.

The SFIs were compared to those of our AHA partners, with particular reference to RUH Bath, which had updated its SFIs in January 2023.

Our proposed SFIs now closely align to those of RUH Bath. Our Scheme of Delegation (SoD) aligns for tender waivers, contracts, disposals, write-offs and charitable funds, but continues to differ for expenditure approval. At RUH, most spend goes through finance for approval. At GWH we want to encourage ownership and accountability for our budget holders by empowering them to spend their budgets as they see fit.

As well as the full version of the SFIs, we have created summary SFIs for reference and easy reading for users. These will be held on the intranet for all-staff access.

1. Scheme of Delegation Changes Proposed

The data in the finance sub-ledger was analysed to identify the number of touchpoints associated with non-purchase order invoices. For a period of 12 months to January 2023, c.8,000 invoices generated c.12,000 formal touchpoints for coding and approvals in the system (this does not include where invoices are moved from one user to another for queries or re-direction). If we were to update the SoD, the number of touchpoints for this mix of invoice values would reduce to c.9,000; a reduction of c.23%.

For purchase orders, there is currently a similar issue with the number of touchpoints, as high-value purchase orders need to go through each approval level from the bottom up. If we were to move to the proposed scheme of delegation, over the period analysed, of the c. 2,400 POs, all bar 70 could have been covered by budget managers or budget holders.

Table 1: Scheme of Delegation Changes Proposed

Role	Old	New	Difference
Budget Manager	<£1,000	<£5,000	Increase of £4,000
Head of Service / Matron / Budget Holder	<£5,000	<£50,000	Increase of £45,000
Divisional Director	<£10,000	<£100,000	Increase of £90,000 (assume covered previously by Exec Co)
Exec Co member	<£10,000	N/A	Remove Level
Executive Director	<£50,000	<£250,000	Increase of £200,000
Chief Financial Officer	<£500,000	<£1,000,000	Increase of £500,000
Chief Executive Officer	<£50,000	<£1,000,000	Increase of £950,000
Board of Directors	>£1,000,000	>£1,000,000	No change

2. Right Person, Right Job

Purchasing through the Oracle finance system is a necessary governance process, but it can also be an administrative burden. Each user is sent a daily email advising of outstanding invoices in their workflow and a link to log in. It takes approximately five minutes to read the email, log into Oracle, open the relevant screens, see the invoice, forward for coding / further information / to a more relevant approver, and approve. If we assume users do this once a day, this equates to c.3 days over a year. With lots of steps in the approval chain, the impact is doubled at each level it goes through. We want to ensure the accountability is in the right place - **with our budget holders** - rather than with the more senior leadership team who may not know the detail of what is required and so are merely dual-approving an order already checked and approved by the budget holder impacted by the spend.

Table 2: Summary table of proposed Scheme of Delegation

	Expenditure & Non-SLA Sales Orders (Income*) Revenue / Capital	Investment Approvals	Tender Waivers	Sign Expenditure Contracts** & Recommendation Reports***	Disposal / Write off of Physical Assets	Losses & Special Payments / Debt Write-Off	Charitable Funds
Board of Executives	£1m +	£1m +	£300k +	£1m +	£500k +		£500k +
Chief Executive	£1m		£300k	£1m	£500k		
Chief Financial Officer	£1m		£200k	£1m	£150k		
Executive Director	£250k						
Deputy Director	£100k						
Deputy Chief Financial Officer			£50k	£100k-£350k	£10k	£10k	£5k
Director of Procurement				£100k-£350k			
Deputy Director of Procurement				£100k			
Charitable Funds Committee							£5k
Trust Management Committee		£1m					
Clinical Divisions							
Clinical Triumvirate / Quad		<£50k and neutral overall					
Clinical Divisional Director	£100k						
Budget Holder / Head of Service / Matron	£50k				£5k	£5k	
Budget Manager	£5k				£1k	£1k	£5k
Support Divisions							
Executive Director	£250k	<£50k and neutral overall					
Deputy Director	£100k						
Budget Holder / Head of Service	£50k				£5k	£5k	
Budget Manager	£5k				£1k	£1k	£5k

3. Purchase Order Project

We want to get to a place where non-purchase orders are minimised, and purchase orders are the default. This project is being led by the Procurement team, and the SoD changes will feed into this. To date, the team have reviewed the types of spend that should be excluded from a requirement to go through a purchase order, and are testing

the ability of corporate spend to adhere to the proposed guidelines, with a view to rolling out mandatory categories of PO spend to the wider Trust later this year.

Using a purchase order process would mean that budget holders would only need to approve requisitions in the system, and no further touchpoints would be required from them – receipting would then be done by relevant team members, with invoices matched to receipts automatically by the system. This would give us full assurance around spend controls and compliance with legal requirements i.e. Public Contract Regulations, ensuring we are spending in a compatible way and have the right compliance in place.

4. Budget Holder Compact

When this proposal was presented and agreed at Trust Management Committee in March 2023, it was discussed that this was the right way to proceed to deliver a more mature budget management governance structure, but that we should formalise expectations on both sides with a budget holder compact. This is included in full at Appendix C, with the summary of expectations below:

What you can expect in terms of Support as a Budget Holder

- ➔ Access to "live" reports on NHS SBS (these refresh every 24 hours so are not real time)
- ➔ Diarised meetings with your finance contact. Regularity to be based on value and complexity of your budget.
- ➔ On-line training accessed through the finance intranet page / ESR (coming in 2023/24)
- ➔ Face-to-face budget holder training opportunities once a quarter
- ➔ Monthly drop-in sessions at Trust HQ for all finance-related face-to-face queries

What is expected of you as a Budget Holder

- ➔ Sign up to deliver your agreed levels of services within budget
- ➔ Regular access of your live budget reports and review of spend, raising any concerns with relevant colleagues and progressing with mitigations to reduce spend where necessary
- ➔ Continual emphasis on driving value for money in the short-, medium- and long-term
- ➔ A robust forecast of what you intend to spend for the remainder of the year
- ➔ Indications of unavoidable cost pressures, investment requests and efficiency plans aligned to service delivery on a 3-year timescale

Escalations

These should be made first through your divisional triumvirate and then onto Finance – Head of Financial Management & Value

5. Recommendation

The SFIs and SoDs are recommended to be updated, bringing us into alignment with RUH Bath for SFIs and updating our SoD to reflect our commitment to trust our budget holders to manage their budget.

Great Western Hospitals
NHS Foundation Trust

Standing Financial Instructions

Reference Number:	
Author & Title:	Johanna Bogle, Deputy Chief Financial Officer Rob Webb, Director of Procurement Caroline Coles, Company Secretary
Responsible Director:	Simon Wade - Chief Financial Officer
Review Date:	February 2023
Ratified by:	Audit, Risk & Assurance Committee
Date Ratified:	tbc
Version:	1

Related Policies and Guidelines	Charitable Funds Standing Financial Instructions Department of Health and Social Care Group Accounting Manual

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Amendment History

Issue	Status	Date	Reason for Change	Authorised

1.Policy Summary

1.1 Great Western Hospitals NHS Foundation Trust (the "Trust") was authorised as an NHS Foundation Trust by Monitor (now part of the new organisation 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 1 December 2008.

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

1.3 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).

1.4 The NHS England (NHSE) 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.

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 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 Financial 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 be 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, Risk and Assurance 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 Financial 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 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 and Chief Financial Officer

3.4 The Chief Executive and the Chief Financial Officer will delegate their detailed responsibilities as permitted by the Constitution and SOs, but they remain accountable for financial control.

3.5 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 GWH's 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 GWH's system of internal control.

3.6 It is a duty of the Chief Executive 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 Financial Officer

3.7 The Chief Financial 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 Financial 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

3.8 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

3.9 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 NHS England, the Terms of Authorisation, the Constitution, Standing Orders, Standing Financial Instructions and the Delegation of Powers.

Contractors and their employees

3.10 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 Chief Executive to ensure that such persons are made aware of their duties under these Standing Financial Instructions.

3.11 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 Financial Officer.

4.Audit

Audit, Risk and Assurance Committee

4.1 In accordance with the Constitution the Board of Directors shall establish an Audit, Risk and Assurance 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 and Assurance 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

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, Risk and Assurance 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, Risk and Assurance 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, Risk and Assurance Committee should immediately inform the Chief Executive 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 Financial Officer to ensure an adequate Internal Audit service is provided and the Audit, Risk and Assurance Committee shall be involved in the selection process when/if the Internal Audit service provider is changed.

Chief Financial Officer

4.3 To support the Audit, Risk and Assurance Committee in their role, it is the responsibility of the Chief Financial Officer 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, Risk and Assurance Committee. The report must cover:

i. 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 and Assurance 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 Financial 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

iv. Explanations concerning any matter under investigation

Role of Internal Audit

4.5 Internal Audit provides an independent and objective opinion to the Chief Executive, the Audit, Risk and Assurance 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 Financial 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 Financial Officer must be notified immediately.

4.9 The Head of Internal Audit, or equivalent title, will normally attend the meetings of the Audit, Risk and Assurance Committee and has a right of access to all Audit, Risk and Assurance Committee members, the Chair and Chief Executive.

4.10 The Head of Internal Audit shall be accountable to the Chief Financial Officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit, Risk and Assurance 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 Financial Officer and shall refer audit reports to the appropriate officers designated by the Chief Executive. Failure to take remedial action within a reasonable period shall be reported to the Chief Executive. 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 Financial 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 Financial 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, Risk and Assurance 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, Risk and Assurance 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 Financial Officer is required to authorise expenditure.

4.17 The External Auditor shall be routinely invited to attend and report to attend and report to meetings of the Audit, Risk and Assurance Committee, and shall be entitled to meet the Audit, Risk and Assurance Committee in the absence of Trust employees, if they so desire.

Fraud and Corruption

4.18 In line with their responsibilities, the Chief Executive and the Chief Financial 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 Financial 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 Financial 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 Financial 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, Risk and Assurance Committee meetings and has a right of access to all Audit, Risk and Assurance Committee members, the Chair and Chief Executive of GWH.

4.24 The LCFS shall be accountable to the Chief Financial Officer. The reporting system for Counter Fraud services shall be agreed between the Chief Financial Officer, the Audit, Risk and Assurance 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, Risk and Assurance Committee meeting, on counter fraud work within GWH.

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, Risk and Assurance Committee any weaknesses in fraud-related systems and any other matters which may have fraud-related implications for the Trust

c. Request from the Chief Executive all necessary support to enable him/her to carry out his/her functions and responsibilities efficiently, effectively and promptly, 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 Chief Executive, the Chief Financial Officer, or the LCFS.

4.28 In accordance with the Freedom to Speak Up (Raising Concerns Policy), the Trust shall have a 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 Financial 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 Chief Executive 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, Risk and Assurance 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 Chief Executive, with the assistance of the Chief Financial 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 Financial Officer will, on behalf of the Chief Executive, 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

g. Enable the Trust to comply with the whole regulatory framework for Foundation Trusts.

5.5 Officers shall provide the Chief Financial Officer with all financial, statistical and other relevant information as necessary for the compilation of such business plans, estimates and forecasts.

5.6 The Chief Financial Officer has overall responsibility to ensure that adequate financial systems are in place to monitor and control financial performance to enable GWH to fulfil its statutory responsibility to meet its annual revenue and capital targets.

5.7 The Chief Financial Officer has the authority to request budget holders to formally sign off annual budgets, as an acknowledgement of ownership.

Budgetary Control and Reporting

5.8 The Chief Financial 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.

5.9 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 Financial Officer shall be responsible for providing budgetary information and advice to enable the Chief Executive and other officers to carry out their budgetary responsibilities.

5.10 The Chief Financial Officer shall keep the Chief Executive 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.

5.11 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

5.12 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.

5.13 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.

5.14 The Chief Executive will delegate to budget holders responsibility for identifying and implementing cost efficiency programmes ("efficiencies") 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

5.15 The Chief Executive, through the Chief Financial 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

f. Provision of regular reports

5.16 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.17 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.18 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive or the Chief Financial Officer.

Capital Expenditure

5.19 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 applications relating to capital are contained in section 15 of these SFIs)

Performance Monitoring Forms and Returns

5.20 The Chief Financial 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

6.1 The Chief Financial 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 Company Secretary 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 Company Secretary 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.

7.Bank Accounts

General

7.1 The Chief Financial 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 Financial 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 GWH's 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 Financial 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

b. The conditions under which each bank and GBS account is to be operated

7.6 The Chief Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 Chief Executive and the Chief Financial 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 Chief Executive or the Chief Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 Financial Officer or Deputy Chief Financial Officer. All write-offs will be reported to the Audit, Risk and Assurance 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 Financial 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

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 Financial 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 Financial 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 Financial 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

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 Financial 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 Financial Officer and reported to the Board.

9.5 The Chief Financial 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, Risk and Assurance 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 Chief Executive 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 Head of Operational Procurement/Senior Contracts Manager 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 Conflicts of interest should be considered throughout the procurement process, with any gifts or other benefits offered throughout a tender process or in the course of business of usual to be declined, unless they are low-cost branded promotional aids such as pens or post-it notes, under

the value of £6 in total. Trust employees to adhere to the "managing conflicts of interest in the NHS policy".

10.3 Directives by the Council of the European Union promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SOs and SFIs.

10.4 The Trust has policies and procedures in place for the control of all tendering activity carried out on behalf of the Trust.

10.5 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

10.6 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)

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

10.7 The following tables outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

10.8 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.

10.9 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.

10.10 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.

Table 1

Contract Value (Excluding VAT)	**Quotations/Tenders**	**Min number invited to Quote/Tender where available**	**Form of Contract**
<£10,000	Single Quotation may be obtained by end user	1	Purchase Order
£10,000 - £24,999	Quotation Authorisation required from Procurement prior to obtaining quotes	2	Purchase Order
£25,000- £75,000	Quotation To be obtained by Procurement with appropriate advertising and market engagement	3	Contract and Purchase Order
£75,001 – Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order
> Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order

10.11 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.

10.12 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).

10.13 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).

10.14 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 will not be required.

10.15 Authorisation to sign a Contract and recommendation report requirements are detailed in Table 2 below.

Financial Limits for the Procurement Process & Placing Contracts

10.16 Authorisation to sign a Contract and recommendation report requirements are detailed in Table 2 below.

10.17 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 the Table 2.

Table 2

Contract Value (Excluding VAT)	**Recommendation Report Required**	**Authorisation To Place or sign Contract**
<£10k (Inclusive of zero nominal value)	No	As per purchase order system approval hierarchy approval
£10k – £25k	Recommendation report required only if contract has not been awarded to the most economically advantageous offer	As per purchase order system approval hierarchy approval
£25k - £100k	Yes	Deputy Director of Procurement
£100k – £350k	Yes	Director of Procurement or Deputy Chief Financial Officer
£350k - £1.0m	Yes	Chief Financial Officer / Chief Executive Officer
£1.0m +	Yes	Trust Board

10.18 The Chief Executive, Chief Financial Officer, Deputy Chief Financial Officer, Director of Procurement, Head of Procurement and Chief Pharmacist may sign and place contracts on the Trust's behalf, providing a valid Contract Approval Document is signed by the relevant Executive Director or Chairman on behalf of the Trust Board. Where appropriate this should include a supporting contract recommendation report.

10.19 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contract.

Electronic Tendering

10.20 All invitations to tender should be on a formal competitive basis applying the principles set out below using the Trust E-Tendering Portal.

10.21 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.

10.22 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

10.23 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

10.24 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.

10.25 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.

10.26 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

10.27 All tenders on the approved form shall be addressed to the appropriate officer according to the appropriate limits specified Table 2.

10.28 The date and time of receipt of each tender shall be endorsed on the unopened tender envelope/package.

10.29 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

10.30 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.

10.31 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.

10.32 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

f. The persons present at the opening shall sign the record, where a manual process has been conducted

10.33 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.

10.34 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)

10.35 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 Financial Officer, Director of Procurement or nominated officer. All decisions should be recorded in line with the procurement process.

10.36 Tenders received after the due time and date may be considered only if the Chief Financial 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 Financial 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.

10.37 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 Financial Officer or nominated officer be regarded as having arrived in due time. A record supporting this decision should be recorded in the procurement log.

10.38 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.

10.39 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.

10.40 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.

10.41 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 Financial Officer.

10.42 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.

10.43 All tenders shall be evaluated on the basis of MEAT (Most Economically Advantageous Tender) and in conjunction with published Award Criteria and Weightings.

10.44 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 Chief Executive or nominated officer (within Table 2).

10.45 All tenders should be treated as confidential and should be retained for inspection.

Extensions to Contract

10.46 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

10.47 Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in Table 1 and will involve procurement department in line with Table 2.

10.48 Unless permitted by SOs, competitive quotations/tenders will be sought for all contracts according to the financial limits specified in Table 1 and will involve procurement department in line with Table 2.

10.49 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.

10.50 No tender shall be considered which bears any mark or name indicating the sender.

10.51 Where the total contract value exceeds £25,000 the Trust has a legal obligation to ensure that they advertise through the appropriate portal in line with Public Contracts Regulations and must subsequently ensure the respective award is also published.

10.52 Where the total contract value exceeds the Public Contracts Regulations Thresholds then the Trust is committed to conducting a legally compliant procurement process in line with the Public Contracts Regulations.

10.53 Where appropriate, pharmacy orders will be placed against National or Regionally/Divisionally agreed Pharmacy Contracts, which should cover the majority of orders placed by the Pharmacy Department.

10.54 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 Financial Officer for further instructions.

10.55 The number of firms to be invited to tender for a particular contract shall be in accordance with the financial limits specified in Table 1. 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 Table 2. 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, Risk and Assurance 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 Table 1.

10.60 Pre-Qualifications stages should be conducted in accordance with Public Contract Regulations.

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. Signed Contracts will be required for all Single Tender Action waivers over £25,000.

10.62 Quotations/ tenders shall be invited for all purchases over a period of time in line with Table 1.

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 Table 1 according to delegated limits.

10.66 All waiving of variation of competitive tendering/quotation procedures shall be reported to the Audit, Risk and Assurance Committee on a six monthly basis highlighting all waivers over £10,000 in line with waivers approved by the Chief Financial Officer.

10.67 All competitive quotations/tenders should come through the e-tendering portal to ensure compliance and published in line with Public Contracts Regulations. 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 Signed Contracts will be required for all Single Tender Action waivers over £25,000.

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 will not be required.

10.70 Formal competition need not be applied (and therefore a waiver is not required) where:

a. The estimated expenditure does not, or is not reasonably expected to, exceed the Contract value set out in SFI 10.9 Table 1

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 SFI 10.3 Table 1. 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. The requirement is to attend a seminar, conference or similar unique event

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 CHARITABLE FUNDS COMMITTEE. In the instance where no plan has been approved, the request will be returned to the relevant department.

10.74 Tenders undertaken from Charity Monies must be carried out in accordance with EU and Public Procurement Regulations, with the project element and its associated cost dictating the type of tender with its respective threshold.

Financial Standing and Technical Competence of Suppliers

10.75 The Chief Financial 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 Financial 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, purchasing 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 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 Chief Executive. The Committee is also responsible for determining the Chief Executive and Executive Executives' level of remuneration.

11.2 Full details of the responsibilities of the Board of Directors Nominations and Remuneration Committee are included in included its terms of reference.

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 Executives.

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 Financial 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:

a) Authorised to do so by the Chief Executive or the Chief Financial Officer

b) Within the limit of his approved budget and funded establishment as defined in the Scheme of Delegation

c) All changes with a financial impact have been through the appropriate Divisional process for authorisation

11.9 Divisional management shall maintain good controls with regards staff appointments to ensure each department remain within their delegated budgetary limits

11.10 All appointments must adhere to the Trust Recruitment and Selection Policy

11.11 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

11.12 Managers will ensure that all new employees and bank workers have

produced the relevant documentation and completed the relevant signing on procedure with Human Resources prior to starting.

11.13 The Human Resources Department shall be notified immediately upon the effective date of any change in state of employment or personal circumstances of an employee being known.

11.14 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.

11.15 The Chief Financial 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 Financial 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

d. Agreeing method of payment

11.21 The Chief Financial 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

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 Financial Officer's instructions and in the form prescribed by the Chief Financial Officer

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 Financial 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 Financial 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 Financial 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 major investments such as PFI's, long term contracts for the provision of services or acquisitions or mergers with other NHS organisations or private sector companies.

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, PFI-funded projects 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 Financial 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 Financial 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 of the Trust's Head of Operational Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

12.6 Once the item to be supplied (or service to be performed) has been identified, the requisitioner should raise a requisition. Obtaining goods and services without an order is only permitted for certain goods and services, such as agency staff, utilities, etc.

System of Payment and Payment Verification

12.7 The Chief Financial 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.

12.8 The Chief Financial 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 Executives/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 Financial 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 Financial 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 Chief Executive 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. contracts above specified thresholds are advertised and awarded in accordance with this policy and EU rules on public procurement

d. For all contracts with a single supplier who's 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.

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 (Monitor); 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 Executives 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 Chief Executive;

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. Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHS England or Department of Health and Social Care;

d. verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive 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;

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. an individual cannot order an item, receipt the item and certify the invoice for payment

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 Financial Officer, or a person with specific delegated powers from the Chief Financial 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's guidance is to be followed (Managing Operating Cash in NHS Foundation Trusts – December 2005).

14.8 The Audit, Risk and Assurance Committee shall set the investment policy and oversee all investment transactions by the Trust. The Chief Financial Officer must ensure compliance with this policy at all times.

14.9 The Chief Financial 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, Risk and Assurance Committee.

14.10 The Chief Financial 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

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 Financial 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 £500,000: Trust Management Committee

c. Commitment of expenditure in excess of £500,000: Board of Directors.

The values quoted above are inclusive of VAT.

15.4 For capital schemes where the contracts stipulate stage payments, the Chief Financial Officer will issue procedures for their management. The Chief Financial 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 Financial Officer shall issue to the Manager responsible for any scheme:

a. Specific authority to commit expenditure

b. Authority to proceed to tender

c. Approval to accept a successful tender

15.6 The Chief Executive will issue a Scheme of Delegation for capital investment management.

15.7 The Chief Financial 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 Financial 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 Financial 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 Financial 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

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, their value 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 Financial Officer that an asset is to be disposed of.

15.15 The Chief Financial 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 Financial 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

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 Financial Officer.

15.20 Whilst each Officer has a responsibility for the security of property of the

Trust, it is the responsibility of Executives 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 Executives 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)

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

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 Executives, one of whom must be the Chief Executive.

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

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 Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. 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 Financial 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 Financial 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 Financial 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 Financial 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 Financial Officer.

17.9 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Chief Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 Financial Officer; and

b. Recorded by the condemning officer in a form approved by the Chief Financial 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 Financial 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 Financial Officer who will take the appropriate action.

Losses and Special Payments

18.5 The Chief Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 Financial Officer must immediately notify:

a. The Board, and

b. The External Auditor.

18.12 Within limits delegated to it by the Board, the Chief Financial Officer shall approve the writing off of losses.

18.13 The Chief Financial 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 Financial Officer should consider whether any insurance claim can be made.

18.15 The Chief Financial 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, Risk and Assurance Committee annually.

19. Information Technology

Responsibilities and duties of the Chief Financial Officer

19.1 The Chief Financial 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 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 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 Financial 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 Executives and employees will send to the Chief Financial 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 Financial 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 Financial 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 Financial Officer shall periodically seek assurances that adequate controls are in operation.

19.8 The Chief Financial Officer will ensure that relevant security details are provided in the contract in line with 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 Financial 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 Financial 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 Chief Executive 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 Financial 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 Financial 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 in the NHS Policy". The policy follows the guidance from the Department of Health and NHS England, in particular Health Circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' which is deemed to be an integral part of these Standing Orders and Standing Financial Instructions.

21.2 Declarations of gifts or other benefits must be made to the Company Secretary 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. This policy follows the guidance contained in the Department of Health circular HSG

(93) 5 ‘Standards of Business Conduct for NHS Staff’ and NHS England’s guidance on managing conflicts of interest in the NHS, and is also deemed to be an integral part of the Standing Orders and these Standing Financial Instructions.

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 Chief Executive 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 Chief Executive. Detail shall be maintained of records so destroyed.

24. Risk Management and Insurance

Risk Management Programme

24.1 The Chief Executive 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 Financial 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 Financial 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 Financial 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 Deputy Chief Nurse.

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 Financial Officer shall be responsible for establishing procedures for the management of expense claims submitted by Trust employees. The Chief Financial 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 Financial 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 Financial Officer shall liaise with the Chief Executive 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 Financial Officer. This includes all Executive Executives of the Trust as well as all officers. The Board has provided the Chief Financial 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 Financial Officer for prior approval. No officer of the Trust outside the - organisational control of the Chief Financial 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 Royal United Hospitals 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 Financial 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 Financial 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 Financial 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 Financial Officer shall arrange for the administration of all existing Charitable Funds held on Trust. The Royal United Hospital Charitable Fund has been formed under an GWH Deed dated 10 September 1996 as amended by a Supplemental Deed dated 9 December 2009. 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 Financial 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 Financial 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 Executives) shall, in cases of doubt, consult the Chief Financial 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 Financial 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 Financial 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 Financial 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 Financial 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 CHARITABLE FUNDS COMMITTEE.

Investment Management

27.18 The CHARITABLE FUNDS 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 Financial 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 Chief Financial Officer. 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 Financial Officer shall advise the Board of Trustees 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 Financial 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 Financial 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 Financial Officer shall prepare the Annual Accounts in the required manner, which shall be submitted to the Board within agreed timescales.

27.26 The Chief Financial 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 Financial 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 Financial Officer unless otherwise dictated by Charity SORP (Statements of Recommended Practice).

27.29 The Chief Financial 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 Financial Officer on the outcome of the annual audit.

27.31 The Chief Financial 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 Financial 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 Financial 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 Chief Executive, as the accounting officer, will ensure that all intellectual property is identified and properly recorded in the Trust's Intellectual Property register.

28.3 The Chief Executive, as the accounting officer, 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 Property register.

28.5 The Chief Executive, as accounting officer, 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 Chief Executive, as accounting officer 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 of employment.

28.7 All documents containing commercially sensitive information must be marked 'Commercial in confidence'.

28.8 The Chief Executive, as accounting officer will ensure that all publications produced by the Trust are marked as Trust copyright. This will include, amongst other items, research reports, manuals, policy documents.

Registering of trademarks and patents

28.9 The Chief Executive, as accounting officer, 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 Chief Executive, as accounting officer, 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 service users.

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 into account:

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 Chief Executive, as accounting officer, 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 Chief Executive, as accounting officer, 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 training that 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, 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 or the Chief Financial 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, Risk and Assurance 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 means the Chief Executive of the Trust;

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 Financial 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;

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 Executives;

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 Great Western Hospitals NHS Foundation Trust

Appendix 1: Authorisation Limits

Revenue and Capital Authorisation Limits – Values exclude VAT

	Expenditure & Non-SLA Sales Orders (Income*) Revenue / Capital	Investment Approvals	Tender Waivers	Sign Expenditure Contracts** & Recommendation Reports***	Disposal / Write off of Physical Assets	Losses & Special Payments / Debt Write-Off	Charitable Funds
Board of Directors	£1m +	£1m +	£300k +	£1m +	£500k +		£500k +
Chief Executive	£1m		£300k	£1m	£500k		
Chief Financial Officer	£1m		£200k	£1m	£150k		
Executive Director	£250k						
Deputy Director	£100k						
Deputy Chief Financial Officer			£50k	£100k-£350k	£10k	£10k	£5k
Director of Procurement				£100k-£350k			
Deputy Director of Procurement				£100k			
Charitable Funds Committee							£5k
Trust Management Committee		£1m					
Clinical Divisions							
Clinical Triumvirate / Quad		<£50k and neutral overall					

Clinical Divisional Director	£100k						
Budget Holder / Head of Service / Matron	£50k				£5k	£5k	
Budget Manager	£5k				£1k	£1k	£5k
Support Divisions							
Executive Director	£250k	<£50k and neutral overall					
Deputy Director	£100k						
Budget Holder / Head of Service	£50k				£5k	£5k	
Budget Manager	£5k				£1k	£1k	£5k

All values exclude VAT.
* The Income and Contracts Accountant to authorise provider to provider sales order following the signing of contracts which will be authorised in accordance with the above limits.
** For contracts that cover more than one financial year this includes the total value of contracts, not just the annual charge.
*** Recommendation reports all go to FIDC, with >£1m also going to Trust Board for approval

Appendix 2: Scheme of Delegation

This appendix 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 them should the need arise. If the Chief Executive is absent powers delegated to them may be exercised by a nominated Officer after taking appropriate advice from the Chief Financial 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.

1. Section 1- Scheme of Reservation (Council of Governors)

REF	THE COUNCIL OF GOVERNORS ("The Council")	DECISIONS RESERVED TO THE COUNCIL
NA	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 Deputy 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 Trust Board). • to represent the interests of the members of the NHS Foundation Trust and the public.
NA	COUNCIL OF GOVERNORS' NOMINATIONS AND REMUNERATION COMMITTEE	The Council of Governors shall establish the Council of Governors' Nominations and Remuneration Committee to: • Periodically review the structure, size and composition (including the skills, knowledge and experience and diversity) required of the Non-Executive Directors and make recommendations to the Council with regard to any changes; • Give consideration to succession planning for 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 and; make recommendations to the Council of Governors concerning plans for succession; • Agree with the Council of Governors a clear process for the nomination of a Non-Executive Director; • For each appointment of a Non-Executive Director, agree a description of the role, capabilities and, expected time commitment required; • Make recommendations for suitable Non-Executive Director / Chair candidates to fill vacant posts within the Committee's remit, for appointment by the Council of Governors; • Make recommendations to the Council of Governors in respect of the re-appointment of any Non-

		Executive Director. Any term beyond six years must be subject to a particularly rigorous review; • Make recommendations to the Council of Governors in regard to any matters relating to the removal of office of a Non-Executive Director; • To be consulted by the Board of Directors on the appointment of the Senior Independent Director and to report on this consultation to the Council of Governors ; • To consider the Non-Executive Director appraisal process; • To receive reports on the appraisal of the Chair and Non-Executive Directors from the Senior Independent Director and the Chair of the Trust respectively; • To recommend to the Council of Governors the remuneration, allowances and other terms and conditions for Non-Executive Directors; taking into account the views of the Chair (except in respect of his/her own remuneration, allowances and other terms and conditions), the Chief Executive Officer and any external advisers.

2. Section 2- Scheme of Reservation (Trust Board)

REF	THE TRUST BOARD ('The Board')	DECISIONS RESERVED TO THE BOARD
NA	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.
NA	THE BOARD	**Regulations and Control** (a) Approval of the Constitution (in accordance with approval framework), a schedule of matters reserved to the Board, Standing Orders and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business. (b) Approval of a scheme of delegation of powers from the Board to employees. (c) Requiring and receiving the declaration of directors' interests which may conflict with those of the Trust and determining the extent to which that director may remain involved with the matter under consideration. (d) Requiring and receiving the declaration of interests from employees which may conflict with those of the Trust via the Audit, Risk & Assurance Committee. (e) Considering instances of failure to comply with the Authorisation, Provider Licence, Constitution and Standing Financial Instructions and taking action where appropriate. (f) Approval of significant changes to organisation structures that require formal consultation under relevant legislation or any changes within a previously approved strategy. (g) To receive reports from committees including those which the Trust is required by the Secretary of State, the Constitution, Standing Financial Instructions or other regulations to establish and to take appropriate action thereon.

		(h) To approve the recommendations of the Trust's committees where the committees do not have executive powers. To establish terms of reference and reporting arrangements of all board committees (and other committees if required). (i) Ratification of any urgent decisions taken by the Chair or Chief Executive in accordance with the Constitution, Scheme of Delegation or Standing Financial Instructions and Standing Orders. (j) Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust, such as charitable funds. (k) Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.
NA	THE BOARD	**Appointments** (a) The establishment, approval of terms of reference, approval of membership including Chairs, reporting arrangements and disbanding of all committees of the Board. (b) The appointment of members to any committee of the Trust and the appointment of representatives on outside bodies. (c) Approval of the Senior Independent Director (having regard to the views of the Council of Governors) from amongst the Non-Executive Directors of the Trust.
NA	THE BOARD	**Strategy and Plans** (a) Development and approval of the strategic aims, objectives and priorities of the Trust. (b) Approval of the Integrated Business Plan, Operational Plan and Annual Budget (including capital budget) and 5 Year Plan. (c) To approve any joint venture or merger with external organisations and acquisitions, subject to requirements set out in the Constitution.

		(d) Approval of strategy for ensuring quality and clinical governance in services provided by the Trust. (e) Approval of strategy for ensuring equality, diversity and inclusivity in both employment and the delivery of services.
NA	THE BOARD	**Policy Determination** (a) Approval of strategy and policy in accordance with the provisions of the Scheme of Delegation. (b) Approval and monitoring of the Trust's policies and procedures for the management of risk. (c) Approval of the Trust's Health & Safety Policy.
NA	THE BOARD	**Financial and Performance** (a) Approval of plans in respect of the application of available financial resources. (b) Approval of the opening or closing of any bank or investment account. (c) Approval of any borrowing. (d) Acquisition, disposal or significant change of use of land and/or buildings (including leases and licences) and approval of the associated financial limits. The introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant if it has a gross annual income or expenditure (that is before any set off) in excess of £5m, over the contract period, £1m in the case of capital spend. (e) Approval of expenditure in excess of £15m with NHS England approval. (f) Approval of individual compensation payments (patients, former patients, carers and other non-staff) non NHS Resolution above the limits of delegation to the Chief Executive and Chief Financial Officer (for losses and special payments) as referred to in the Scheme of Delegation.

		(g) To approve proposals for action on litigation against or on behalf of the Trust which are over £50,000 except where these are made in accordance with NHS Resolution instructions. (h) Approval of any applications for public dividend capital.
NA	THE BOARD	**Reporting Arrangements** (a) Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and employees of the Trust. (b) All monitoring returns and submissions required by NHS England, the Care Quality Commission, the Charity Commission and any others will be approved by the Board via the Finance, Infrastructure & Digital Committee. (c) Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive. (d) Consideration and approval of the Trust's Annual Report including the Annual Accounts and the Quality Accounts. The Board of Directors may choose to delegate authority to approve the Annual Report & Accounts to the Audit, Risk & Assurance Committee to meet NHSE's deadline for submission of the Annual Report & Accounts. (e) Receipt and approval of the Annual Report(s) for funds held on trust (e.g. charitable funds).
NA	THE BOARD	**Investment Policy** (a) To approve the investment policy for exchequer funds and discharge of trustee responsibilities in relation to non-exchequer funds. (b) To approve Private Finance Initiative (PFI) proposals. (c) To approve any purchase of shareholding.

		(d) To review and approve alternatives to NHS Resolution risk pooling schemes. (e) To approve any substantive changes to the Trust's insurance or indemnity arrangements in relation to Directors and staff liability.
NA	THE BOARD	**Audit Arrangements** (a) The receipt of the annual management letter from the external auditor and agreement of action on the recommendation where appropriate of the Audit, Risk and Assurance Committee. (b) The receipt of the annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit, Risk and Assurance Committee

Delegation of powers to committees and sub-committees

The Board may determine that some of its powers can be exercised by Committees. The Board has delegated some functions to a number of committees, details of which are set out in their respective Terms of Reference.

The Board will determine the reporting requirements in respect of those committees. In turn those committees may delegate functions to a number of sub-committees or groups, details of which are set out in their respective Terms of Reference, but the delegate of powers to sub-committees must be expressly authorised by the Board.

Staff are authorised to act in accordance with their terms of appointment and in accordance with Trust policies and procedures.

The Constitution also specifies delegated authority to directors and the Company Secretary.

3. Section 3 - Decisions/duties delegated by the Board to Committees within the SFI

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
For full duties and responsibilities see terms of reference for each Board Committee		
SFI pg 10	AUDIT, RISK AND ASSURANCE COMMITTEE	The Committee will advise and support the Board through: (a) overseeing Internal and External Audit services; (b) reviewing financial and information systems, monitoring the integrity of the financial statements and any formal announcements relating to the Trust's financial performance and reviewing significant financial reporting judgments; (c) reviewing the establishment and maintenance of an effective system of corporate governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives; (d) monitoring compliance with Standing Orders and SFIs and the scheme of delegation; (e) reviewing schedules of losses and compensations and making recommendations to the Board; (f) Reviewing schedules of debtors/creditors balances over 6 months old and over a *de minimus* limit as defined by the Audit, Risk and Assurance Committee and related explanations/action plans; (g) Reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly. (h) Monitoring and reviewing the effectiveness of the Trust's internal audit function and ensuring that it meets any mandatory standards set by NHS England and any relevant UK professional and regulatory requirements; (i) Monitoring the independence and objectivity of the External Auditor; **(j)** Receiving reports from the Local Counter Fraud Service (LCFS) and monitor the work of the LCFS service.

SFI pg 39	BOARD OF DIRECTORS REMUNERATION COMMITTEE	The Committee shall determine the appropriate remuneration and terms of service for the Chief Executive, Executive Directors posts that will enable the Trust to attract and retain the best candidates.
SFIs pg 66	CHARITABLE FUNDS COMMITTEE	In line with its role as a corporate trustee for any funds held in trust, either as charitable or non- charitable funds, the Board of Directors will establish a Charitable Funds Committee to administer those funds in accordance with any statutory or other legal requirements or best practice required by the Charities Commission. This paragraph must be read in conjunction with the Standing Financial Instructions.

4. Section 4 – Duties from the NHS Foundation Trust Accounting Officer Memorandum (IRG 24/15 5 August 2015)

REF	DELEGATED TO	DUTIES DELEGATED
7	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 a whole; • 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.
8	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; ıe efficient and effective use of all the resources in their harge. 1 www.gov.uk/government/publications/managing-public-money
9	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 they are 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 they are 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 themselves; • ensure that, in the consideration of policy proposals relating to the expenditure for which they are 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.

10	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.
11	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] [2]www.gov.uk/government/publications/public-sector-internal-audit
12	ACCOUNTING OFFICER	See that appropriate advice is tendered to the board of Executives 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.
13	ACCOUNTING OFFICER	Set out in writing thier 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.
14	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, they should seek an instruction to proceed in writing from the Board or Council before proceeding.
16-20	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.
22	BOARD OF DIRECTORS	Appoint an acting Accounting Officer (normally the Chief Financial Officer) 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.

5. Section 5 – Authorities/duties delegated from Standing Orders

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1A.1	CHAIR	Final authority in interpretation of Standing Orders (SOs) as set out in the Constitution
3.2.2	CHAIR	Call meetings.
3.8	CHAIR	Give final ruling in questions of order, relevancy and regularity of any matters.
3.13.1	CHAIR	Having a second or casting vote
3.15	BOARD	Suspension of Standing Orders
3.15.5	AUDIT, RISK AND ASSURANCE COMMITTEE	Audit, Risk and Assurance Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)

5.1	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.)
4.2	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 Director members.
4.4.1	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.
4.4.2	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.
4.4.4	ALL	Disclosure of non-compliance with Standing Orders and this scheme of reservation and delegation to the Company Secretary as soon as possible.
7.1	THE BOARD	Declare relevant and material interests.
7.15.2	COMPANY SECRETARY	Maintain Register(s) of Interests of members of the Board upon receipt of new or amended information.
8.1.1	DIRECTORS	Comply with the Directors' Code of Conduct and any guidance and best practice advice issued by NHS England.
8.2.2	DIRECTORS	Disclose relationship between self and candidate for staff appointment. (Company Secretary to report the disclosure to the Board.)
9.1	COMPANY SECRETARY/ NOMINATED OFFICER	Keep common seal of the Trust in safe place and maintain a register of sealing.
9.2.3	CHIEF EXECUTIVE	Sign all documents which will be necessary in legal proceedings.

6. Section 6 – Authorities/duties delegated from Standing Financial Instructions

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
SFI 2.4	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible.
SFI 3.5	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.
SFI 3.4	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
SFI 3.6	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
SFI 3.7	CHIEF FINANCIAL 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) Providing financial advice to members of Board and Officers; e) Maintaining such accounts, certificates etc. as are required for the Trust to carry out its statutory duties.
SFI 3.9	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.
SFI 3.10	CHIEF EXECUTIVE	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.
SFI 4.1	AUDIT, RISK AND ASSURANCE COMMITTEE	Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control.
SFI 4.1 (i)	CHAIR OF AUDIT, RISK AND ASSURANCE COMMITTEE	Raise the matter at the Board meeting where Audit, Risk and Assurance Committee considers there is evidence of ultra vires transactions or improper acts.
SFI 4.3	CHIEF FINANCIAL OFFICER	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit, Risk and Assurance Committee in the selection process when/if an internal audit service provider is changed.)
SFI 4.6	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with guidance within the Government Internal Audit Standards.
SFI 4.18	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Monitor and ensure compliance with any relevant guidance issued by NHS England or NHS Counter Fraud Authority.
SFI 4.20	CHIEF FINANCIAL OFFICER	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
SFI 5.1	CHIEF EXECUTIVE	Compile and submit to the Board a Plan which takes into account financial targets and forecast limits of available resources.
SFI 5.4	CHIEF FINANCIAL OFFICER	Submit budgets to the Board for approval
SFI 5.11	CHIEF FINANCIAL OFFICER	Ensure adequate training is delivered on an ongoing basis to budget holders.
SFI 5.15	CHIEF EXECUTIVE	Delegate budget to budget holders.
SFI 5.16	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
SFI 3.7 (b)	CHIEF FINANCIAL OFFICER	Devise and maintain systems of budgetary control.

SFI 5.12 – 5.14	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 of virement • no permanent employees are appointed without the approval of the Chief Financial Officer other than those provided for in the budgeted establishment as approved by the Board • identifying and implementing cost improvements, cost savings and income generation initiatives to achieve a return that meets the requirements of Monitor; 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 control responsibilities.
SFI 5.14	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation initiatives with budget holders in line with the Annual Plan and a balanced budget.
SFI 5.20	CHIEF FINANCIAL OFFICER	Submit financial monitoring returns.
SFI 5.20	EXECUTIVE EXECUTIVES	Submit governance returns.
SFI 6.1	CHIEF FINANCIAL OFFICER	Preparation of annual accounts
SFI 6.2	COMPANY SECRETARY	Preparation of the annual report
SFI 6.5	COMPANY SECRETARY	Submit to Annual Report and Accounts to

		NHS England and put forward to be laid before Parliament each year.
SFI 7.1 & 7.2	CHIEF FINANCIAL OFFICER	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
SFI 7.10	CHIEF FINANCIAL OFFICER	Advise the Board on the Trust's ability to pay interest on and repay capital debt and new borrowing.
SFI 7.10	CHIEF FINANCIAL OFFICER	Report periodically on current debt, loans and overdrafts.
SFI 7.11	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust.
SFI 7.16	CHIEF FINANCIAL OFFICER	Will advise the Board on investments and report, periodically, on performance of same.
SFI 7.17	CHIEF FINANCIAL OFFICER	Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.
SFI 8.1	CHIEF FINANCIAL OFFICER	Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
SFI 8.5	ALL EMPLOYEES	Duty to inform the Chief Financial Officer of money due from transactions which they initiate/deal with.
SFI 9.2	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable legally binding agreements with service commissioners for the provision of NHS services.
SFI 10.66	CHIEF FINANCIAL OFFICER	Report waivers of tendering procedures to the Audit, Risk and Assurance Committee.
SFI 5.7.4	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
SFI 5.7.4	CHIEF EXECUTIVE or CHIEF FINANCIAL 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 Chief Executive or

		the Chief Financial Officer.
SFI 5.7.5	CHIEF EXECUTIVE OR NOMINATED REPRESENTATIVE	Responsible for the receipt and safe custody of tenders received.
SFI 5.7.5	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
SFI 5.7.9	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Where one tender is received will assess for value for money and fair price.
SFI 5.7.9	CHIEF EXECUTIVE	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 Chief Executive.
SFI 5.7.9	CHIEF FINANCIAL 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.
SFI 5.7.15	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
SFI 10.19	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
SFI 5.7.18	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
SFI	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust
SFI 11.1	BOARD OF DIRECTORS	Establish a Board of Directors Remuneration Committee.
SFI 11.3	BOARD OF DIRECTORS REMUNERATION COMMITTEE	Report in writing to the Board its decisions and its bases about remuneration and terms of service of Executives
SFI 11.7	CHIEF FINANCIAL OFFICER	Approval of variation to funded establishment of any department.

SFI 11.20	CHIEF FINANCIAL 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;
SFI 11.21	CHIEF FINANCIAL OFFICER	Issue instructions listed in the SFI.
SFI 11.22	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.
SFI 11.23	CHIEF FINANCIAL 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.
SFI 11.19	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.
SFI 12.1	CHIEF FINANCIAL OFFICER	Determine the level of delegation of non-pay expenditure to budget managers.
SFI 12.4	CHIEF FINANCIAL 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.
SFI 12.4 (c)	CHIEF FINANCIAL OFFICER	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
SFI 12.7	CHIEF FINANCIAL OFFICER	Shall be responsible for the prompt payment of accounts and claims in accordance with contract terms or national guidance.
SFI 12.8	CHIEF FINANCIAL 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 Financial 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
SFI 12.9 (b)	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment.
SFI 12.9 (d)	CHIEF FINANCIAL OFFICER	Approve proposed prepayment arrangements.
SFI 12.10	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.
SFI 5.9.2.7	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
SFI 12.11	OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer.
SFI 5.12	CHIEF EXECUTIVE	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;
SFI 15.1	CAPITAL PRIORITISATION AND MANAGEMENT GROUP	Ensure that a business case is produced for every significant capital expenditure proposal.
SFI 15.2 (f)	CHIEF FINANCIAL OFFICER	Certify professionally the costs and revenue consequences detailed in the

		business case for capital investment.
SFI 15.7	CHIEF FINANCIAL OFFICER	Issue procedures for management of contracts involving stage payments.
SFI 15.4	CHIEF FINANCIAL OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
SFI 15.5	CHIEF FINANCIAL OFFICER	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender.
SFI 15.6	CHIEF EXECUTIVE	Issue a Scheme of Delegation for capital investment management.
SFI 15.7	CHIEF FINANCIAL OFFICER	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
SFI 15.10	CHIEF FINANCIAL OFFICER	Maintenance of asset registers and arranging for a physical check of assets against the asset register.
SFI 15.15	CHIEF FINANCIAL OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
SFI 15.17	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
SFI 15.18	CHIEF FINANCIAL OFFICER	Approval of fixed asset control procedures.
SFI 15.19	BOARD, EXECUTIVE MEMBERS AND STAFF	All significant discrepancies revealed by verification of physical assets to fixed asset registers to be notified to the Chief Financial Officer.
SFI 15.20	BOARD, EXECUTIVE MEMBERS AND STAFF	Responsibility for security of Trust property.
SFI 15.20	EXECUTIVES AND SENIOR OFFICERS	Apply such appropriate routine security practices in relation to Trust property.
SFI 15.20	BOARD, EXECUTIVE MEMBERS AND STAFF	Report any damage to the Trust's premises, vehicles and equipment or any losses in accordance with Trust procedure.
SFI 17.3	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to the Chief Financial Officer's responsibility for

		systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded.
SFI 17.3	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks.
SFI 17.3	DESIGNATED ESTATES MANAGER	Responsible for control of stocks of fuel oil and coal.
SFI 17.4	DESIGNATED MANAGER / PHARMACEUTICAL OFFICER	Security arrangements and custody of keys.
SFI 17.5	CHIEF FINANCIAL OFFICER	Set out procedures and systems to regulate the stores.
SFI 17.6	CHIEF FINANCIAL OFFICER	Agree stocktaking arrangements.
SFI 17.8	CHIEF FINANCIAL OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
SFI 17.9	CHIEF FINANCIAL OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
SFI 17.9	DESIGNATED PHARMACEUTICAL OFFICER	Operate system for slow moving and obsolete stock, and report to the Chief Financial Officer evidence of significant overstocking.
SFI 17.11	CHIEF FINANCIAL OFFICER	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
SFI 19.1	CHIEF FINANCIAL OFFICER	Responsible for accuracy and security of computerised data.
SFI 19.3	CHIEF FINANCIAL OFFICER	Satisfy themselves that new computer systems (including finance systems) and 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.
SFI 19.5	CHIEF FINANCIAL	Shall publish and maintain a Freedom of Information Scheme or

	OFFICER	adopt a model Publication Scheme approved by the information Commissioner.
SFI 19.4	RELEVANT OFFICERS	Send proposals for general computer systems to the Chief Financial Officer.
SFI 19.6	CHIEF FINANCIAL 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.
SFI 19.7	CHIEF FINANCIAL OFFICER	Seek periodic assurances from the provider that adequate controls are in operation.
SFI 19.9	CHIEF FINANCIAL 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
SFI 19.10	CHIEF FINANCIAL OFFICER	Where computer systems have an impact on corporate financial systems the Chief Financial 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; Have adequate controls in place; and (d) such computer audit reviews as are considered necessary are being carried out

SFI 20.2	CHIEF EXECUTIVE	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.
SFI 20.3	CHIEF FINANCIAL 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.
SFI 20.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
SFI 23.1	CHIEF EXECUTIVE	Retention of document procedures in accordance with Department of Health Guidance.
SFI 24.1	CHIEF EXECUTIVE	Develop a risk management programme in line with NHS assurance framework requirements, which must be approved and monitored by the Board.
SFI 24.1	BOARD OF DIRECTORS	Approve and monitor risk management programme.
SFI 24.5	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.
SFI 24.6	CHIEF FINANCIAL OFFICER	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme.
SFI 24.7	CHIEF FINANCIAL 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 Financial 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 Financial 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.
SFI 25.1	CHIEF FINANCIAL OFFICER	Establish procedures for the management of expense claims.
SFI 26.1	CHIEF FINANCIAL OFFICER	Approve the contract or transaction in relation to credit finance commitments
SFI 26.2	CHIEF FINANCIAL OFFICER	Approve leasing agreements and hire purchase undertakings.
SFI 27.9	CHIEF FINANCIAL 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.
SFI 27.10	CHIEF FINANCIAL OFFICER	Arrange for the administration of all existing charitable Funds held on Trust
SFI 27.11	CHIEF FINANCIAL OFFICER	Ensure that all charitable Funds held on Trust are currently registered with the Charities Commission in accordance with the Charities Act 2011 or subsequent legislation.
SFI 27.12	CHIEF FINANCIAL OFFICER	The Chief Financial 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
SFI 27.15	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 Financial Officer.
SFI 27.16	CHIEF FINANCIAL OFFICER	Produce guidelines to Officers as to how to proceed when offered funds.
SFI 27.16 (B)	CHIEF FINANCIAL 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 their duty
SFI 27.17	THE BOARD	Give final approval for major appeals, defined as events raising in excess of £100,000.
SFI 27.17	CHARITABLE FUNDS COMMITTEE	Give final approval for smaller appeals, defined as events anticipating to raise less than £100,000
SFI 27.18	CHARITABLE FUNDS COMMITTEE	Be responsible for all aspects of the management of the investment of Funds held on Trust.
SFI 27.18	CHIEF FINANCIAL OFFICER	Be responsible for the appropriate treatment of all investment income.
SFI 27.20	CHARITABLE FUNDS COMMITTEE	Exercise of expenditure discretion (can be delegated to the Chief Financial Officer).
SFI 27.22	CHIEF FINANCIAL OFFICER	Advise the CHARITABLE FUNDS COMMITTEE and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee
SFI 27.23	CHIEF FINANCIAL 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 to replace 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 accounted for.
SFI 27.24	CHIEF FINANCIAL 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
SFI 27.25	CHIEF FINANCIAL OFFICER	Prepare the Annual Accounts
SFI	CHIEF FINANCIAL	In relation to the non-charitable trust funds

27.26	OFFICER	prepare any required returns to NHS England.
SFI 27.26	CHIEF FINANCIAL OFFICER	Prepare an annual trustees report regarding charitable trust funds and make the required return to the Charities Commission
SFI 27.27	CHIEF FINANCIAL OFFICER	Maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.
SFI 27.28	CHIEF FINANCIAL OFFICER	Determine a basis for the distribution of investment income to the charitable Funds held on Trust and the recovery of administration costs.
SFI 27.29	CHIEF FINANCIAL OFFICER	Ensure that the records, accounts and returns receive adequate scrutiny by the Trust's Internal Audit during the year
SFI 27.30	CHIEF FINANCIAL OFFICER	Advise the Board of the outcome of the annual audit.
SFI 27.31	CHIEF FINANCIAL OFFICER	Identify all costs directly incurred in the administration of all Funds held on Trust and charge such costs to the appropriate trust accounts
SFI 27.33	CHIEF FINANCIAL OFFICER	Ensure that the Trust's liability to taxation and excise duty is managed appropriately
SFI 28.1	CHIEF EXECUTIVE	Ensure that all intellectual property is identified, protected and used for the benefit of the Trust, the NHS and service users.
SFI 28.2	CHIEF EXECUTIVE	Ensure that all intellectual property is identified and properly recorded in the Trust's Intellectual Property register.
SFI 28.3	CHIEF EXECUTIVE	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 intellectual property.
SFI 28.4	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.
SFI 28	CHIEF EXECUTIVE	Responsible for compliance with the SFIs as they relate to the identification, protection, use and licensing of Trust and third party intellectual property.

Great Western Hospitals
NHS Foundation Trust

Standing Financial Instructions - Summary

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1.Policy Summary

1.1 The Standing Financial Instructions (SFIs) are rules to ensure our financial governance is robust. They form detailed guidance for all Trust staff about what financial decisions or commitments can be made at which levels of materiality. They apply to all staff members, regardless of role.

1.2 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, Risk and Assurance 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 Financial Officer, as soon as possible

2. Duties and Responsibilities

2.1 Essentially, the Trust must provide value for taxpayer money, and safeguard its assets from loss or damage. Anyone involved with creating cost or using the property of the Trust is responsible for ensuring that they use the resources wisely, and following related policies and procedures.

2.2 Overall, the Chief Executive Officer 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 GWH's 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 GWH's system of internal control.

2.3 The Chief Financial Officer is responsible for ensuring that the SFIs are relevant and policies and processes are in place to provide instruction and control to spend our resources well, and to report on what we have done with our money.

2.4 The Council of Governors are responsible for holding the Non–Executive Directors individually and collectively to account for the performance of the Board of Directors, and representing the interest of the members of the Trust as a whole and the interests of the public.

3. Thresholds Tender Guide

3.1 The Trust shall ensure that competitive tenders or quotations are invited for the supply of goods and services.

3.2 The following tables outline the correct procurement process to be followed relative to value and the type of product or service being purchased.

Table 1 – Thresholds for Quotations and Tenders

Contract Value (Excluding VAT)	Quotations/Tenders	Min number invited to Quote/Tender where available	Form of Contract
<£10,000	Single Quotation may be obtained by end user	1	Purchase Order
£10,000 - £24,999	Quotation Authorisation required from Procurement prior to obtaining quotes	2	Purchase Order
£25,000- £75,000	Quotation To be obtained by Procurement with appropriate advertising and market engagement	3	Contract and Purchase Order
£75,001 – Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order
> Public Contract Regulations threshold	Tender by Procurement	4	Contract as specified in Tender and Purchase Order

3.3 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.

3.4 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).

3.5 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).

Appendix 1: Authorisation Limits

Revenue and Capital Authorisation Limits – Values exclude VAT

	Expenditure & Non-SLA Sales Orders (Income*) Revenue / Capital	Investment Approvals	Tender Waivers	Sign Expenditure Contracts** & Recommendation Reports***	Disposal / Write off of Physical Assets	Losses & Special Payments / Debt Write-Off	Charitable Funds
Board of Directors	£1m +	£1m +	£300k +	£1m +	£500k +		£500k +
Chief Executive	£1m		£300k	£1m	£500k		
Chief Financial Officer	£1m		£200k	£1m	£150k		
Executive Director	£250k						
Deputy Director	£100k						
Deputy Chief Financial Officer			£50k	£100k-£350k	£10k	£10k	£5k
Director of Procurement				£100k-£350k			
Deputy Director of Procurement				£100k			
Charitable Funds Committee							£5k
Trust Management Committee		£1m					
Clinical Divisions							
Clinical Triumvirate / Quad		<£50k and neutral overall					
Clinical Divisional Director	£100k						

Budget Holder / Head of Service / Matron	£50k				£5k	£5k	
Budget Manager	£5k				£1k	£1k	£5k
Support Divisions							
Executive Director	£250k	<£50k and neutral overall					
Deputy Director	£100k						
Budget Holder / Head of Service	£50k				£5k	£5k	
Budget Manager	£5k				£1k	£1k	£5k

All values exclude VAT.
* The Income and Contracts Accountant to authorise provider to provider sales order following the signing of contracts which will be authorised in accordance with the above limits.
** For contracts that cover more than one financial year this includes the total value of contracts, not just the annual charge.
*** Recommendation reports all go to FIDC, with >£1m also going to Trust Board for approval

Report Title	**Responsible Officer Annual Report**				
Meeting	**Trust Board**				
Date	**3 August 2023**	Part 1 (Public)	x	Part 2 (Private)	
Accountable Lead	Dr Jon Westbrook - Chief Medical Officer				
Report Author	Amy Smith, Medical Revalidation & Job Planning Specialist & Dr Jon Westbrook, Chief Medical Officer				
Appendices	A Framework of Quality Assurance for Responsible Officers and Revalidation, Annex D – Annual Board Report and Statement of Compliance and Appendix A.				

Purpose							
Approve		**Receive**		**Note**	x	**Assurance**	x
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 in respect of: process/outcome/other (please detail):

Significant		**Acceptable**		**Partial**		**No Assurance**	
High level of confidence / evidence in delivery of existing mechanisms / objectives		General confidence / evidence in delivery of existing mechanisms / objectives		Some confidence / evidence in delivery of existing mechanisms / objectives		No confidence / evidence in delivery	

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' 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 purpose of the Responsible Officer annual board report is to monitor compliance, review requirements and demonstrate continuous improvements. Oversight of the appraisal, revalidation process and compliance is monitored monthly at the Medical Staff Support Group (Professional Standards) where any need for support, intervention, concerns or failure to engage are identified and escalated.

Deployment of electronic workforce systems (SARD: Secure Appraisal Revalidation Database) for medical staff for revalidation, appraisal, and electronic job planning) commenced in July 2022 across the Trust.

Revalidation and appraisal are now business as usual with a fully integrated system, with final stages of implementing first cycle of electronic job plans for 22/23 job plans. Appraisal processes are more robust with improved compliance and strengthened oversight for the organisation.

Moving forward, focussing on quality assurance of appraisals to further support doctors across the trust and as we move into the next job planning cycle for 23/24 and utilise the outputs and level of information available which could also prove useful in future workstreams under workforce planning across the trust.

Link to CQC Domain	**Safe**	**Caring**	**Effective**	**Responsive**	**Well Led**

– select one or more					
Links to Strategic Pillars & Strategic Risks – select one or more	★				X
Key Risks – risk number & description (Link to BAF / Risk Register)					**Risk Score**
Consultation / Other Committee Review / Scrutiny / Public & Patient involvement	Appraisals and revalidations are reviewed monthly at the Medical Staff Support Group (Professional Standards).				
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?			X
Does this report provide assurance to improve and promote equality, diversity and inclusion / inequalities?			X
Explanation of above analysis:			

Recommendation / Action Required The Board/Committee/Group is requested to:	
▪ The Committee is asked to note and accept this summary.	
Accountable Lead Signature	
Date	27 July 2023

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2022

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g., consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of Great Western Hospitals NHS Foundation Trust executive management team can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: To ensure the Deputy CMO completes the appropriate CPD training for the role.

Comments:

Deputy Chief Medical Officer (Dr Steve Haig) completed Responsible Officer Training and now supports appraisal and revalidation procedures.

Action for next year: None required

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year: Continue to work within the resources available to deliver the service.

Comments: The Medical Job Planning and Revalidation Specialist and newly dedicated Medical Job Planning and Revalidation Administrator have been in post for a year and oversee the strengthened and more robust revalidation and medical job planning processes with support of the CMO office. The system has been in place since the summer of 2022 which has helped improve the oversight and compliance of all activity and better supports trust's doctors with these processes. Transfer of appraisals to the new system is now complete and the new job plans will continue to be uploaded to SARD.

Action for next year: Continue to embed and deliver a high-level service with a focus on quality and outcomes.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Bed in new system and support medical staff in the transition. Update the MAG form based on the new national template when available

Comments: The trust's new SARD system has been fully rolled out to all medical practitioners supporting staff with the transition and is now business as usual. The system continues to link directly to GMC Connect and updates daily providing an accurate and up to date record of revalidation status for all doctors for whom GWH is the designated body. Automatic emails are sent to the revalidation inbox when a doctor adds or removes their connection to GWH. GMC connect is also updated manually by administrators when necessary, by keeping track of monthly new starters and leavers and working alongside the recruitment team.

Action for next year: Continue to maintain up to date records and support medical staff.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Continue to ensure that the changes made in the policy are fully embedded into revalidation and appraisal process.

Comments: Policy has been uploaded to trust T-drive and easily accessible via SARD for doctors. Process is monitored at monthly Medical Staff Support Group (professional standards) meeting. Policy is due to be reviewed in January 2024.

Actions for next year: Continue to embed policy and processes and plan for review in January 2024.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Facilitate an external peer review for 2023.

Comments: Due to new system roll out this peer review is yet to take place. However, new appraisal allocation process has been developed and implemented as per trust policy to ensure appraisers will undertake an even number of appraisals, provides advance notice of appraisees and their due dates, helps with supporting a timely and efficient appraisal process for appraisees and avoids reciprocal appraisals. It also prevents exceeding the maximum number of consecutive appraisals. Overall, have seen an increase in average compliance.

Action for next year: Continue with facilitating an external peer review for 2023/24

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: Continue to support locum and short-term placement doctors while they are working at GWH

Comments: There has always been an induction for all locum staff when they start with the Trust. Following learning from the COVID pandemic, changes have been made to the induction of locums into GWH. The booking length that identifies a locum as long term has been reduced from 3 months to 6 weeks. At 6 weeks they will now have access to a trust IT account. This will give them access to emails and Site Comms which will support their professional development. Report to be taken to PPPC to confirm that the changes have been made and that induction process if compliant.

The new process of identifying locums as long term from 6 weeks is now embedded and a report was taken through PPPC. Transfer of information forms are completed if requested by other organisations that the doctor works at.

Action for next year: Continue to support locum and short-term placement doctors while they are working at GWH

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: Strengthened Medical Appraisal team (see above) and implementation of SARD software systems. Increased SPA tariff for doctors undertaking up to 10 appraisals (less than 10 is paid pro rata). Continue to monitor the information that is included on 'other practice forms' to ensure that there is a robust transfer of data.

Comments: Automatic notifications have been set up in the SARD system at 3 months, 6 weeks, 2 weeks and 1 day before. Biweekly meetings with Trust appraisal lead take place along with Medical Revalidation and Job Planning Specialist mid-month reminders. Doctors that work in other organisations, this is predominantly the Ridgeway Hospital, are required to complete an 'other practice form'. This allows for evidence of any complaints or incidents to be shared with GWH. This also occurs with the doctors from the Prospect Hospice. Monthly quality assurance checks take place with SARD with support from CMO office. The trust launched the refreshed approach to medical appraisal with a revised and rebalanced approach to medical appraisal in February 2023 with a stronger focus on doctors' professional development and wellbeing. Please see Appendix A reflecting improved compliance.

Action for next year: Continue to monitor and quality assure the information that is included on 'other practice forms and quality of appraisals on newly launched template to ensure that there is robust information.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue monitoring the appraisal process

Comments: At the monthly MSSG meeting all overdue appraisals are discussed and or escalated. If there are mitigating reasons these are documented.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

If not, a plan is developed to support the doctor to achieve their appraisal. If there is continuing non-engagement with the appraisal process the doctor is discussed with the GMC ELA and if appropriate a Non-Engagement Referral is made. There have been no Failure to Engage notices in the year 2022/23.

Action for next year: Continue to monitor the appraisal process.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Monitor implementation of the updated policy.

Comments: Policy has been uploaded to trust T-drive and easily accessible via SARD for doctors. Process is monitored at monthly Medical Staff Support Group (professional standards) meeting. Policy is due to be reviewed in January 2024.

Action for next year: Continue to embed policy and processes and plan for review in January 2024.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Refresher training being planned to include update on SARD utilisation. Along with the recognised remuneration for appraisers there will be a new job description to clarify roles and responsibilities and objective

Comments: Job description with roles and responsibilities and objectives has been developed and circulated along with the launch of the appraiser allocation process. New appraisal training took place November 2022 and refresher training in March 2023. The trust currently has 95 trained appraisers and are now all undertaking appraisals. The job planning guidance has been revised to identify specific SPA recognition for colleagues undertaking up to 10 appraisals (less than 10 is paid pro rata).

Action for next year: Work with SARD and appraisal lead to develop in house refresher training package to provide ongoing support to appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal

network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Appraisers are required to reflect on feedback as part of their own appraisal process. Appraiser feedback is monitored to identify areas where additional training/support may be required. Comments: Appraisee's provide appraiser feedback, which is collated into a report in SARD, which is shared with the appraiser yearly and uploaded to their own appraisal for reflection. The ASPAT tool has be adapted at the Trust and built into the SARD system for future use. Action for next year: Utilise ASPAT tool within system to support and identify areas where additional training/support may be required. Appraiser development/refresher day being planned for 23/24.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The MSSG is a new group with the strengthening of appraisal processes in its remit and will be reviewed at 12 months Comments: Quality assurance is maintained by monthly MSSG meetings. These are attended by the Chief Medical Officer, Appraisal Lead, Medical Job Planning and Revalidation Specialist and the Medical Job Planning and Revalidation Administrator and the Deputy CMO for Medical Workforce. The committee regularly review quality assurance and create actions on an ad hoc basis as required. Action for next year: Continue to monitor via MSSG

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Great Western Hospital NHS FT	
Total number of doctors with a prescribed connection as at 31 March 2023	435
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	456
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	83
Total number of agreed exceptions	80

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Continue to engage with the GMC ELA and invite them to present to consultant groups so that the medical staff are aware of changes in GMC registration and revalidation process.

Comments: The RO has monthly meetings with the GMC ELA to discuss all investigations that are on-going and any concerns about engagement in the appraisal process. The GMC ELA is involved in any conversations about deferrals or Failures to Engage and this has helped to avoid the need to reach formal process

Action for next year: CMO and Deputy CMO will continue to attend all regional RO development days to facilitate shared learning on appraisal across SW Region

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Continue with the current policy and monitor impact of SARD

Comments: Medical Revalidation & Job Planning Specialist and Administrator support with revalidation compliance with CMO office and this is monitored at MSSG. Where a deferral has been made, the RO will write to the doctor involved to explain the reasoning behind the decision. If appropriate the Clinical Lead and HR Business Partner are included so that they are able to support the doctor. The most common reason remains the lack of evidence of colleague or patient feedback. The trust recently launched digital MSF within SARD to support with timely completion and higher response rates.

Action for next year: Continue with the current policy and monitor impact of SARD.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Progress towards full job plan compliance being monitored and reported to Trust Board.

Comments: The new E job planning module in SARD launched in August 2022 with all 22/23 job plans entered and are either at submitted or completed stage and reviewed by Clinical Leads, Heads of Service and Associate Medical Directors. The trust has a monthly Medical Working Consistency and Advisory Group where monitoring of progress and a check and challenge panel for attending specialities on a 12-month rolling rota takes place.

Action for next year: Continue with progress towards full job plan compliance, monitoring and reporting to Trust Board.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Continue training and feedback for the new cohort of Case Investigators and Case Managers.

Comments: The MSSG is set up to better triangulate disparate areas of medical performance so that concerns around performance, conduct, health complaints etc can be seen as one offering the opportunity to better support doctors in difficulty and for earlier intervention if concerns are evolving. Significant events (IR1's), complaints, mandatory training, national audits are all provided with the appraisal reminder paperwork.

Action for next year: Continue training and feedback for the new cohort of Case Investigators and Case Managers. Further 10 clinical staff and 10 HR staff booked into Investigator training for 2023.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: To continue to review investigations when they are completed to ensure that the correct process was followed and illicit any learning from the investigation process. For MHPS level investigations a NED is appointed to provide oversight of the process and ensure progress is in line with policy.

Comments: This is covered in the Medical and Dental Revalidation and Appraisal Policy, reviewing investigations to ensure that the investigation followed policy and if there is any learning for change.

Action for next year: Continue to review investigations upon completion, ensuring the correct process has been followed.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: HR team report to the MSSG on progress with any on-going investigation. The reporting of this information is strictly confidential, and reporting stored in a secure folder.

Comments: The Chief Medical Officer and Medical HR Business Partner meet regularly to discuss any on-going investigations or concerns. The Chief Medical Officer meets as required with the nominated Non-Executive Director to discuss on-going investigations to ensure that the correct process is being followed. A monthly report is presented to Board with anonymous data on current investigations and exclusions or restrictions in practice.

Action for next year: HR Business Partner continues to report to the MSSG on progress with any on-going investigation. The reporting of these information is strictly confidential, and reporting stored in a secure folder.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Continue to build a clear structure for notifying NHS England of concerns about GPs, if issues arise.

Comments: The RO continues to communicate with any other RO relevant to the practice of an individual doctor. The GPs working in the GWH Primary Care Network are not connected to GWH but to NHS England. This relationship has strengthened over the past 12 months with a more robust system for raising and discussing concerns. The RO is in direct communication with the counterpart at the local private hospital to ensure concerns are shared between the two organisations should these arise

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action for next year: Continue to build a clear structure for notifying NHS England of concerns about GPs, if issues arise.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Continue to develop the MSSG meeting to ensure robust oversight.

Comments: The MSSG is diverse and includes the trust lead for Inclusion and Diversity to minimise the risk of unconscious bias impacting on case management and decision making. All members of MSSG are up to date with Equality and Diversity training.

Action for next year: Continue to develop the MSSG meeting to ensure robust oversight. SAS representative now included in the membership.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Continue to monitor the pre-employment checks.

Comments: The trust has the TRAC recruitment system, and all processes and checks are monitored throughout the year in conjunction with the general recruitment team to standardise processes. Pre-employment checks include GMC check, national insurance number, right to work checks (Passport/Visa), DBS check, an occupational health check, forms including Confidentiality, Data Protection & Caldicott Statement and Self Declaration

Action for next year: Continue to monitor the pre-employment checks.

Section 6 – Summary of comments, and overall conclusion

Appraisal, revalidation, and job planning processes are more robust and improved in the past 12-months, with strengthened oversight for the organisation and support for doctors with a small, dedicated team and intuitive system in place.

The trust is seeing improved appraisal compliance and promising job planning compliance figures evidenced within the system following rapid entry of job plans. Final stages of implementing electronic job planning across the Trust's Medical workforce now focus on realising the newly created Job Planning policy and guidance documents and embedding the annual job planning cycle. Please see Appendix A reflecting improved compliance.

Moving forward, focussing on quality assurance of appraisals to further support doctors across the trust and as we move into the next job planning cycle utilise the outputs and level of information available which could also prove useful in future workstreams under workforce planning across the trust.

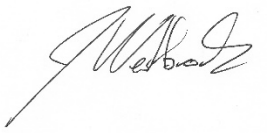
Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Great Western Hospitals

Name: Dr J Westbrook Signed: 

Role: Chief medical Officer and Responsible Officer

Date: 15/06/2023

NHS England
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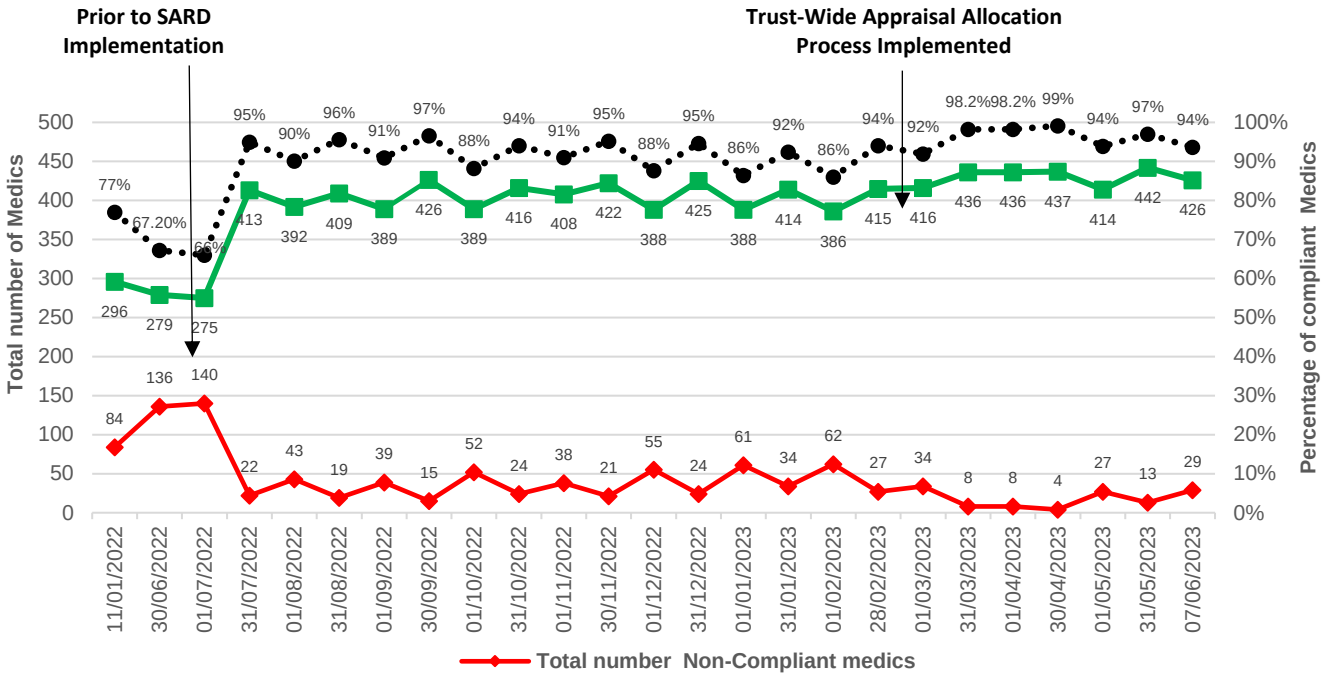
This publication can be made available in a number of other formats on request.

Publication reference: B1844

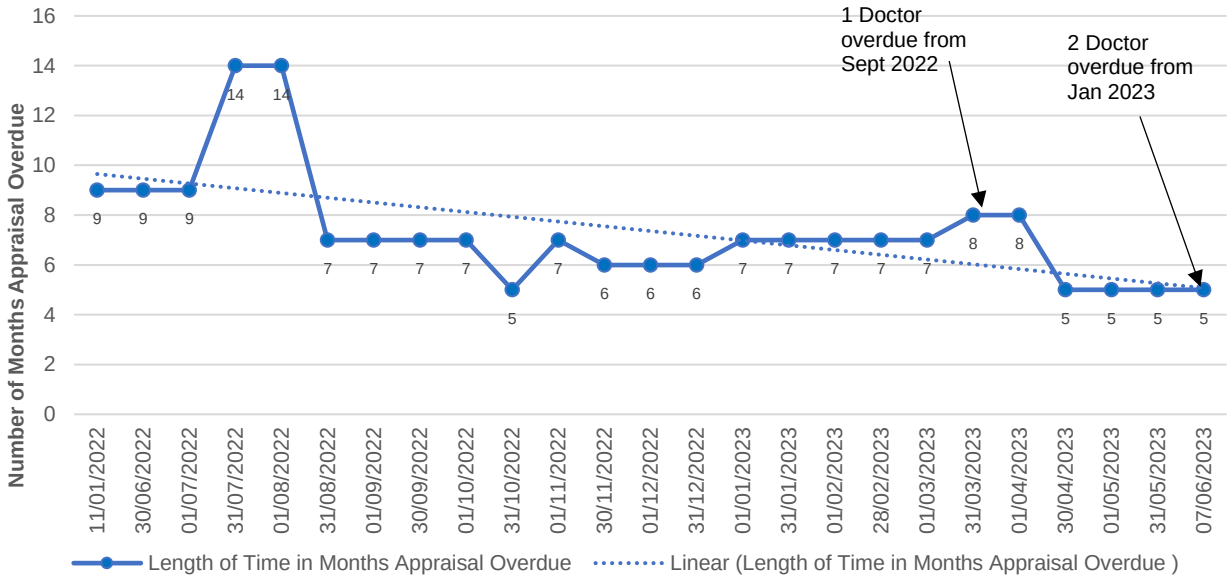
Trust-wide Medical Appraisal Compliance Month on Month



The chart above demonstrates the improved appraisal compliance since SARD was implemented: with the lowest compliance at 66% on 1st July 2022 and the highest since implementation at 99% in April 2023. Compliance has also remained relatively static since implementation.

The length of time an appraisal is overdue has also reduced with the longest at fourteen months and the most recent being five months overdue demonstrated in the chart below.

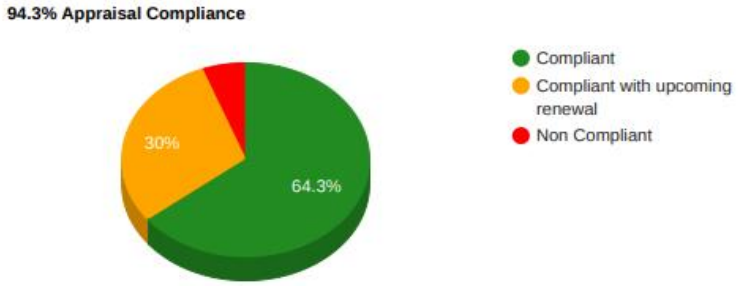
Length of Time Medical Appraisal Overdue



Appraisal Compliance Chart SARD as of June 2023

PRIVATE AND CONFIDENTIAL:
Great Western Hospitals NHS Foundation Trust - Appraisal Compliance

SARD



94.3% Appraisal Compliance
83.9% have started an Online Appraisal
Overall
381 out of 454 medics have started an online appraisal.
357 out of 428 compliant medics have started an online appraisal.
24 out of 26 non compliant medics have started an online appraisal.
0 out of 0 medics with unknown compliance have started an online appraisal.

The chart above is a snapshot of live trust compliance within SARD available to the trust. As of 16th June 2023, the trust is currently at 94.3%. The SARD system operates in real time allowing us as a trust to provide insight on the most up to date information to support our medics as well as monitoring job plans against trust policy and guidance and identifying discrepancies to effectively plan to meet the needs across the organisation.