University Hospitals Bristol and Weston NHS Foundation Trust

COUNCIL OF GOVERNORS

Meeting to be held on Wednesday, 21 May 2025 at 14.00 – 16.30 in Clifton & Hotwells Rooms, Ground Floor, St James' Court, Cannon Street, Bristol, BS1 3LH

AGENDA

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS	PAGE NO.
Preliminary Business					
1.	Welcome and Apologies	Information	Group Chair	14.00 (5 mins)	verbal
2.	Declarations of Interest	Information	Group Chair		
3.	Foundation Trust Members' Questions	Information	Group Chair		
4.	Minutes of Previous Meetings: • 21 November 2024 • 23 April 2025 (Private)	Approval	Group Chair		
5.	Matters Arising and Action Log	Approval	Group Chair		
6.	Group Chair's Report	Information	Group Chair	14.05 (15 mins)	
Strategic Outlook					
7.	Group Chief Executive's Report	Information	Group Chief Executive	14.20 (15 mins)	
8.	**Theme for this month:** Finance and Digital (including an update on the Annual Plan)	Discussion	Executive and Non-executive Members of the Finance, Digital and Estates Committee	14.35 (40 mins)	verbal
BREAK 15.15-15.25					
9.	Governor Questions	Discussion	Group Chair	15.25 (20 mins)	verbal
Governor Decisions and Updates					
10.	Lead Governor Report	Information	Group Chair	15.45 (5 mins)	
11.	Governor and Membership Forward Look	Information	Corporate Governance Manager	15.50 (10 mins)	
12.	Trust Constitution	Approval	Joint Chief Corporate Governance Officer	16.00 (10 mins)	
13.	Business Cycle and terms of reference for Governor Meetings	Approval	Corporate Governance Manager	16.10 (5 mins)	
14.	Governors Log of Communications	Information	Group Chair	16.15 (5 mins)	

NO.	AGENDA ITEM	PURPOSE	PRESENTER	TIMINGS	PAGE NO.
Concluding Business					
15.	Any Other Urgent Business	Information	Group Chair	16.20 (10 mins)	verbal
	Date and time of next meeting: • **Tuesday, 22 July 2025, 10.00 – 12.30**	Information	Chair		

University Hospitals Bristol and Weston NHS Foundation Trust

Minutes of the Council of Governors Meeting on Thursday, 21 November 2024, held on Level 2 of St James' Court, Cannon Street, Bristol, BS1 3LH and on Microsoft Teams

Present

Name	**Job Title/Position**
Ingrid Barker	Joint Chair of UHBW and NBT
Grace Burn	Appointed Governor, Youth Involvement Group (online)
John Chablo	Public Governor
Carole Dacombe	Public Governor
Rob Edwards	Public Governor
Tom Frewin	Public Governor
Sarah George	Appointed Governor, University of Bristol
Suzanne Harford	Public Governor
Jude Opogah	Staff Governor, Non-clinical Staff (online)
Mark Patteson	Public Governor
Annabel Plaister	Public Governor
Janis Purdy	Public Governor
John Rose	Public Governor
Martin Rose	Public Governor
John Sibley	Public Governor (online)
Tony Tanner	Public Governor
Others in attendance:	
Linda Kennedy	Non-executive Director
Arabel Bailey	Non-executive Director
Emma Wood	Chief People Officer and Deputy Chief Executive
Rosie Benneyworth	Non-executive Director
Marc Griffiths	Non-executive Director
Rachel Hartles	Membership and Governance Officer (Minutes)
Emily Judd	Corporate Governance Manager
Mark Pender	Head of Corporate Governance
Julian Newberry	Head of Learning and Workforce Development
Alex Nestor	Deputy Chief People Officer
Sam Chapman	Associate Director of Organisational Development and Wellbeing
Guy Dickson	Deputy Chief People Officer
Eric Sanders	Director of Corporate Governance

Ingrid Barker, Joint Chair, opened the meeting at 10.00.

Minute Ref:	**Item**	**Actions**
COG:01/11/24	**Chair's Introduction and Apologies**	
	The Joint Chair, Ingrid Barker, welcomed everyone to the Council of Governors meeting. Apologies from Governors had been received from Ben Argo, Lisa Gardiner, Aalia Herbert, Richard Posner, Stuart Robinson, Libby Thompson and David Wilcox.	

	It was noted that Governors Grace Burn, Jude Opogah, and John Sibley, and Non-executive Directors Rosie Benneyworth and Marc Griffiths, had joined the meeting online. Ingrid outlined the agenda for the Council of Governors meeting, which included a spotlight session on the People Committee in UHBW. To this end, Ingrid welcomed Linda Kennedy, Arabel Bailey, Rosie Benneyworth and Marc Griffiths (Non-executive Directors) to the meeting. Ingrid also welcomed the senior leaders of the People Directorate to the meeting.	
COG:02/11/24	**Declarations of Interest**	
	There were no new declarations of interest from Governors relevant to items on the agenda.	
COG:03/11/24	**Foundation Trust Member Questions**	
	The following question had been raised in advance of the meeting by a Foundation Trust member: *"In regards to our members at Unity Sexual Health Services, the Unison Branch and members within UHBW, are very concerned that longstanding members of staff (nurses, doctors, administrators and support staff) are currently at risk of losing their jobs, potentially being TUPEd across to other organisations, or being forced to move to other areas of the Trust if UHBW either are not successful in the sexual health procurement exercise, or the service is substantially slimmed down.* *We are also most concerned about the effect any change in sexual health services will have on our vulnerable patients many of whom are unable to speak up for themselves.* *Can the Trust board guarantee that sexual health services in the Trust will continue to meet the needs of our patients, many of whom are vulnerable, and that the needs of loyal NHS staff will be paramount in the consideration of changes to sexual health services?"* Emma Wood, Chief People Officer and Deputy Chief Executive, explained that the contract for the provision of Sexual Health services in Bristol was currently in the process of being tendered. She confirmed that UHBW had put a bid in, and once the procurement had been completed, the options for staff would be made clearer. However, Emma confirmed that UHBW were committed to the Sexual Health Services within the area. It was also confirmed that the contract related to the sexual health provision in Bristol only, and the provision in Weston General Hospital was not impacted. John Rose, Public Governor, highlighted a number of occasions when the Unity Health Service had been discussed with the Governors due to some issues that had arisen, and noted that UHBW was the 'host service'. He asked that Governors be kept up to date with the process and how the provision would work in future, which was agreed by the board members as and when there was news to share.	

	Martin Rose, Public Governor, asked when the procurement was due to finish. Emma Wood said she would investigate this and provide a response outside of the meeting. It was agreed that a full response would be provided to the Foundation Trust member via the Governors Log. **POST MEETING NOTE:** The procurement process was due to finish in mid-December 2024 and an update would be provided to Governors once the outcome was announced.	
COG:04/11/24	**Minutes from Previous Meeting**	
	Governors considered the minutes of the meeting of the Council of Governors held on 16th July 2024. Any comments for the private meeting were requested to be emailed to the Corporate Governance team. Governors also considered the minutes of the Annual Members Meeting on 10th September 2024. There were no comments received. **Members RESOLVED to approve the minutes of the Council of Governors meeting held in public and private on 16th July 2024 as a true and accurate record of the proceedings subject to the above changes. Governors NOTED the minutes of the Annual Members Meeting on 10th September 2024.**	
COG:05/11/24	**Matters Arising and Action Log**	
	The completed actions were noted, and outstanding actions were reviewed as follows: COG: 03/07/24: Foundation Trust Members Questions *Share TED Talk on Black Mothers Matter once available with the Council of Governors.* This had been shared with Governors via the Governors Newsletter. **Action Closed.** COG: 03/07/24: Foundation Trust Members Questions *Update on the Freedom to Speak Up session at the Board Development Day to be fed back to the Council of Governors.* An update had been provided within the Action log and was spoken to under the Chief Executive's Report. **Action Closed.** COG: 04/07/24: Minutes from the Previous Meeting *Minutes to be updated to reflect the question from John Rose accurately.* Minutes had been rewritten to accurately reflect John Rose's question. **Action Closed.** COG: 08/07/24: Theme for this month: Digital in UHBW *Ben Argo and Corporate Governance to arrange a question to be raised on the Governors log for an update on the Reasonable Adjustments Digital Flag.* A question had been added to the log and subsequently answered. **Action Closed.**	

	COG: 10/07/24: Membership Strategy *Circulate the link for registering for Health Service Discounts for Foundation Trust Members.* The link had been added to the Governors Newsletter. **Action Closed.** COG: 11/07/24: Governor and Membership Forward Look *Corporate Governance Team to investigate the options for appointing a Local Authority Governor from a different local authority to Bristol City Council.* A new Appointed Governor from Bristol City Council had been appointed. **Action Closed.** COG: 13/07/24: Governors Log of Communications *Corporate Governance Team to share the report on Legacy Licenses to the Council of Governors for information.* The report on legacy licences had been added to Convene for Governors to access. **Action Closed.** Further to a discussion around receiving minutes and actions, it was agreed for all minutes and actions to be circulated as close to two weeks after a meeting as possible. **ACTION: ensure minutes and action logs are circulated to Governors as soon as possible and as close to two weeks after meetings.** **Members RESOLVED to approve the action log.**	**Corporate Governance Team**
COG:06/11/24	**Chair's Report**	
	Ingrid Barker, Joint Chair, took her written report as read by Governors, and highlighted work she had undertaken since her report was written. She explained that she continued to meet with Government officials, which included the new leader of Bristol City Council, Tony Dyer, and Health Minister Karin Smyth, MP for Bristol South. Ingrid also attended the NHS Providers Conference in Liverpool in November 2024 where there were a number of key-note speeches, including one from the Rt. Hon Wes Streeting MP, Secretary of State for Health and Social Care who shared his priorities and vision for the NHS at what was a pivotal time for the service. Carole Dacombe, Public Governor, asked about the mood amongst Chairs with the sheer volume of change that was happening within the NHS. Ingrid explained that with the recent 'Darzi' Report and the conversations held around the Labour 10-Year Plan, there had been a variety of information available to understand the feelings amongst the leaders of the national Trusts. She concluded that the general mood was generally positive nationally. John Rose, Public Governor, highlighted the amount of work that Ingrid had been doing, and asked about the involvement that Ingrid had in the development of the Hospital Group model arrangements. Ingrid agreed that there could be future updates within her report on emerging arrangements.	

	ACTION: Ingrid Barker to ensure a standing update is placed within the Chair's Report on Group Hospital Development. She explained that she had been heavily involved in both boards meetings and had a series of Board to Board meetings to discuss the arrangements of the Hospital Group. Eric Sanders, Director of Corporate Governance, advised that Governors would also be getting regular updates in other meetings, and once the arrangements had been developed they would be shared with Governors. Carole Dacombe thanked Ingrid Barker for her commitment and enthusiasm towards Governors within her role. She commended the Governors newsletter that was sent monthly with an update from Ingrid. **Members RESOLVED to:** • **Receive the Chair's Report for information.**	Joint Chair
COG:07/11/24	**Chief Executive's Report**	
	Emma Wood, Chief People Officer and Deputy Chief Executive, provided an update on the main issues facing the Trust on behalf of Maria Kane, Joint Chief Executive Officer. Highlights from the update included: • The NHS 10-year plan consultation had been opened and was available for public and professional input. The Trust was due to contribute and would be engaging with local stakeholders to ensure the voice of UHBW was heard within the feedback. The long-term workforce was to be reviewed once the wider 10-year plan had been announced. • The 'Darzi' Report had shown gaps within the wider NHS system and included information on re-engaging staff and patients. Work was ongoing to ensure the Trust was using the information contained in the report to re-energise and re-engage communities and workforces to bring out the best of the Trust. • The Trust has engaging in a collaborative 2025-26 operational planning process with North Bristol NHS Trust (NBT). • The Trust's winter plan was in full effect, although it was acknowledged that there were still a high proportion of patients with No Criteria to Reside (21.9% across UHBW, 18.2% in Bristol and 28.4% in Weston). • The Trust Board was spending time with the NBT Board to ensure the benefits of the group were realised by all, and how this would be communicated to the staff and public. The first single managed services were moving forward and Cardiology had started to appoint joint roles. The maternity services had also started to launch single point of access clinic referrals for all sites. With regards to corporate enablers, a collaborative bank had been launched and therefore staff nurses had been able to choose work on either NBT or UHBW sites. This was soon to be piloted with Healthcare Support Workers in the next phase. • The Trust Clinical Strategy had been approved at the Trust Board earlier in November and focus was turning to how to implement the strategy within the Trust. • The Emergency Department Patient Experience results had been published today, and showed the Trust was ranked in the top 15 nationally for patient experience.	

	Freedom to Speak Up (FTSU) Update Eric Sanders, Director of Corporate Governance, gave an update on the work that was being done at Board level in relation to FTSU. He explained that the Board, during a development day in September, had refreshed their understanding of the origin of 'speaking up' and had considered a range of data relating to quality and patient safety, people as well as speaking up. The key action from the discussion was for more regular updates to Board meetings which presented triangulated data; as well as learning from areas that were doing well. Mark Patteson, Public Governor, asked about the No Criteria to Reside data and what the Trust could do internally in order to make sure patients could be looked after appropriately while ensuring the bed space within the Trust was available for patients with the greatest need. Emma Wood agreed that it was a system issue as well as a local issue. She highlighted that the 'every minute matters' programme, a programme looking at every minute of a patient's stay in hospital, was linked into the discharge team and ensuring the space was made available as soon as the patient was able to be discharged. This included better use of the Discharge Lounges, using Same Day Emergency Care units and Acute Medical Units to ensure patients were placed on the most appropriate pathway for their needs. Further questions were asked around the length of the stay of patients and how longer-term patients were being managed. Emma highlighted the Complex Discharge Hubs and Home discharge teams who were committed to getting patients home as soon as possible. John Chablo, Public Governor, asked about the recruitment teams and how the staff were being recruited. Emma Wood explained that there was one recruitment team for both Trusts, which continued to recruit to each sovereign Trust. Asked whether there was scope for more joint roles, Emma explained that there would be flexibility in recruitment for some roles, but the majority of positions would be recruited to one Trust or the other. John Rose, Public Governor, asked about the benefits case for the group model work, and who was doing this. Emma Wood explained that this work was being completed by both Trusts, although the Executive Directors were leading the work in conjunction with Teneo, the Strategic Partner. It was also highlighted that the Governors discussed the benefits case at a Governor Development Seminar in October 2024. John Sibley, Public Governor, commented on the No Criteria to Reside patients, and highlighted that this was a permanent ongoing conversation. He suggested that the Local Authorities needed to help with discharging patients. Ingrid Barker, Trust Chair, agreed wholeheartedly and also said that there were many different third sector organisations and local authority groups working together to help solve the issue. Rosie Benneyworth, Non-executive Director, suggested that part of the 10-year plan could look at the key enablers to resolve the problem on a longer term basis. Further to a question on whether NHS Providers were discussing this issue, Ingrid confirmed that this was an ongoing issue that was discussed often at NHS Providers meetings.	

	Rob Edwards, Public Governor, highlighted the community issues that were also causing patients to return to the hospital. Ingrid Barker agreed that the social care issue was prominent and were being discussed at many levels within and outside of the Trust. **Members RESOLVED to:** • **Receive the Chief Executive's Report for information.**	
COG:08/11/24	**Theme for this month: People Committee**	
	Linda Kennedy, Arabel Bailey, Rosie Benneyworth and Marc Griffiths (Non-executive Directors) and Emma Wood (Chief People Officer) presented the spotlight session on the People Committee. Linda Kennedy highlighted that the People Strategy ran until 2025, and focussed on the four 'pillars', Growing for the Future, New Ways of Working, Inclusion & belonging, and Looking after our People, which linked to the four Trust values of Collaborative, innovation, respectful and supportive. A video was played to highlight the work completed against the People Strategy since its launch in 2022. Alex Nestor, Deputy Chief People Officer, highlighted that in response to the results of staff survey and exit questionnaires, the Trust had built a plan to recruit more nurses internationally and a 'grow your own pipeline' had been created. Violence Reduction Officers were also appointed to tackle violence and aggression against staff. Sam Chapman, Associate Director of Organisational Development and Wellbeing, highlighted the work on Pro-equity, designed to build a place where everyone felt truly safe to be themselves. The journey started by listening to the staff voice, focusing on sexual safety, anti-racism, and anti-ableism until the end of November 2024. This had so far resulted in an anti-racist community commitment; new guidance on what to do if someone experiences, sees or hears about sexual misconduct at work; adding the NHS England sexual misconduct training to the Trust's online training system; and created a plan for real, meaningful change so that everyone felt safe to be their whole self at work. There was expected to be an integrated plan for pro-equity by the end of March 2025. Sam Chapman further advised of a collaborated approach with NBT to offer NHS Health Checks until March 2025. It included a cholesterol test, blood pressure and cardiovascular risk score. NHS Health Checks were inclusive to all colleagues and included a confidential 30-minute check by a Registered Wellbeing Nurse with signposts to additional holistic support. GP referrals were made for abnormal results. Guy Dickson, Associate Director of HR Services, highlighted the changes made in agency staff spend, which had decreased from £2.5m per month to an average of £400k per month. This had been achieved by implementing a long term Nursing Workforce Strategy to fill permanent vacancies, improving the Bank staff 'offer' including improvements to Bank work experience, and some short term financial incentives to move Nurses from agency to bank. There had also been a sharp focus on rostering and agency booking practices, analysing usage data, rates and hotspots.	

	Julian Newberry, Head of Education, highlighted the work on leadership, management and coaching, which included the development of the mandated Compassionate & Inclusive Leader Programme, a managers toolkit, coaching and mentoring platforms and the 'Bridges' programme to focus on increasing the number of ethnically minoritised staff in management roles. New career pathways had been implemented and 384 clinical apprentices were currently working in the Trust. There was also considerable advancement to completing an administration and clerical career pathway which would draw upon curriculum programmes and current apprenticeship provision. Emma Wood, Chief People Officer, advised of the focus on the Group model work in relation to the People Committee and the plan for a Joint Group People Strategy from 2025. Linda Kennedy finished the presentation by highlighting just some of the reports that the People Committee scrutinised in order to be assured that the work was progressing well. Annabel Plaister, Public Governor, asked about the retention of internationally educated nurses and whether there were any figures that could be provided. She also asked about vaccination uptake and whether there were any figures on these as well. Alex Nestor explained that the retention of internationally educated nurses was important, and work was underway to ensure there were clear progression opportunities for this cohort of staff. Alex agreed to confirm the retention figures outside of the meeting, although it was agreed that the figure was low. **ACTION: Alex Nestor to confirm the retention figures of Internationally Educated Nurses to the Council of Governors.** Sam Chapman confirmed that the vaccination rates had been low but were reflective of the national picture. Conversations were being held nationally with vaccination clinics to understand any learning from other Trusts to increase uptake. Sam also suggested that there was expected to be a flurry of uptake near the end of the vaccination period. It was also confirmed that the vaccinations given outside the clinic were not included, although Sam agreed to provide the final uptake figures to the Council of Governors which would include vaccinations given in-house and externally. There was a large communication campaign involving the Senior Leaders of the Trust promoting vaccinations and highlighting the benefits. **ACTION: Sam Chapman to provide final uptake figures for in-house and externally acquired vaccinations for both COVID-19 and flu.** John Rose, Public Governor, asked about the Physicians Associate (PA) roles in the national media and whether the Trust had found similar issues in relation to PAs overstepping their remits. Emma Wood confirmed that there were only 10 PAs in the Trust, and they had been invaluable in providing care within the Trust but had not stepped outside of their remit. The Trust was waiting to understand the outcome of the national review. Marc Griffiths, Non-executive Director, highlighted that the media stories around this area had provided a blanket negative	Deputy Chief People Officer Associate Director of Organisational Development and Wellbeing

	view of this position, however the review brought a positive reform to the roles and ensured they would be more valuable in the future. Mark Patteson, Public Governor, asked whether the costs for Bank staff had increased with the decrease of agency costs. It was confirmed that the costs for Bank staff had not increased as much as agency spend had decreased. The Governors commended the presentation provided and celebrated the fantastic work showcased by the team. They valued the update and looked forward to seeing the new Joint People Strategy in 2025. **Members RESOLVED to:** • **Receive the theme of the month discussion for information.**	
COG:09/11/24	**Governor Questions**	
	Ingrid Barker, Joint Chair, invited the Governors to ask any questions they felt relevant to discussions so far today or in relation to the Public Board meeting held in November 2024. Carole Dacombe, Public Governor, asked about the FTSU update that was provided to Governors and highlighted the original concern related to staff groups that were under-represented within the FTSU data, including medical and dental professions as well as facilities teams who may not have immediate or easy access to the required support. She asked what was being done to increase awareness in these staff groups and how this was being addressed. Eric Sanders, Director of Corporate Governance, confirmed this issue had been discussed within the Board Development session, along with the barriers to speaking up. A doctor had recently been brought on as a FTSU champion to help with reaching out to this specific area, and active work on ensuring all Trust staff were aware of the FTSU route for raising concerns was underway. Eric also highlighted how important the triangulation of data would be in ensuring that whichever route a staff member used to raise any concern was captured and that they were supported in their concerns. Arabel Bailey, NED Champion for FTSU, added that she planned to visit staff to talk and hear about their thoughts and feelings directly to bring the data to life. John Rose, Public Governor, further asked how staff knew when an issue had been resolved. Eric Sanders explained that the FTSU Guardian and Deputy were working with managers to ensure the staff who raised concerns were kept informed, as much as possible, about a concern and when it had been resolved. **Members RESOLVED to:** • **Note the questions asked by Governors.**	
COG:10/11/24	**Trust Constitution**	
	Eric Sanders, Director of Corporate Governance, requested the approval of minor changes that had been made to the Trust Constitution to include the role of the Hospital Managing Director on the Executive Board, and amending the term ‘delegate NED’ to ‘associate NED’.	

	Once it was confirmed that changes discussed in the recent Governors Strategy Group had been made, the Governors in the room and online approved the changes made to the Trust Constitution. **Members RESOLVED to approve the amendments to the Trust Constitution.**	
COG:11/11/24	**Governor and Membership Forward Look**	

	Emily Judd, Corporate Governance Manager, gave the Governors an update on the Governor and Membership Forward look. She explained that two Governors had joined the Council of Governors and four Governors had stood down. An election was held at the beginning of November for the position of Lead Governor; this was due to Mo Phillips standing down as Lead Governor and as a member of the Council of Governors. There were two nominated candidates for the role and it was confirmed that Ben Argo had been elected as the Lead Governor for 12 months, with Martin Rose continuing as the Deputy Lead Governor. Martin was thanked for his work as Deputy Lead Governor so far. Emily Judd then explained that focus was turning towards elections in 2025, with the process beginning in January 2025. A communication plan in line with the membership strategy objectives was being created and would be shared with Governors in due course.
	
	<u>Nominations and Appointments Committee Reviews</u>
	Emily Judd asked the Council of Governors to approve a number of items that had recently been discussed at the Nominations and Appointments Committee.
	
	The Council of Governors were advised that there were three positions available on the Nominations and Appointments membership, and two people had nominated themselves for these roles. The Council of Governors approved Janis Purdy, Public Governor, and Grace Burn, Appointed Governor, to be appointed to the membership of the Nominations and Appointments Committee.
	
	The Council of Governors were provided with revised versions of the Terms of Reference and Business Cycles for 2024-2026. The documents were approved for use.
	
	Members RESOLVED to:
	• **Receive the Governor and Membership Forward look for information.**
	• **Approve:**
	  ○ **The appointment of Janis Purdy and Grace Burn to join the Nominations and Appointments Committee membership;**
	  ○ **The reviewed Nominations and Appointments Committee Terms of Reference;**
	  ○ **The updated Nominations and Appointments Committee Annual Business Cycle for 2024-25 and 2025-26.**	

COG:13/11/24	**Governor's Log of Communications**	

	Ingrid Barker, Joint Chair, noted the updates in the Governor's Log of Communications. She highlighted that since the last meeting on 16th July 2024: • One question had been added to the log. • One question had been answered on the log and was awaiting the Governor response. • Two questions had been closed on the log. • No questions were outstanding on the log. It was noted that the question from the Foundation Trust Member would be added to the Governors log for a full response. **Members RESOLVED to:** • **Receive** the Governors Log of Communications for information.	
COG:14/11/24	**Any Other Business**	
	Prior to the end of the meeting, Ingrid Barker, Joint Chair, thanked Mo Phillips for her work as Governor over the past seven years, and as Lead Governor for the last six years. She wished Mo well for the future. A gesture of thanks was presented to Mo who had attended the meeting as an observer.	
COG:15/11/24	**Meeting close and date of next meeting**	
	The Chair declared the meeting closed at 12.00. The date of the next meeting would be: • **Council Of Governors; Friday, 24 January 2025** • It was acknowledged that this meeting would be rescheduled to enable attendance from Maria Kane, Joint Chief Executive.	

University Hospitals Bristol and Weston NHS Foundation Trust

Council of Governors meeting – Wednesday, 21 May 2025
Action Log

Actions following Council of Governors meeting held on 21 November 2024					
No.	**Minute reference**	**Detail of action required**	**Responsible Officer**	**Completion date**	**Additional comments**
1.	COG: 05/11/24	**Matters Arising and Action Log** Ensure minutes and action logs are circulated to Governors as soon as possible and as close to two weeks after meetings.	Corporate Governance Team	January 2025	**Suggest action closed** All minutes are circulated as soon as possible after meetings and the Team is working to decrease the time between the meetings and minutes circulation in future.
2.	COG: 06/11/24	**Chairs Report** Ingrid Barker to ensure a standing update is placed within the Chair's Report on Group Hospital Development.	Group Chair	January 2025	**Suggest Action Closed** This will be included moving forward.
3.	COG: 08/11/24	**Theme of the Month** Alex Nestor to confirm the retention figures of Internationally Educated Nurses to the Council of Governors.	Deputy Chief People Officer	January 2025	**Suggest Action Closed** This was provided to Governor via the January 2025 Governors Newsletter.
4.	COG: 08/11/24	**Theme of the Month** Sam Chapman to provide final uptake figures for in-house and externally acquired vaccinations for both COVID-19 and flu.	Associate Director of Organisational Development and Wellbeing	March 2025	**Suggest Action Closed** The Trust's final vaccination uptake figures for the 24/25 season are as follows: <u>Flu seasonal vaccination</u> Only frontline healthcare workers, including bank staff (CQUIN cohort): 6489 All UHBW frontline and non-frontline staff: 7200 <u>COVID-19 seasonal vaccination</u> All UHBW frontline and non-frontline staff: 5677 *The flu CQUIN was paused and there is currently no CQUIN relating to COVID-19 vaccinations.*

Report To:	Council of Governors		
Date of Meeting:	Wednesday 21st May		
Report Title:	Group Chair's Report		
Report Author:	Ingrid Barker, Group Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)		
Report Sponsor:	Ingrid Barker, Group Chair of North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW)		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			✓
	The report sets out information on key items of interest to the Council of Governors including activities undertaken by the Group Chair, and Vice Chairs.		
Key Points to Note *(Including any previous decisions taken)*			
This report is the same report that was provided to the Public Board meeting on Tuesday 13th May 2025. The Group Chair reports to every Public Board meeting with updates relevant to the period in question. This report covers the period (9 April – 13 May) since the last meeting.			
Strategic and Group Model Alignment			
The Group Chair's report identifies her activities, along with key developments at the Trust and further afield, including those of a strategic nature.			
Risks and Opportunities			
Not applicable.			
Recommendation			
This report is for discussion and information. The Board is asked to note the activities and key developments detailed by the Group Chair.			
History of the paper (details of where paper has <u>previously</u> been received)			
Meeting in common of the Board of Directors of NBT and the Board of Directors of UHBW held in Public	Tuesday 13th May 2025		
Appendices:	N/A		

1. Purpose

1.1 The report sets out information on key items of interest to the Trust Board, including the Group Chair's attendance at events and visits as well as details of the Group Chair's engagement with Trust colleagues, system partners, national partners and others during the reporting period.

2. Background

2.1 The Trust Board receives a report from the Group Chair to each meeting of the Board, detailing relevant engagements she has undertaken and important changes or issues affecting UHBW and NBT and the external environment during the preceding months.

3. Activities across both Trusts (NBT and UHBW)

3.1 The Group Chair has undertaken several meetings since the last report to the Boards in Common report on 8 April 2025:

- Monthly meeting with both organisations' Non-Executive Directors (NEDs)
- Monthly meeting with the Vice-Chairs
- 121 meetings with Lead Governor, Ben Argo
- Group Hospital Development Update Session for Governors on 9 April
- Governor/Non-Executive Director engagement session
- Visit to NBT Theatres
- 1-1s with all Non-Executive Directors at UHBW and NBT
- Regular 3-way touch point meetings with both Vice chairs
- A pre-consultant interview discussion with a candidate for Consultant post
- Visit to Major Trauma Service at NBT
- Research STAR Award Team Party
- Attended the evening dinner to welcome our International visitors from Marengo group, India

4. Communications

The Communications teams of both Trusts have been very helpful in making the above visits more visible to all colleagues and to UHBW Governors. For UHBW this has been through its platform Viva Connect and a newsletter to Governors. I would like to thank both teams for their support in this. For NBT this has been through its weekly staff newsletter, NBT News and intranet platform, LINK. The post Board meeting videos summarising main points from each Board meeting in public that have been taking place at NBT will continue with the new Group Board and the first one was recorded following the 8th May Board and shared with colleagues from both trusts and governors.

5. Connecting with our Partners

5.1 The Group Chair has undertaken several visits and meetings with our partners:

- Attended the City Partners Conference Call
- Panel member for Non-Executive Director interviews for Sirona Care and Health
- Engagement meeting with Kevin Peltonen-Messenger, Chief Executive Officer for Healthwatch
- Introduction meeting with Jos Moule, Chair of Grand Appeal

- Group Chair and Group Chief Executive meeting with Councillor Dyer, Nick Hibberd and Hugh Evans from Bristol City Council
- 1-1 with Jeff Farrar, Chair, BNSSG Integrated Care Board
- Attendance at the BNSSG Integrated Care Partnership Board
- Group Chairs' visit to AWP Callington Road Hospital with Paul Miller, Chair, AWP NHS Trust
- Engagement meeting with Chrissie Thirlwell, Head of Bristol Medical School and Professor Cancer Genomics, University of Bristol

6. National and Regional Engagement

- 1-1 with Sue Doheny
- Catch up meeting with Habib Naqvi MBE, Chief Executive, NHS Race and Health Observatory
- Attended an NHS Confederation Conference webinar with a focus of 'reimagining how we work with our universities, colleges and schools'

7. Vice-Chairs Report

The Vice-Chairs undertook a variety of visits and meetings:

7.1 Vice Chair (UHBW)

- Meeting with Clinical Chair, Women's and Children's Division and visit
- Bi-monthly meetings with site Hospital Managing Director
- Regular meetings with chair and NBT vice chair
- Attendance at Joint Non-Executive Director briefings
- Interview panel for Group Executive roles
- Visit to Estates and Facilities Division
- Visit to Haematology and Oncology Centre
- Attendance at the Finance Digital and Estates Committee and Audit Committee UHBW

7.2 Vice Chair (NBT)

- Visit to Community Diagnostic Centre at Cribbs Causeway
- Regular meetings with chair and UHBW vice chair
- Attendance at Joint Non-Executive Director briefings
- Attendance at Quality and Outcomes Committee NBT
- Visit to NMSK Divisional Tri
- Visit to Ward 34b NBT
- Attendance at the BNSSG Primary Care Committee
- Meetings with site Hospital Managing Director
- Interview panel for Group Executive roles

8. Summary and Recommendations

The Trust Board is asked to note the content of this report.

Report To:	Council of Governors		
Date of Meeting:	21 May 2025		
Report Title:	Group Chief Executive Report		
Report Author:	Xavier Bell, Group Chief of Staff		
Report Sponsor:	Maria Kane, Group Chief Executive		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	The report sets out information on key items of interest to the Council of Governors, including engagement with system partners and regulators, events, and key staff appointments.		

Key Points to Note *(Including any previous decisions taken)*

The report seeks to highlight key items of interest that provide important context for the business of the Bristol NHS Group, and which the Council of Governors should be aware of. These are structured into four sections:

- National Topics of Interest
- Integrated Care System Update
- Strategy and Culture
- Engagement & Service Visits

Strategic Alignment

This report highlights work that aligns with the Trusts' strategic priorities.

Risks and Opportunities

There are both risks and opportunities linked to the changes at ICB-level. The ICB will be focused on cost-reduction planning and delivery, which may impact local priorities. There are also opportunities for the Bristol NHS Group to support colleagues and provide local leadership where relevant.

Recommendation

This report is for Information. The Council of Governors is asked to note the contents of this report.

History of the paper (details of where paper has <u>previously</u> been received)

N/A

Appendices:	N/A

Group Chief Executive's Report

Background

This report sets out briefing information from the Group Chief Executive for Council of Governor members on national and local topics of interest that have taken place since April 2025.

1. National Topics of Interest

1.1. NHS Leadership Event

I attended a national CEO leadership event held in London at the end of April. The day focused on providing more information around the 10 Year Plan and current transformation across the NHS following the announcement significant of significant structural changes in the NHS in March, including the merger of NHS England and the expectation of significant reductions in ICS corporate spend.

1.2. The NHS Performance Assessment Framework for 2025-26

The new NHS Performance Assessment Framework for 2025-26 was published on 27 March. This new framework will be used to assess both ICBs and Trust providers to ensure that health services are effective, efficient and patient-centred. It will be used to replace the previous framework which has been in place since 2022.

The framework will be released for consultation and testing, which does include applying it to Trust and ICB plans for 2025-26 during quarter one. Feedback will be collected as part of the testing and will help inform the finalised framework that will be issued for use from July.

In summary, every ICB and provider will be allocated a segment that will indicate its level of delivery from 1 (high performing) to 4 (poorly performing), and with an additional segment 5 to indicate those where the greatest level of support and improvement required. Organisations will be assessed across a wide range of functions from both a tactical and strategic perspective. Provider segmentation score will be based on their delivery score only. It is anticipated that high performing organisations in segment 1 will receive greater autonomy. Segment 3 and 4 organisations will be considered for further support and interventions which may include enforcement. Segment 4 organisations will receive a diagnostic review, and this will determine if they enter segment 5 and under the Recovery Support Programme. Data used to calculate segments will be published in an interactive web-based public accountability tool which will be made available from July.

Leadership capability will form part of the assessment process and insights gathered will be used to help direct performance improvement activities from the central and regional NHS teams. Guidance on this is still being developed and will be published once ready

1.3. NHS Impact

I have attended a number of National Improvement Board meetings in 2025, the most recent on 15 May. I have attended two National Improvement Board meetings since the last report. The business plan for 2025-26 has been refined and is now focused on delivery of the following key objectives:

- Establish a joined-up system for improvement across the NHS, its partners, and the communities it serves.
- Develop the skills and capability of NHS Managers and leaders in improvement and system leadership.
- Accelerate both the small steps of continuous improvement and the bigger leaps of radical transformation
- Create an NHS wide learning system to more rapidly spread innovation, reduce unwarranted variation and enable sharing of practice from “the best of the NHS to the rest of the NHS.”

2. Integrated Care System Update

2.1 In early May, NHSE shared the first version of the Model Integrated Care Board (ICB) Blueprint with ICB leaders. This document is intended to help ICBs produce plans to reduce their running costs by up to 50%. These plans must be completed by the end of May 2025 and delivery by the end of Q3.

The Model ICB Blueprint also outlines a shift towards positioning ICBs as strategic commissioners, with a key role to play in delivering the aims and ambitions of the 10-year Health Plan. ICBs will have a role in improving population health, reducing inequalities, and ensuring access to high-quality care for the patients within their catchment area.

Engagement will continue to take place with ICBs and with providers to inform the development of a final model for how ICBs will operate into the future.

3. Strategy and Culture

3.1 Group Launch

The Bristol NHS Group was officially launched on 28 April with communications sent to all staff and external stakeholders, as well as press releases. This was an opportunity to share our Group Benefits Case, focused on the “Four Ps”, for the benefit of our **Patients**, our **People**, the **Populations** we serve, and the **Public Purse**. We also launched the Group name and logo. The feedback has been very positive, with great engagement from staff via a joint virtual Town Hall which I led on Wednesday 30 April.

4. Engagement and Visits

4.1 Bristol City Council visit

The Group Chair and I attended a reciprocal visit with Councillor Tony Dyer, Bristol City Council Leader, Nick Hibberd, CEO of Bristol City Council, and Hugh Evans, Director of Adult Social Care. Topics included a Group update, the impact of the NHS changes including at ICB level, an update from the Council on their new corporate strategy and a conversation on the neighbourhood health plans.

4.2 Full-Hearted Care Awards

I was delighted to attend the Full Hearted Care Awards on Friday, 16 May, celebrating the extraordinary work of colleagues, teams and volunteers around UHBW who help bring full-hearted care to live every day, in many different ways.

4.3 Service Visits

I have visited a number of areas, and met with senior clinical staff across the Trusts in April and May including:

- New Elective Centre at NBT
- Education Centre at UHBW

Recommendation

The Governors are asked to note the report.

Maria Kane
Group Chief Executive

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Council of Governors		
Date of Meeting:	Wednesday 21st May 2025		
Report Title:	UHBW 25/26 Operating Plan		
Report Author:	Rebecca Dunn, Director of Business Development and Improvement Evelyn Elliott, Head of Commissioning and Planning Jeremy Spearing, Director of Operational Finance David Markwick, Director of Performance Emma Harley, Head of Strategy Workforce Planning and Intelligence		
Report Sponsor:	Jane Farrell, Chief Operating Officer & Neil Kemsley, Chief Financial Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			Y
	To inform the Council of Governors of the detail of the UHBW 25/26 Operating Plan, as submitted to NHSE on 27th March 2025.		

Key Points to Note *(Including any previous decisions taken)*

This report was provided to the Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public on Tuesday 8th April 2025.

This report summarises the UHBW 2025/26 Operating Plan. It provides an overview of the activity and performance, finance and capital and workforce plans that have been submitted as part of the Bristol, North Somerset and South Gloucestershire Integrated Care System submission to NHS England (NHSE) made on the 27 March 2025.

The UHBW 2025/26 Operating Plan, and the BNSSG ICS Operating Plan is compliant with all the NHSE requirements across performance, finance and workforce.

Performance and activity

The plan is compliant with all national performance requirements. A focus of the work has been on working with divisions to identify productivity. Appendix 1 details the productivity opportunities that were provided by NHSE and are included within UHBW's plan.

The assumed impact of the Elective Centre which is expected to open in Q2/3 has also been included in the performance and activity plans.

Finance

The plan is compliant with breakeven requirements associated with income and expenditure, and capital. The plan is based on delivering £53m of savings. Opportunities for efficiency have been provided by NHSE and incorporated into the UHBW plan. These are detailed in Appendix 2.

Adding to the savings requirement, the plan includes Trust investment decisions to resolve critical quality/safety issues totalling £4.0m.

The Trust capital plan of £44.8m assumes over-programming at c25% (based on previous years); work will be completed in 25/26 to more accurately programme capital expenditure and remove the reliance on overprogramming.

The Trust will need to continue to work on delivery of the financial plan; the key next steps are:

- PFIG materially progressing the savings identification and managing the subsequent delivery against the £53.0m savings requirement;
- Securing formal agreement of Associate Commissioner funding envelopes;
- Finalising the costs associated with elective activity delivery within the envelope available on the expectation of improved productivity;
- Full testing of the Trust's workforce controls and VCP processes in light of the requirement to reduce workforce back to funded establishments;
- Re-visiting the Trust's capital plan in response to the outcome of the national capital bids via the Trust's Capital Group and Capital Programme Steering Group; and
- In light of the risks within the Trust's financial plan, the Trust will look to fully mitigate these during quarter 1 and undertake a formal forecast outturn assessment based on quarter 1 financial results that will inform a potential re-setting of the financial plan, particularly savings and elective activity delivery.

Workforce

The plan is compliant with the workforce reductions that have been outlined by NHSE. The plan assumes a reduction in substantive staff of 337.5 FTE, this is partially offset by investments totalling 175 FTE, leaving a net change of -162.5 FTE to Staff in Post. It is anticipated that this can be achieved through vacancy controls, utilising turnover and attrition. Significant reductions in bank and agency staff are also included, which will support delivery of the Trust savings targets.

Risks to delivery of plan

The key risks to the Trust delivery of the 2025/26 plan are detailed within the report. Operational, financial, quality and workforce risks have been identified and work will be ongoing throughout the financial year to mitigate these risks.

Next steps

- The operating plan for 2025/26 has been approved, and received Board assurance, via the Finance, Digital and Estates Committee on 25th March 2025; the NHSE Board Assurance document can be seen in Appendix 3.
- UHBW has now moved into delivery. This involves further communication and engagement with Divisions, and with staff more widely, and the establishment of monitoring to ensure that delivery is kept on track throughout the financial year.
- Delivery of the plan will be led by the Clinical Divisions and supported by the Trust Executive and corporate functions.
- Included within the delivery of the plan are priorities for improving health inequalities. These have been developed in partnership with the ICS and can be seen in Appendix 4.
- Monitoring of the 25/26 Operating Plan will be ultimately overseen by the Trust Board, with Executive Committee providing oversight of the various Executive-led subgroups with responsibility for the different components of the plan: for example, the Planning and Delivery Group, the Capital Programme Steering Group, the Clinical Quality Group and the Performance and Finance Improvement Group.
- Where the UHBW operating plan interfaces with partner organisations, the Integrated Care System Operational Delivery Groups and Health and Care Improvement Groups will be utilised.

- Partnership working and collaboration will underpin both the delivery of the BNSSG System Plan and the UHBW Operating Plan for 2025/26.

Strategic and Group Model Alignment

This report is directly linked to the following Patient First objectives:

- 'Making the most of our resources'. Achieving break-even ensures our cash balances are maintained and therefore we can continue to support the Trust's strategic ambitions subject to securing CDEL cover.
- 'Timely care', together, we will provide timely access to care for all patients, meeting their individual needs.
- 'Experience of care', together, we will deliver person-centred, compassionate and inclusive care every time, for everyone.

It has been constructed working in partnership with NBT and the ICB.

Risks and Opportunities

The plan is ambitious and there are key risks associated with delivery as set out in section 6.

Recommendation

This report is for **Information.**

The Council of Governors is asked to note that the UHBW 25/26 Operating Plan was approved by the Finance, Digital & Estates Committee and has been submitted to NHS England. UHBW has moved swiftly into delivery of the plan for the new financial year.

History of the paper (details of where paper has <u>previously</u> been received)

Finance, Digital and Estates Committee	25 March 2025
Meeting in common of the Board of Directors of UHBW and the Board of Directors of NBT held in Public	8 April 2025

Appendices:	Annual Plan Summary Appendix 1: Productivity data Appendix 2: Savings plan maturity levels Appendix 3: Board assurance framework Appendix 4: Health inequalities

University Hospitals Bristol and Weston NHS Foundation Trust

UHBW 2025/26 Operating Plan

Public Board
8th April 2025

University Hospitals Bristol and Weston NHS Foundation Trust

UHBW 2025-26 Operating Plan

Contents

Tables

1. Introduction

1.1 Purpose

1.1.1 The purpose of the paper is:

- To inform the Board of the detail of the University Hospitals Bristol & Weston NHS Foundation Trust (UHBW) 2025/26 Operating Plan, as submitted to NHS England (NHSE) on 27th March 2025.

1.2 External context

1.2.1 National planning guidance[i], published by NHSE, was issued on the 30th January (delayed from expected release in December 2024). The guidance has reduced the number of key priorities for 2025/26:

- Elective Care & Waiting Times: Aiming to ensure 65% of patients receive elective treatment within 18 weeks by March 2026. Each Trust is expected to deliver a 5% improvement. For cancer, systems should aim for 75% compliance with the 62-day diagnosis standard and 80% with the 28-day Faster Diagnosis Standard by March 2026
- Improve A&E waiting times and ambulance response times compared to 2024/25. By March 2026, at least 78% of patients should be seen within four hours in Accident & Emergency (A&E).
- Improve patient access to general practice and improve their experience, while also increasing access to urgent dental care by providing 700,000 additional urgent dental appointments.
- Improve patient flow in mental health crisis and acute pathways by reducing the average length of stay in adult acute beds. Improve access to mental health services for children and young people, aiming to provide care to 345,000 more individuals aged 0 to 25 compared to 2019.

1.2.2 Systems have been asked to deliver the priorities whist continuing to collaborate to:

- Implement reforms;
  - developing neighbourhood health service models (hospital to community)
  - transitioning from analogue to digital, and
  - tackling health inequalities (treatment to prevention)
- Operate within financial budgets and improving productivity
- Prioritise quality and safety of services

1.2.3 The revenue finance and contracting guidance has been set out to support the delivery of the planning guidance. The guidance sets out the arrangements for capping ERF (Elective Recovery Fund) as a fixed allocation (based on month 8 24/25 forecast outturn (FOT)), and capping activity through the use of contractual leavers with both acute trusts and independent sector providers.

1.3 Approach taken to developing the operating plan

1.3.1 The 2025/26 UHBW operating plan has been developed in collaboration with Divisional leadership teams, partners at North Bristol Trust (NBT) and at the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Board (ICB). Working closely with the Divisions a balanced approach to performance delivery and financial management has been achieved. Information provided by NHSE on productivity and efficiency opportunities has been integral to the development of the UHBW plan.

1.3.2 Workforce changes have responded to NHSE requirements and carefully triangulated to savings and investment plans through liaison with various corporate and Divisional teams. Furthermore, realistic targets for key workforce indicators have been agreed through Executive Committee and are aligned to savings plans.

1.3.3 Divisional issues have been collated from known issues raised in Divisional Strategy Deployment Reviews, through Trust governance groups and through review of Divisional risk registers. Risks and

issues have been reviewed and prioritised jointly with the Trust senior leaders, through Planning and Delivery group and Executive Committee.

1.3.4 Non-financial mitigation to clinical risks and quality issues has been encouraged and supported by Executives through Divisional leadership teams wherever possible. Where investment is the only identified means of mitigating a high risk or quality issue, this has been heavily scrutinised by both local and corporate clinical leadership before conclusions have been reached at Executive level.

1.3.5 Changes to service delivery, be that resulting from savings plans or through improvement or transformation work, are tested through UHBW's well established Quality and Equality Impact Assessment (QEIA) process, with line of sight to the Trust Clinical Quality Group and Board-level Quality Committee.

1.3.6 The Trust capital plan has been developed in conjunction with Divisions and iterated through the Capital Programme Steering Group. It responds to opportunities for use of National Capital over and above CDEL (Capital Department Expenditure Limits) restrictions. Furthermore, new system planning mechanisms (an ICB led System Capital Board) have enabled stronger collaboration with local partners than ever before. This has strengthened the development of the System Plan and will ensure that available capital reaches the areas of greatest of need across BNSSG.

1.3.7 Where appropriate, business cases to support the need for investment are moving through the business development process for scrutiny and support across all disciplines.

2. Activity Plan

2.1 Summary of system and Trust approach

2.1.1 The Trust has worked collaboratively with system partners to agree consistent planning assumptions for the 2025/26 annual plan. The Trust approach was initiated with a demand-based modelling exercise to inform activity requirements. This model was based on achieving the national ambitions related to Referral to Treatment (RTT) performance by 31st March 2026. The modelling also focussed on ensuring that both cancer and diagnostic waiting times could achieve the national and local ambitions.

2.1.2 Demand modelling was shared with Divisions who subsequently developed a series of delivery plans describing schemes that will be introduced or continued that will support the levels of activity required to meet the ambitions referenced above. Divisional delivery plans have primarily been focused on productivity benefits and are being reviewed and stress-tested by corporate colleagues, ensuring that the plans are well defined, feasible and affordable.

2.2 Independent sector utilisation

2.2.1 The Trust's review of current independent sector utilisation continues to contribute towards a system wide evaluation of contracted and subcontracted services. Whilst a number of existing contracts will be extended into 2025/26, the delivery planning process is exploring opportunities to repatriate activity from the independent sector to be delivered by the Trust.

2.3 Approach to productivity

2.3.1 The delivery planning process has encouraged Divisions to consider how productivity improvements could address any modelled gap between capacity and demand. The Trust undertook demand and capacity analysis using Gooroo Planner (a modelling tool). The future requirement to achieve a sustainable waiting list size was compared with both the current 2024/25 baseline, but also the activity delivered in the same period in 2019/20. This has enabled the corporate team to explore with divisions how productivity levels could be restored to 2019/20 levels through check and challenge sessions.

2.3.2 **Theatre improvement**
The Trust has an established theatre improvement programme. The focus of this programme in 2024/25 was on establishing 6-4-2, scheduling and utilisation meetings for adults and paediatrics. The benefits of this approach have become business as usual with the Trust now consistently delivering over 80%

capped utilisation. In 2025/26, the Trust's theatre improvement programme will be refocussed to consider the perioperative pathway. The objective is to develop a consistent framework for the Trust's pre-operative assessment services that meets national guidelines. At present, pre-operative assessment is delivered on several different sites by different clinical teams. There will be a consideration of how patients are identified for optimisation in advance of surgery and prehabilitation services. It is anticipated that this approach will reduce the number of last-minute cancellations associated with patients not being fit on the day of their procedure or their operation not being needed. This will also further improve capped utilisation rates towards the Getting It Right First Time (GIRFT) standard of 85% by reducing downtime associated with last minute cancellations. The focus on optimisation also has the potential to reduce length of stay and improve the outcomes for patients admitted for surgery.

2.3.3 **Outpatient programme**

The Trust has an established outpatient improvement programme. In 2024/25, the focus of this programme was on realising the benefits of deploying the DrDoctor patient engagement portal. In 2025/26, there will continue to be a focus on optimising the use of DrDoctor Appointment Notifications, Reminders and Digital Letters. There will also be a new focus on expanding the use of DrDoctor Basic Rescheduling in preparation for a later roll out of Patient Led Booking. The Trust is participating in the national pilot for the Wayfinder project. This enables patients to receive notifications, reminders and letters in the NHS App rather than via the DrDoctor patient engagement portal. The incorporation of Digital Letters in the NHS App is pending. There will also be a focus on the delivery of the Outpatients 2025 business case including the standardisation of clinic builds, establishment of a modern call centre function and corporately led scheduling of outpatient activity. Finally, this programme will also incorporate some of the priorities outlined in the national planning guidance including the expansion of Advice and Guidance services and increase in the use of Patient Initiated Follow Ups (PIFU) for benchmarked specialties like Ophthalmology.

2.4 Summary of Trust activity plan

2.4.1 The Trust activity plan steps up from the previous rolling 12 months and shows a significant increase in activity levels delivered in 2019/20. The ambition to prevent patients waiting 52 weeks or longer and meet core elective care performance targets necessitates this increase and is supported by the operational divisions' productivity-driven delivery plans. The principal risks to delivery are due to limited beds, high volumes of patients with no criteria to reside (with associated length of stay increases) and workforce challenges.

2.4.2 An overview of the Indicative Activity Plan (with Trust adjustments to the 19/20 baseline) is shown below:

Table 1: Trust 2025/26 indicative activity plan

				Plan vs 2024/25		Plan vs 2019/20	
Point of Delivery	**2019/20 Outturn**	**2024/25 FOT**	**2025/26 Plan**	**Difference**	**% Difference**	**Difference**	**% Difference**
Elective Day Cases	74,620	79,497	84,280	4,783	106.0%	9,660	112.9%
Elective Inpatients	14,075	14,605	15,021	416	102.8%	946	106.7%
TOTAL Electives	**88,695**	**94,102**	**99,301**	**5,199**	**105.5%**	**10,606**	**112.0%**
New Outpatients	283,866	281,753	296,795	15,042	105.3%	12,929	104.6%
Follow Up Outpatients	597,622	666,918	686,666	19,748	103.0%	89,044	114.9%
TOTAL Outpatients	**881,488**	**948,671**	**983,461**	**34,790**	**103.7%**	**101,973**	**111.6%**
Emergency Zero LoS	21,214	36,353	39,637	3,284	109.0%	18,423	186.8%
Non Elective Zero LoS	526	198	194	-4	98.0%	-332	36.9%
TOTAL Non Elective Zero*	**21,740**	**36,551**	**39,831**	**3,280**	**109.0%**	**18,091**	**183.2%**
Emergency 1+ Day LoS	42,186	43,618	45,263	1,645	103.8%	3,077	107.3%
Non Elective 1+ Day LoS	2,959	1,984	1,919	-65	96.7%	-1,040	64.9%
TOTAL Non Elective Zero*	**45,145**	**45,602**	**47,182**	**1,580**	**103.5%**	**2,037**	**104.5%**
ED Attendances	**195,698**	**211,911**	**223,754**	**1,580**	**105.6%**	**2,037**	**114.3%**

*Acute specialties only, excludes Well Babies, Maternity

2.4.3 Plans will continue to be stress tested and monitored with divisions to support the delivery of the activity levels and the related performance standards. Associated risks are included below in section 6.

3. Performance

3.1 Summary of performance targets and objectives

3.1.1 The Trust is working towards delivering the performance standards and targets as set out in the Operational Planning Guidance. Table 2 shows the core national standards confirmed by the Operational Planning Guidance for 2025/26 and the UHBW performance ambition as stated in the Trust's operational planning submission:

3.1.2 ***Table 2: Trust summary of performance targets and objectives***

	Current UHBW performance	2025/26 NHSE target	2025/26 UHBW ambition to be stated in operational planning submission
RTT 18 Weeks Wait	64.2% at end of February 2025	>=65% by March 2026 nationally. Each provider to deliver minimum 5% improvement Baseline for improvement is November 2024. UHBW reported 62.8%. Therefore, target for 2025/26 is 67.8%.	67.8% by end of March 2026
RTT 1st OPA Wait	66.6% at end of February 2025	>=72% by March 2026 nationally. Each provider to deliver minimum 5% improvement Baseline for improvement is November 2024. UHBW reported 66.7%. Therefore, target for 2025/26 is 71.7%.	71.7% by end of March 2026
RTT 52 Weeks Wait	1.5% (824 / 54,000) at end of February 2025	>1% of total waiting list by end of March 2026	>1% of total waiting list by end of March 2026
Cancer 62 Day	74.2% at end of January 2025 (note target for 2024/25 is 70%)	75% by end of March 2026	75% by end of March 2026
Cancer 28 Day FDS	77% at end of January 2025 (note target for 2024/25 is 77%)	80% by end of March 2026	80% by end of March 2026
UEC A&E 4 Hour*	71.7% at end of February 2025	>=78% by end of March 2026 A higher percentage of patients admitted, transferred and discharged from Emergency Department (ED) within 12 hours across 2025/26 compared to 2024/25	78% from September 2025

Notes:
*A&E 4 hour-performance includes a performance uplift applied by NHSE which takes into account the Sirona type 3 performance

3.2 Bristol Elective Centre

3.2.1 The Elective Centre (EC) is currently being constructed on the Southmead Hospital site. It is due to open in the late Summer / Autumn. This standalone facility will feature four operating theatres and 40 beds, as well as 12 medirooms. It will provide capacity for an additional 6,500 procedures per year to be carried out.

3.2.2 The EC will be used to accommodate existing elective orthopaedic activity which will be transferred from the Brunel Hospital building. This will create a corresponding amount of operating theatre and inpatient bed capacity within the Brunel Hospital. The benefit associated with this capacity has been shared between UHBW and NBT.

3.2.3 The Trust has been working with NBT to develop plans for a displacement model. This will involve existing trauma and orthopaedic, Gastrointestinal (GI) surgery and Gynaecology activity transferring from the Bristol Royal Infirmary (BRI), St Michael's Hospital (SMH) and South Bristol Community Hospital (SBCH) into the Brunel Hospital.

3.2.4 The capacity created for backfill on the BRI and SMH sites will be used to deliver additional Thoracic, Oral and Maxillofacial, Ear, Nose and Throat, Cardiac and Paediatric Surgery in the BRI, Ophthalmology (cataract) surgery in SBCH, and it will facilitate the expansion of the Trust's robotic surgery programme, with a second robot being introduced in STMH for Gynaecology and GI Surgery.

3.2.5 Where possible, the plans for transfer and backfill also incorporate opportunities to deliver growth and additional productivity.

3.3 Community Diagnostic Centre (CDC)

3.3.1 The North Bristol Community Diagnostic Centre (CDC) went live in April 2024. These services are provided in partnership between NBT and Inhealth. Some endoscopy activity is delivered by Inhealth under contract with NBT on behalf of NBT, the ICB and UHBW. The Trust continues to work with NBT and Inhealth to ensure appropriate pathways are in place to manage the referrals and activity, and ensure the appropriate process and agreements are in place.

3.3.2 The Weston CDC went live in April 2024 and undertakes activity to support delivery of the performance targets.

4. Financial Plan

4.1 Introduction

4.1.1 The 2025/26 Financial Plan has been constructed with reference to the 2025/26 national planning guidance issued by NHS England on 30th January 2025. The Trust's Financial Plan has been constructed alongside the Bristol, North Somerset & South Gloucestershire System. This narrative describes the System's and the Trust's Financial Plans that will be submitted to NHSE on 27th March 2025 in accordance with the NHSE deadline.

4.1.2 Alongside the national planning guidance, a one-year funding settlement for 2025/26 only has been provided for revenue and capital allocations; the Government's Spending Review will conclude in June 2025 and will set Government Departmental plans for a minimum of three years. The funding allocated to the BNSSG System and Specialised Commissioners has informed the Financial Plan.

4.1.3 Similar to revenue, the capital settlement beyond 2025/26 will be set out in the Spending Review. However, for capital planning purposes beyond 2025/26, systems should assume they will receive at least 80% of their 2025/26 core allocation. The 2025/26 capital guidance sets out the 2025/26 NHS capital allocation which is split into three categories:

- £4.9bn for system level allocations to fund day-to-day operational investments;
- £1.1bn for previously committed funds, for example, the New Hospital Programme; and

- £4.1bn for other national capital programmes.

4.1.4 NHSE has also outlined proposals to introduce adjustments to the capital regime that will provide further financial freedoms and flexibilities for high-performing systems and providers (exclusively Trusts and systems in tiers one and two of the NHS Improvement and Assessment Framework). The Trust is currently operating in tier two. The proposals are:

- Enhanced flexibility for high-performing systems – systems in tier one or two that deliver break-even would be allowed to invest in capital expenditure above their allocated budgets using available cash balances up to a limit set between £20m and £30m; and
- Capital retention for high-performing providers - providers in tier one or two that deliver a surplus would have the flexibility to invest capital equivalent to their surplus for the following two financial years. The capital would have to be directed towards projects that improve revenue performance.

4.1.5 For the 2025/26 Financial Plan submission, providers and Systems have been asked to submit a detailed one-year capital plan and a high-level four-year capital plan that is CDEL compliant on an annual basis.

4.1.6 The development of the 2025/26 Financial Plan requires a sharp focus on break-even underpinned by elective performance recovery, productivity improvement and recurrent savings delivery. The 2025/26 Financial Plan is based on a number of key building blocks:

- The BNSSG system and Trust's recurrent deficit as at 31st March 2025 and 31st March 2026 as per the approved System Medium Term Financial Plan (MTFP);
- The Trust's 2025/26 elective patient care income, elective care payment limits and costs of delivering the waiting time access / performance targets;
- The current status of the Trust's savings program; and
- The inclusion of the NHSE productivity opportunities in the Trust's savings program and/or the Trust's patient activity plan.

4.1.7 In the context of the Trust's significantly rising operating costs, including headcount growth of c20% since March 2020 and a material a deterioration in the Trust's productivity since March 2020 as measured by the National Cost Collection Index (NCCI) from 93 to 107, and the NHSE productivity opportunities, the Trust faces significant challenges and difficult choices in landing the revenue break-even plan. These are:

- The level of expenditure required to deliver the elective patient activity volumes necessary to meet NHSE waiting times performance targets. Four activity scenarios have been considered by the Trust's Chief Operating Officer (COO) in the context of cost affordability. The chosen option predicted to deliver the waiting times performance targets requires a further productivity improvement (beyond c1% for day case and c3.5% for inpatient activity) for the costs of elective delivery to remain affordable;
- Investment plans to resolve new quality and safety risks or regulatory requirements which cannot be deferred for twelve months and can only be mitigated through investment at £4.0m rather than a re-prioritisation of existing Divisional resources. The Trust's Executive Committee agreement to proceed with the investments has resulted in the Trust's savings plan increasing from £49m to £53m;
- The Trust's savings requirement of £53m (or c5% of operating expenditure). The Trust's savings plan includes a planned reduction in the Trust's workforce of at least 300 FTE (full-time equivalent) in both clinical and corporate services against the c2,000 FTE growth since March 2020. (NB the overall headcount reduction will be partially mitigated due to investments being made).
- There is a very clear expectation that all services will also return their staff in post position back to their approved funded establishments.

4.2 2025/26 BNSSG System Financial Plan – revenue

4.2.1 The Trust's Financial Plan should be seen in the context of the financial position of the BNSSG System. The key aspects of the BNSSG System plan are as follows:

- All ICBs have received core allocation growth of 4.40%, with a Convergence Factor applied to ICB Core, Primary Medical Care and Specialised Services Allocations (maximum +/- 0.5%) to move closer to fair share allocations;
- Allocation growth includes a Cost Uplift Factor (CUF) of 4.15%;

- An NHSE efficiency requirement of 2.00%. This is an increase of 0.9% or c£24m from the BNSSG ICB medium-term financial plan and the NHSE requirement in 2024/25;
- The CUF assumes a headline pay award of 2.8% and assumes a 1.8% increase for the employers National Insurance contribution increase as result of the Government's October 2024 budget;
- The Elective Recovery Fund (ERF) mechanism will change in 2025/26. In 2024/25, ERF operated as fully variable income without a limit and any over-performance was paid by central NHSE. For 2025/26, there is a fundamental shift to an elective care payment limit held at ICB level with ICBs now expected to manage the affordability of elective activity. The BNSSG ICB allocation is £283m based on:
    - Funding embedded in core allocations/contracts;
    - 2024/25 allocation for ERF to take funded levels to target (which was 103% of 2019/20);
    - Overperformance in 2024/25 (using submitted forecast outturns from Month 8);
    - Funding for the Elective Centre – this is now aligned on an activity basis to the business case. This is £12.1m and represents an allocation for all ICB commissioners; and
    - A national scale back of 28% to the 2024/25 overperformance.
- Providers and ICBs would need to agree and document a planned level of activity, and associated financial value, to be reimbursed on a variable or activity basis. This financial value represents the elective care payment limit or cap and is the maximum amount the commissioner would be required to pay the provider for elective activity. The value of the elective payment limit for the Trust is £212m;
- NHSE 2024/25 business rules leading to revenue/capital consequences will be adhered to in 2025/26. Based on BNSSG as a system submitting a break-even financial plan for 2025/26 and delivering the 2024/25 break-even plan, BNSSG will receive financial incentive funding of £30.2m in 2025/26 of which c£13m is capital;
- Mental Health Investment Standard (MHIS) retained and must grow in line with ICB core allocation growth of 4.40%; and
- NHS minimum contribution to adult social care will increase in total by 3.90%, which translates to an overall 1.70% minimum contribution to the Better Care Fund (BCF).

4.2.2 The BNSSG System planned net income & expenditure is break-even.

4.3 2025/26 BNSSG System Financial Plan – capital

4.3.1 The 2025/26 BNSSG System capital allocation as advised by NHSE is £160.5m. This allocation consists of £156.7m provider allocation which includes a share of national programme funding of £73.2m. The national programme funding is subject to NHSE scheme approval and scheme delivery in 2025/26. Primary care capital of £3.8m is also available to the system. The overall allocation is as follows:

£m	
72.1	2025/26 BNSSG ICB capital allocation;
2.1	Primary care business as usual and GP IT;
13.1	Fair shares allocation for delivery of system break-even in 2024/25;
87.3	**Subtotal – operational capital allocation**
27.0	National programme funding for estates safety – subject to NHSE approval
24.5	National programme funding for constitutional standards - subject to NHSE approval
1.7	National programme funding for primary care – subject to NHSE approval
20.0	National programme funding - RACC schemes subject to NHSE approval
160.5	**Total – System capital**

4.3.2 The allocation of the System CDEL and the System 2025/26 capital plan was agreed at the System Capital Board meetings on 4th February 2025 and 4th March 2025. Membership includes the BNSSG Chief Finance Officers, Business Planning, Finance, Digital and Estates colleagues. During January and February, the System capital prioritisation undertook a moderation check using provider risk assessments and this was presented to all partner organisations to ensure all partner organisations are aware of the level of estates and operational risks being carried by sovereign Boards.

4.3.3 The national programme funding of £732.2m is pending confirmation from NHSE. The Trust has submitted bids of £41.4m of which £26.8m is included with the Trust's 2025/26 capital plan. The timeline for NHSE approval of the submitted bids is currently unclear.

4.3.4 In addition to the system operational capital at £38.6m, the Trust will receive capital external to the system allocation, for example, charitable funding and PDC directly from NHSE. Therefore, the Trust's total 2025/26 capital plan is £44.8m as per section 4.6.

4.4 2025/26 Trust Financial Plan – revenue

4.4.1 The Trust has constructed the 2025/26 Financial Plan in accordance with NHSE's timetable and aligns with the BNSSG System funding allocation. The key income aspects are as follows:

- Total planned full year income of £1,298.5m includes:

£m	
559.7	BNSSG ICB income
455.6	NHSE Southwest Specialised Commissioning income;
68.5	Associate Commissioners e.g. BSW[1], Somerset, Gloucestershire
81.8	Other patient care income e.g. Local Authorities, private patients;
1,165.6	Subtotal income from patient care; and
132.9	Other operating income.
1,298.5	**Total Income**

- The full year NHSE Specialised Commissioner income of £455.6m is aligned with the Specialised Commissioners position following informal discussions and agreement on methodology.

4.4.2 The Trust's 2025/26 key operating expenditure drivers are:

- The starting point of 2024/25 forecast outturn, removing specific non-recurring items and adding the full year effect of 2024/25 investments.
- The non-recurring items of £87.7m at c6% mainly relate to:

£m	
46.7	Non-recurrent Commissioner income;
15.7	Non-recurrent savings
14.3	Corporate and Division mitigations; and
11.0	Other – net slippage on Divisional cost pressures and investments
87.7	**Total – 2024/25 non-recurring items**

- The net full year effect of 2024/25 investment decisions of £13.3m are:

£m	
(3.7)	FYE of savings delivered in 2024/25;
2.9	Paediatric Gender Service;
2.2	Healthy Weston 2 Phase 1;
1.5	RNDA/TNA[2] apprenticeship programme 2024/25 cohort;
1.3	2024/25 critical safety investments;
1.6	Targeted Lung Health Checks (TLHC) development;
1.5	Digital cost pressures;
1.0	Clinical divisions cost pressures;
1.8	Prior year commissioner funded investments;
3.2	Other divisional FYE items
13.3	**Total – full year effect of 2024/25 investments**

- Inclusion of elective investments at £7.5m to secure additional elective activity to underpin the delivery of the performance targets;
- In the second financial year of Group, gross investments of £7.8m primarily into corporate areas, offset by gross benefits of £5.7m relating to cost savings and income generation opportunities and external funding of £2.1m;
- New for 2025/26, the inclusion of backfilling vacated theatre capacity at the Trust due to activity transferring to the new Bristol Elective Centre at a net cost of £1.5m;
- New for 2025/26, Trust investment decisions totalling £4.0m relating to unavoidable quality, clinical safety or regulatory requirements as agreed by the Trust's Executive Committee as follows:

£m

[1] BSW - Bath and North East Somerset, Swindon and Wiltshire

[2] RNDA/TNA – Registered Nurse Degree Apprenticeship/Trainee Nurse Associate

○	0.64	Commissioner contract changes;
○	0.60	D&T[3] Division - regulatory/contractual requirements;
○	0.39	Women's & Children's Safer staffing review;
○	0.09	Paediatric BMT[4] Service investment;
○	0.24	Additional Consultants at Weston General Hospital;
○	0.18	Additional Emergency Medicine Consultants at the BRI;
○	0.08	Teledermatology;
○	0.17	Nursing apprenticeship programme;
○	0.29	Support of growth in Paediatric Immunology and Nutrition Support;
○	1.00	Support of activity growth in BHOC[5];
○	0.10	Neurophysiology service;
○	0.25	Extension to System C contract;
	4.03	**Total – 2025/26 Trust investment decisions**

- Additional net financing costs of £4.7m. Of this, £3.4m relates to additional depreciation costs and £1.1m relates to a planned increase in net interest expenses;
- The application of the NHS gross inflation uplift of 4.15% at £46.3m. A full assessment of any potential shortfall in inflation funding will be undertaken in quarter 1 pending the final 2025/26 pay award for all staff alongside various supplier contracts applying the Retail or Consumer Prices Index;
- Full delivery of Trust's total savings requirement of £53.0m or c5% primarily as a reduction against operating expenditure. The Trust's savings position is set out in section 4.5. The savings target of £53.0m is constructed as follows:

	£m	
○	20.0	National requirement of 2.0%;
○	29.0	Additional 3% to meet the Systems MTFP recovery trajectory (including recovering the shortfall in recurring savings in 2024/25);
○	4.0	Additional requirement to fund quality, safety and regulatory issues.
	53.0	**Total – Trust's 2025/26 savings requirement**

4.4.3 The Trust's 2025/26 planned net income & expenditure position is break-even and summarised in Table 3.

4.4.4 ***Table 3 – 2025/26 planned net income & expenditure position***

Statement of Comprehensive Income and Expenditure	2024/25 Forecast Outturn £M	2025/26 Financial Plan £M
Operating Income from patient care activities	1,152.8	1,165.6
Other Operating Income	128.7	132.9
Total Income	**1,281.5**	**1,298.5**
Operating Expenditure		
Employee expenses	(771.8)	(795.5)
Non pay expenses	(470.3)	(444.4)
Subtotal - Operating Expenditure	**(1,242.1)**	**(1,239.9)**
Financing		
Depreciation and amortisation	(43.7)	(47.1)
Net finance expense	(11.3)	(12.4)
Total Expenditure	**(1,297.1)**	**(1,299.4)**
Net surplus/(deficit) including technical items	**(15.6)**	**(0.9)**
Less technical items	15.6	0.9
Net surplus/(deficit) excluding technical items	**0.0**	**0.0**

[3] Diagnostic and Therapies
[4] BMT - Bone Marrow Transplant
[5] BHOC – Bristol Haematology and Oncology Centre

4.5 2025/26 Trust Savings Programme

4.5.1 The 2025/26 savings targets for clinical Divisions and Estates & Facilities has been set based on 4.0% of 2024/25 recurrent budget (excluding pass-through costs) and, subject to Executive Committee approval, 5.0% for corporate services, a total of £37.1m. Additional further corporate mitigations of £15.9m are required to reach the Trust's savings target of £53.0m. Currently, the Trust has identified savings of £48.5m or 92% of which £40.7m are recurrent. £4.5m remains unidentified. The position is summarised in Table 4A. Table 4B provides a savings summary by type.

4.5.2 ***Table 4A – 2025/26 Division and corporate services savings summary***

Division	Total Savings Target £M	Total Recurrent Savings Identified £M	Total Non-Recurrent Savings Identified £M	Total Savings Identified £M	Balance (Unidentified) £M
Diagnostics & Therapies	4.1	2.8	0.8	3.6	(0.5)
Medicine	4.6	4.9	0.1	5.0	0.4
Specialised Services	4.6	2.9	0.8	3.7	(0.9)
Surgery	7.5	6.6	1.0	7.6	0.1
Weston	2.4	1.7	0.3	2.0	(0.4)
Women's & Children's	7.1	5.4	1.5	6.9	(0.2)
Estates & Facilities	2.3	2.2	0.3	2.5	0.2
Finance	0.6	0.3	0.2	0.5	(0.1)
HR	0.7	0.7	0.0	0.7	0.0
Trust Headquarters	1.8	1.4	0.1	1.5	(0.3)
Digital Services	1.4	0.6	0.2	0.8	(0.6)
Corporate requirement	15.9	11.2	2.5	13.7	(2.2)
Total	**53.0**	**40.7**	**7.8**	**48.5**	**(4.5)**

4.5.3 ***Table 4B - 2025/26 savings plans by cost type***

Cost Type	Subjective Type	Total Recurrent Savings Identified £M	Total Non-Recurrent Savings Identified £M	Total Savings Identified £M	Workforce Reduction WTE
Pay	Substantive	12.9	1.8	14.7	300.2
Pay	Bank	10.4	0.1	10.5	247.6
Pay	Agency	2.8	0.0	2.8	34.3
Non-Pay	Blood	0.3	0.0	0.3	
Non-Pay	Clinical Supplies	5.6	1.6	7.2	
Non-Pay	Drugs	1.3	0.4	1.7	
Non-Pay	Establishment Expenses	0.2	0.0	0.2	
Non-Pay	Other Expenditure	3.9	3.5	7.4	
Income	Income from Activities	1.9	0.3	2.2	
Income	Income from Operations	1.4	0.1	1.5	
Total		**40.7**	**7.8**	**48.5**	**582.1**

4.5.4 Included within the £53.0m of savings for Trust delivery, the Trust is also required to deliver corporate mitigations of £3.6m through technical financial opportunities.

4.5.5 Based on the 2024/25 forecast outturn savings delivery of £32.6m, a clear step change in savings delivery and productivity is required to achieve the savings target of £53.0m. This significant step-change is in part met through the requirement to reduce both the funded establishment and substantive staff in post by a minimum of 300wte and a reduction in the use of temporary workforce by 282wte.

4.5.6 Productivity analysis data has been developed by NHSE and shared with provider Trusts. For the Trust, this identifies potential productivity opportunities totalling £71.7m. Of the £46.8m of operational productivity identified within this, NHSE expects 50% to be cash releasing. A further £24.8m of Trust efficiency have also been highlighted. This information has been used as part of the Trusts Cost Improvement Programme (CIP) identification process. Further details of which can be found in appendix 1.

4.5.7 The third cut of savings plans from Divisions and corporate services were received on the 12th March 2025 and inform the current savings position. The next six weeks will require considerable focus on CIP implementation in order to increase the confidence that the Trust will deliver its target of £53.0m in year, either by recurring or non-recurring means. However, there is further work to do across the organisation to enact enhanced pay controls and review structures and processes across all Divisions to ensure that reductions are recurrent, safe and sustainable. The intention is to fully identify 100% of savings in the fourth cut due mid-April 2025 with an exit position of 100% of savings being delivered recurrently (full year effect) by 31st March 2026.

4.5.8 The Trust has revised and strengthened the approach to productivity and efficiency to better address the ongoing savings requirement and deliver the targets above. The Productivity and Financial Improvement Group (PFIG) is established along with a number of corporate workstreams focusing on specific areas to drive better savings delivery and productivity. The Trust also retains its existing and well-established system of process and governance.

4.5.9 The Trust continues to use all available benchmarking sources to identify areas for improvement and develop actions plans to ensure delivery. The Trust is using the National Productivity packs, Model Health System, NCCI (National Cost Collection Index), Service Line Reporting (SLR) and GIRFT as key tools to identify efficiency opportunities and a more formal process is being rolled out across the Trust to follow up all opportunities from this source. The Trust is also working with regional groups to identify further opportunities.

4.5.10 The Trust also has a series of programmes focussing on increased and robust expenditure controls including in the areas of non-pay, drugs and pay areas particularly medical staffing and nursing. Further work streams dedicated to delivering transactional savings have also been established.

4.5.11 In the event that we do not make the required progress in closing the current savings gap, or in balancing divisional budgets, the implementation of more stringent workforce cost controls will be required.

4.5.12 Savings schemes are assessed for impact on quality and patient safety through the completion of Quality & Equality Impact Assessments where required based on a clear set of criteria. For schemes meeting the criteria, the QEIA templates are subject to review and sign-off by the Trust's Chief Nurse & Midwife (CNM) and Chief Medical Officer (CMO).

4.5.13 Performance against savings targets is reported monthly and reviewed at regular divisional accountability reviews. Oversight of delivery is provided through the monthly PFIG meeting chaired by the Trust's Hospital Managing Director (HMD). Progress regarding savings delivery is also reviewed monthly at Executive led divisional reviews.

4.6 2025/26 Trust Financial Plan – capital

4.6.1 The Trust's capital plan for 2025/26 is £44.8m. The plan also includes leased assets under IFRS 16 at £7.9m. The plan is pending NHSE decisions in relation to capital bids submitted by the Trust worth £41.1m of which £26.8m would fund capital investment already included in the Trust's plan. The plan has been prioritised using a risk-based approach within the Trust and is co-ordinated by the Trust Capital

Group. The process was also supported by a dedicated Divisional Director and Clinical Chair review in late February. The capital plan is also a result of the joint acute and system approach to capital prioritisation and planning.

4.6.2 Submitting a balanced capital plan within the available envelope has required a reduction in gross capital allocations of £10m pending the outcome of the national capital bids. The plan outlined here for approval will therefore continue to develop under the oversight and governance of the Trust's Capital Programme Steering Group (CPSG) during quarter 1.

4.6.3 In summary, the sources of capital funds to meet the planned expenditure of £44.8m are as follows:

£m	
32.4	NHSE CDEL allocation for non-leased assets;
7.9	NHSE CDEL allocation for leased assets;
1.5	Charitable funding; and
3.0	Public Dividend Capital (PDC) expected from NHSE.
44.8	**Total planned sources of capital funding**

4.6.4 The sources of funds will be applied against the following key scheme headings including planned slippage or over-programming at c25%. The overriding principle of agreeing what can actually be delivered in 2025/26 through monthly scheduling and the conclusion of the 2024/25 financial year mean these may change:

£m	
19.5	Slippage and pre-commitments from 2024/25;
12.1	Multi-year major capital programme;
2.2	Multi-year Strategic Schemes;
12.7	Fixed allocations, mainly estates projects at £10.0m and contingency at £2.0m;
3.0	Digital;
(12.6)	Less assumed over-programming at c25%.
36.9	Subtotal – 2025/26 planned net capital expenditure excluding leased assets
7.9	Leased assets (under IFRS 16)
44.8	**Total planned application of capital funding**

4.7 2025/26 Trust Financial Plan – Statement of Financial Position

4.7.1 The Trust's Statement of Financial Position (SoFP) takes into consideration the Trust's planned revenue net income and expenditure position, planned capital investment and key aspects of treasury management in relation to working capital and financing such as PDC dividend repayment and loan principal repayment.

4.7.2 Key highlights of the Trust's planned SoFP as at 31st March 2026 are as follows:

- Non-current assets increasing to £656.8m as a result of the capital plan of £44.8m, in year depreciation of £47.1m and revaluation of land and buildings of £14.5m, based on 2% increase in indices;
- Net current liabilities of £28.8m from an opening forecast outturn liabilities position of £12.0m;
- Stock levels held at £19.0m;
- A closing cash balance of £54.0m, a planned decrease of £28.8m during the year; and
- A reduction in borrowings of £14.1m relating to £5.8m on loans and on £8.3m leases.

4.7.3 The Trust's Statement of Financial Position is summarised in Table 5.

4.7.4 ***Table 5 - The Trust's Statement of Financial Position***

Statement of Financial Position	2024/25 Forecast Outturn £M	2025/26 Q4 Plan £M
Non-Current Assets		
Property plant and equipment & Intangibles	534.1	546.6
Right of use assets (IFRS16)	109.0	108.7
Receivable	1.5	1.5
Total Non-Current Assets	**644.6**	**656.8**
Current Assets		
Inventories	19.0	19.0
Receivables	49.9	49.9
Cash	82.8	54.0
Total Non-Current Assets	**151.7**	**122.9**
Current Liabilities		
Trade payables	(142.6)	(130.6)
Borrowings	(13.5)	(13.5)
Other	(7.6)	(7.6)
Total Current Liabilities	**(163.7)**	**(151.7)**
Net Current Assets/Liabilities	**(12.0)**	**(28.8)**
Non-Current Liabilities		
Borrowings	(128.8)	(114.7)
Provisions	(2.1)	(2.1)
Total Non-Current Liabilities	**(130.9)**	**(116.8)**
Total Net Assets Employed	**501.7**	**511.2**
Financed by		
Public Dividend Capital	337.7	337.7
Revaluation Reserve	52.4	63.4
Other Reserves	0.1	0.1
Income and Expenditure - Opening	113.5	111.5
Income and Expenditure - In Year	(2.0)	(1.5)
Total Taxpayers' and Others' Equity	**501.7**	**511.2**

4.8 2025/26 Trust Financial Plan – Cashflow Statement

4.8.1 Cash will be a key issue heading into 2025/26 with the majority of NHS organisations having deficit positions in 2024/25 and liquidity constraints as they head into 2025/26. NHSE has written to provider organisations stating that a stricter cash regime and therefore reduced access to emergency cash will be implemented from the 1st April 2025. However, as a result of the Trust's twenty-two year tracked record of break-even or better, the Trust's cash remains relatively very strong for 2025/26.

4.8.2 The cashflow statement summarises cashflows arising from the Trust's planned: operating activities (i.e. revenue financial performance and working capital management); investing activities (mainly the Trust's capital plan); and financing activities (covering leases, loan interest and loan principal repayments).

4.8.3 The key highlights of the Trust's planned cashflow statement are:

- £42.6m net cash inflow from operating activities including a working capital net cash outflow of £12.0m;
- £41.4m net cash outflow from investing activities with £46.0m linked to the Trust's capital plan; and
- £30.0m net cash outflow from financing activities mainly relating to lease and loan principal repayments of £14.0m and PDC payment of £13.6m.

4.8.4 The Trust's planned cashflow statement is summarised in Table 6.

4.8.5 *Table 6 - The Trust's Cashflow Statement*

Statement of Cash Flows	2025/26 @ 31/03/2026 Plan £M
Cash flows from operating activities	
Operating Surplus / (Deficit)	11.3
Depreciation and Amortisation	44.8
Impairments and Reversals	-
Losses on Disposal	-
Income from Donations	(1.5)
(Increase)/Decrease in Assets	-
Increase/(Decrease) in Liabilities	(12.0)
Net cash flow from operations	**42.6**
Cash flows from Investing Activities	
Interest Received	3.1
Purchase of Assets	(46.0)
Donated Assets	1.5
Net cash flow from Investing Activities	**(41.4)**
Cash flows from Financing Activities	
Public Dividend Capital received	-
Loans	(5.8)
Interest Paid	(2.4)
Capital element - leases	(8.2)
Public Dividend Capital - paid	(13.6)
Net cash flows from Financing Activities	**(30.0)**
Increase/(decrease) in cash	**(28.8)**
Opening balance	82.8
Closing cash balance	**54.0**

4.9 2025/26 Trust Financial Plan – summary

4.9.1 The key headlines for the Trust's Financial Plan are:

- A planned net income and expenditure position of break-even;
- A capital plan at £44.8m that is compliant with the Trust's CDEL with over-programming or slippage assumed at c25%; and
- A cash balance of £54.0m as at 31st March 2026.

4.10 Trust budget setting

4.10.1 2025/26 budgets will be set to divisional operating plans as part of the Trust's annual planning approach and aligned with the methodology used to construct the Trust's Financial Plan. This means budgets are based on 2025/26 divisional normalised financial positions, with 2024/25 rollover recurrent budgets adjusted for material and significant adverse variances which are unavoidable or outside the control of the Division. The 2025/26 recurrent budgets will therefore be set at a level which:

- Includes funding to deliver the required activity volumes;
- Resolves historic funding issues; and
- Removes the need to identify material mitigations to achieve an on-budget position.

4.10.2 Budgets will also be adjusted to remove budget equating to the 2025/26 divisional savings targets, fund the new for 2025/26 unavoidable cost pressures and 'must-do' quality and safety issues agreed by the Trust's Executive Committee, including, for example:

- Support for safer staffing levels on Apollo and Caterpillar wards;
- Investment to restart the Paediatric BMT service;

- Significant growth in BHOC, Paediatric Immunology and Paediatric Nutrition Support.
- Contract changes related to sexual health services and activity from Welsh Commissioners.
- Increases in the consultant workforce to support A&E, Acute and Care of the Elderly services.
- Regulatory compliance within Medical Physics and Laboratory Medicine; and
- Unavoidable contractual commitments e.g. System C contract.

4.10.3 The 2025/26 approach is different from the budget setting approach in 2024/25 and seeks to better align the Trust's Financial Plan with divisional budgets. Divisions have been working with the corporate finance team during Q4 to implement the new approach. Both Division's and corporate teams will know their budgets prior to the 1st April 2025 as the planning process concludes, with the exception of those items pending further discussion and decision regarding elective investments which, when finalised, will be allocated to Divisions in the month the cost commences

4.10.4 The Trust continues to apply and monitor the key financial controls. Financial controls refer to financial procedures, processes, and governance as well as the operational management and decision-making regarding use of resources. The financial controls in place to support the Trust to deliver its responsibilities cover:

- Financial reporting and review;
- Financial oversight; and
- Financial controls and processes.

4.11 Financial Risk Assessment

4.11.1 The key financial risks are presented here.

4.11.2 Risk of not delivering the Trust savings of £53m

The Trust's recurring savings requirement of £53m is a 65% increase on the Trust's 2024/25 forecast savings delivery of £32.6m. Securing additional savings plans alongside operational delivery will require a significant step change in delivery from Divisions and corporate services. The principle focus of PFIG will be driving pay savings to help secure the step change in delivery. Currently within the plan, identified savings plans have the following maturity level ratings: Maturity 1 & 2 schemes = £24.5m / 47%; Maturity 3 schemes = £24.0m / 45%, Maturity 4 / Unidentified – £4.5m / 9%. Further details can be seen in appendix 2. Due to the additional assurance work required, the risk of delivery for the savings requirement is currently assessed as ***very high***.

4.11.3 Risk that the planned value of elective activity and therefore elective income is not delivered.

The Financial Plan is based on the elective activity plan agreed between the Trust's COO Team and clinical Divisions that delivers required waiting times / performance standards for 2025/26. The activity requires volume increases above 2024/25 forecast outturn levels of c3% for day case activity, c7% for elective inpatient activity and c4% for first outpatient attendance activity. The value of elective patient care income is c£226m. This is significantly higher than the elective care payment limit introduced for 2025/26 of £212m. It is therefore unlikely that elective care income will be lower than the payment limits hence the risk of underperformance against the elective income plan is assessed as ***low***.

4.11.4 Risk that the Trust's elective access / performance targets cannot be delivered within the cost envelope

The break-even plan assumes the revenue cost of meeting the Trust's elective access/performance targets can be delivered within the envelope of £7.5m. This envelope assumes further improvement in operational productivity beyond c1% for day case activity and c3.5% for elective inpatients which is currently under review. This risk is assessed as ***high***.

In the event that, at the end of Q1, there is a mismatch between the costs of delivering performance standards and the funding available, then further consideration will be required at Board level with regard to the performance versus financial dilemma this poses.

4.11.5 Risk that assumed additional income of £14.0m is not secured

The break-even position includes assumed patient care income (not linked to activity) of £11.5m and £2.5m of other operating income. For context, the 2024/25 plan included additional corporate income/mitigations of £13.2m which have been realised in 2024/25. Therefore, this risk is assessed as ***medium***.

4.11.6 Risk that assumed operational expenditure slippage of £10.6m is not repeated in 2025/26

Operational expenditure slippage assumptions of c£10.6m relate to expected ongoing slippage against Divisions budgets and plans to increase their expenditure in 2025/26 as services look to recruit into vacant posts up to their funded establishments in support of elective recovery. Certain operational services have continued to find recruitment into posts challenging due to the lack of workforce supply. The extent to which the financial benefit of £10.6m is repeated in 2025/26 presents a ***medium*** risk to the Trust's break-even plan.

4.11.7 Risk that the Trust does not deliver capital expenditure in line with its CDEL of £40.3m

The Trust's net capital plan assumes schemes to the value of c25% will not be delivered in 2025/26 due to constraints relating to operational access (disruption to services and decant challenges), supplier selection and lead-time constraints and regulatory compliance (2024 Building Safety Act). A recent assessment of the Trust's buildings has concluded that the majority of the buildings fall within the scope of Building Safety Act which will add additional lead times to projects of typically six months. Therefore, this risk is assessed as ***high***.

4.11.8 Risk that the assumed funding from all Commissioners are materially mis-aligned

Against the Trust planned patient care income of £1,165.6m, the Trust has not received a formal response to the Trust's income proposals from associate Commissioners. Approximately £68m or c12% of the Trust's planned income is, therefore, at risk. The Trust has applied a methodology broadly based on the 2024/25 forecast outturn (for which we are currently being paid) adjusted to 2025/26 prices. The Trust has formally written to the associates accordingly. This risk is assessed as ***medium***.

4.11.9 Strategic Financial Risks

The scale of the Trust's recurrent deficit and CDEL constraints presents a significant risk to the Trust's strategic ambitions. Further work is required to develop the mitigating strategies whilst acknowledging the Systems strategic capital prioritisation will now need to take forward the Joint Clinical Strategy. This risk is assessed as ***high***.

4.12 Key next steps for the Finance Plan

4.12.1 The Trust will need to work through a number of significant remaining next steps in order to progress delivery of the 2025/26 Financial Plan. The key next steps are:

- PFIG materially progressing the savings identification and managing the subsequent delivery against the £53.0m savings requirement;
- Securing formal agreement of Associate Commissioner funding envelopes;
- Finalising the costs associated elective activity delivery within the envelope available on the expectation of improved productivity;
- Full testing of the Trust's workforce controls and VCP processes in light of the requirement to reduce workforce back to funded establishments;
- Re-visiting the Trust's capital plan in response to the outcome of the national capital bids via the Trust's Capital Group and Capital Programme Steering Group; and
- In light of the risks within the Trust's financial plan, the Trust will look to fully mitigate these during quarter 1 and undertake a formal forecast outturn assessment based on quarter 1 financial results

that will inform a potential re-setting of the financial plan, particularly savings and elective activity delivery.

4.13 Conclusion and recommendation

4.13.1 The Trust's 2025/26 Financial Plan presents a significant revenue financial challenge for the Trust with a savings requirement of £53.0m. However, the early conclusion of the Financial Plan provides the System, Trust and the Divisions with a clear focus on savings identification and delivery and elective activity delivery necessary to deliver the break-even plan.

4.13.2 The Committee is recommended to approve the 2025/26 Financial Plan under delegated authority on behalf of the Trust Board and to note, in doing so, the risk assessment in section 4.11 and the key next steps section 4.12

5. Workforce plan

5.1 System approach

5.1.1 The BNSSG workforce planners' network provided oversight in the construction of each organisation's workforce plan ensuring that they are developed consistently and in line with NHSE/I guidance. The Trust's workforce plan will be submitted as an excel full-time equivalent (FTE) plan alongside a Workforce Checklist both documents have been issued as part of the NHSE workforce planning instructions.

5.2 Summary of Trust plan

5.2.1 The submission of the 27th March will include a reduction in staff in post of 337.5 FTE profiled across the year. This includes transfer of 10 FTE to the Elective Centre, changes in commissioning requirements of 27.5 FTE, and a reduction of 300 FTE as part of CIP delivery (including the planning guidance ambition to reduce support functions). There is also growth in Staff in Post (SIP) of 175 FTE through roles associated with service developments, priority services and the Group transitional investment requirements. This gives a net change of -162.5 FTE to Staff in Post. It is anticipated that this can be achieved through vacancy controls, utilising turnover and attrition.

5.2.2 There is also a planned average bank reduction of 187 FTE, with a figure of 341 FTE in March 2026, and a reduction in agency of 33 FTE.

Table 7: Trust 2025/26 funded establishment plan

	Funded Establishment		
	Year End (31-Mar-25)	Year End (31-Mar-26)	Change
	FTE	FTE	FTE
Total Workforce (WTE)	12,922.0	12,760.3	-161.7

Table 8: Trust 2025/26 staff in post plan

Staff-in- Post		
Year End (31-Mar-25)	Year End (31-Mar-26)	Change
FTE	FTE	FTE

Total Workforce (WTE)	13,297.0	12760.8	-536.2
Total Substantive	12,328.6	12166.1	-162.5
Total Bank	866.0	525.0	-341.0
Total Agency	102.4	69.7	-33

5.2.3 Monitoring of the plan will be managed via the monthly Provider Workforce Returns (PWR) returns to NHSE/I and shared with ICB.

5.3 Workforce challenges

5.3.1 The Workforce plan submission will address the following assumptions:

5.3.1.1 Agency

30% reduction in Agency spend (as per NHSE planning guidance)

The Trust is expecting to deliver a reduction in agency spend, through a saving in pay (rates) reduction in addition to a reduction in than FTE. The key assumptions included in the plan are:

- Direct engagement rolled out to all agency staff.
- Continue roll out of regional of price caps to deliver significant savings
- Agency rates, particularly for medical staff, are high, meaning that small reductions in FTE usage will achieve more than 1 FTE average cost saving, and that reductions in agency may not directly correlate with reduction in staff in post.
- Additional agency controls have been instigated for medical agency booking including sign off from Divisions Pay Control Panels, and sign off required from the Medical Directors Office, Head of Medical Strategic Workforce Planning and the Head of Resourcing.
- Agency FTE usage reductions for nursing will focus on the reduction in RMN usage through the corporate Mental Health Care Support Workers project as well as continued control processes that have delivered will in 2024-25.
- As per planning guidance there will be a focus on removing the minimal use of administration and clerical agency FTE.

5.3.1.2 Bank

10% reduction in Bank (as per NHSE planning guidance)

The revised plan assumes a Bank target reduction to 5.2% Maximum FTE as % of total workforce numbers, currently use is at 6.4%. Stringent bank controls will be necessary across all staff groups, for nursing this will be undertaken by the Nursing Establishment Controls group.

In addition, there will be a focus on reducing bank rates, this includes plans not to apply the full pay award to bank rates once the pay award for 2025/6 is announced. The interim pay award will be applied in April 2025 because it is necessary to comply with the National Living Wage.

A review of break-glass rates has reduced the allowance from 50% to 30% and in all cases will be subject to Executive or on-call manager approval out of hours. The ‘allocate on arrival’ incentive has been reduced from 30% to 20% and its application restricted further. Any remaining specialty specific bank rates that had been agreed through the Trust Pay and Assurance Group will be reviewed with the intention to reduce or remove, most of which will cease from March 2025.

5.3.1.3 Delivery of Pay CIP

The plan assumes a 300 FTE reduction in SIP and funded establishments to support CIP achievement (based on staff in post FOT March 31st 2025 to March 31st 2026). This reduction is inclusive of the annual planning target to reduce growth in support function since 2022.

5.3.2 These reductions will be assessed for impact on quality and patient safety through the completion of a QEIA where required based on a clear set of criteria.

Options to deliver substantive workforce FTE reduction include:

1. ***Vacancy Controls*** have been developed and will be operationalised through Divisional Pay Control Panels. These controls are role specific, and monitoring will be undertaken via a workforce subgroup tasked with overseeing its implementation by Productivity and Financial Improvement Group (PFIG). Current leaver numbers demonstrate that significant savings can be achieved through turnover and attrition if vacancy controls are implemented, this will support delivery of the 300 FTE staff in post reduction required to deliver CIP.

2. ***Alternative options for delivery*** include permanent hours reductions, and there is potential for a Mutually Agreed Redundancy Scheme although, details are yet to be confirmed by NHSE. It is unlikely that redundancy will be a key driver of headcount reductions, because there is no funding available in year for redundancy costs and will likely take 9 months to achieve thereby not delivering in year savings.

5.3.2.1 **Other Staff in Post changes**

- The plan includes growth in funded headcount establishment of 175 FTE.
- This is associated with service developments, priority services and the group transitional investment requirements.
- Staffing to provide additional operating capacity associated with the Elective Centre is included within this figure. Recruitment will be phased over the year in preparation for September 2025, the date that UHBW will utilise the additional theatre capacity.

5.4 Workforce priorities in 2025/26

5.4.1 The workforce plan is predicated on the control of workforce numbers, primarily through the Divisional vacancy control process, delivery of identified workforce cost savings, reductions in high-cost agency and premium workforce costs and improvements in productivity.

5.4.2 PFIG will lead and oversee the delivery of work-streams through the following programmes/groups associated with workforce productivity and controls:

- Nursing Establishment Controls Group, including bank and agency controls.
- Medical and Dental Workforce advisory group oversees the job plan review. and agency controls. Agency controls will be monitored via the South West Regional Medical Sub-group and Strategic Workforce Oversight Group through the ICB and into NHSE
- Divisional Pay Control Panels and Strategic Delivery Group meetings.

5.4.3 The Trust Strategic Workforce Priorities are:

- Mission Critical Medical Workforce Plan
- Corporate Project Pro- Equity
- The People Strategy will be redrafted in collaboration with our Group partners at NBT.

6. Summary of key risks to delivery of the 2025/26 Operating Plan

6.1 Operational

- If the no criteria to reside bed consumption is not reduced there is a risk that availability of acute beds will impact on performance delivery
- There is a risk that urgent and emergency growth impacts planning assumptions
- There is a risk that the expected headcount reduction in the acute sector adversely impacts on performance delivery and quality of care, QEIAs will be used to mitigate this

- Failure of critical equipment / infrastructure due to CDEL constraints and access to clinical areas for redevelopment work
- Delivering improvements in productivity is fundamental to achievement of the plan, there is a risk that this will be slower to deliver than the plan allows
- Increasing follow up demand presents a risk to new to follow up ratio which could impact RTT performance delivery
- Impact of Collective Action from General Practice and Pharmacies and any further Industrial Action

6.2 Financial

- Corporate mitigations are not available in 2025/26, there is therefore a risk that the breakeven plan has no contingency available should, for example, savings delivery does not meet plan requirements
- There is a risk that the capital plan cannot be delivered in accordance with CDEL due to operational constraints, e.g. access to clinical areas, supplier lead times, project management capacity
- There is a risk of material misalignment between the Trust's income assumptions and the commissioner allocations, leading to non-delivery of the financial plan

Finance risks are further detailed in section 4.11.

6.3 Quality

- There is a risk that the QEIA process does not accurately capture the risks associated with CIP delivery and/or service developments and that there are unintended consequences on patient care/staff wellbeing
- There is a risk that areas of known quality and safety risks cannot be resolved within financial plan

6.4 Workforce

- There is a risk that recruitment to key long-standing vacancies is not achieved, therefore compromising operational delivery and/or savings plans
- There is a risk that vacancy controls place undue pressure on staff wellbeing therefore impacting key workforce metrics, such as turnover and sickness absence rates

7. Operating plan next steps and monitoring

7.1 Next steps

- The operating plan for 2025/26 has been approved, and received Board assurance, via the Finance, Digital and Estates Committee on 25th March 2025; the NHSE Board Assurance document can be seen in Appendix 3.
- UHBW has now moved into delivery. This involves further communication and engagement with Divisions, and with staff more widely, and the establishment of monitoring to ensure that delivery is kept on track throughout the financial year.
- Delivery of the plan will be led by the Clinical Divisions and supported by the Trust Executive and corporate functions.
- Included within the delivery of the plan are priorities for improving health inequalities. These have been developed in partnership with the ICS and can be seen in Appendix 4.
- Monitoring of the 25/26 Operating Plan will be ultimately overseen by the Trust Board, with Executive Committee providing oversight of the various Executive-led subgroups with responsibility for the different components of the plan: for example, the Planning and Delivery Group, the Capital Programme Steering Group, the Clinical Quality Group and the Performance and Finance Improvement Group.
- Where the UHBW operating plan interfaces with partner organisations, the Integrated Care System Operational Delivery Groups and Health and Care Improvement Groups will be utilised.
- Partnership working and collaboration will underpin both the delivery of the BNSSG System Plan and the UHBW Operating Plan for 2025/26.

7.2 Recommendations

7.2.1 The Trust Board is asked to note that the UHBW 2025/26 Operating Plan was approved by the Finance, Digital & Estates Committee and has been submitted to NHS England. UHBW has moved swiftly into delivery of the plan for the new financial year.

[i] 2025/26 priorities and operational planning guidance

Appendix 1: Productivity Data

Clinical and operational productivity

	University Hospitals Bristol and Weston NHS Foundation Trust Opportunity					
	Benchmarked position*	*Opportunity (£)*	*Assumed cost base of PoD (£)*	*Opportunity as % of spend*	*Cash releasing (£)*	*Extra activity / beddays*
1 Non-elective overnight stays	47 out of 135 acute and specialist trusts on opportunity as % of spend	£4.8m	£242.5m	2.0%	£2.4m	0.14 LoS opportunity (days) 6,522 Annual beddays opportunity
2 A&E and SDEC	100 out of 135 acute and specialist trusts on opportunity as % of spend	£2.9m	£143.6m	2.0%	£1.4m	2,684 SDEC
3 Elective opportunity	110 out of 135 acute and specialist trusts on opportunity as % of spend	£31.5m	£258.4m	12.2%	£15.7m	18,379 Episodes
4 Outpatient opportunity	80 out of 135 acute and specialist trusts on opportunity as % of spend	£4.3m	£114.9m	3.8%	£2.2m	9,560 Attends
5 Other acute	N/A Assessed as 2.0% of baseline spend	£3.3m	£165.5m	2.0%	£1.7m	N/A
Total ClinOps productivity		£46.8m	Total Trust Opex: £1,251m	3.7%	£23.4m	N/A

- UHBW's productivity opportunity is £46.8m of which NHSE expects 50% as cash releasing
- Trusts are ranked 1 to 135 in terms of opportunity as % of spend - 1st being the largest opportunity and 135th being the lowest (i.e. most productive). Non-elective overnight stays rank is exception to this rule, where UHBW is 47th best of 135.

Appendix 1: Productivity Data

	Efficiency			
	University Hospitals Bristol and Weston NHS Foundation Trust Opportunity			
	Benchmarked position*	***Opportunity (£)***	***Assumed cost base of PoD (£)***	***Opportunity as % of spend***
6 **Temporary staffing**	83 of 135 acute and specialist trusts on Temporary staffing (as % of pay)	£13.7m	£790m	1.7%
7 **Corporate services**	81 of 135 acute and specialist trusts on savings (as % of corporate services spend)	£8.5m	£65m	13.1%
8 **Medicines**	106 of 135 acute and specialist trusts on savings (as % of total medicine spend)	£2.2m	£189m	1.1%
9 **Commercial**	131 of 135 acute and specialist trusts on savings (as a % of non-pay spend, excluding medicines)	£0.5m	£323m	0.1%
Total Efficiency		£24.8m	Total Trust Opex: £1,251m	2.0%

- The Trust's efficiency opportunity is £24.8m
- The same ranking as for productivity applies – highest opportunity (least efficient) is most highly ranked (i.e. 1/135)

University Hospitals Bristol and Weston NHS Foundation Trust

Appendix 1: Productivity Data

#	Productivity area	From provider productivity pack	From provider productivity pack	Estimation of what can be delivered in 2025/26 (£m)	Activity productivity in plan (Volume)
1	Non-elective overnight	£4.80	2.00%	£2.40	
2	A&E and SDEC	£2.90	2.00%	£1.00	10,934
3	Elective opportunity	£31.50	12.20%	£12.80	1,201
4	Outpatient opportunity	£4.30	3.80%	£1.90	12,849
5	Other acute activity	£3.30	2.00%	£1.30	
6	Temp staffing	£13.70	1.70%	£14.00	
7	Corp services	£8.50	13.10%	£6.90	
8	Medicines	£2.20	1.10%	£1.70	
9	Commercial	£0.50	0.10%	£1.50	
10	Other local opportunities			£9.50	
	Total	**£71.70**		**£53.00**	**24,984**

- UHBW's operational productivity opportunity is £46.8m of which NHSE expects 50% as cash releasing. Trust efficiency is identified as an additional £24.9m.
- An internal assessment of opportunities shows expected savings of £53.0m
- Currently there are £48.5m in the Trust savings programme relating to productivity.
- 24,984 volume of additional clinical activity through productivity – 3.5% ELIP, 1% Day Case, 6.1% OPFA, 5.2% ED attendance.

2025/26 FINANCIAL PLAN & BUDGET – Appendix 2: CIP Maturity Levels

Subjective Type	Subjective	1	2	3	4	Total
Pay	Admin & Clerical & Estates	£553	£644	£334		£1,530
	Medical staff - Consultants	£829	£559	£2,988		£4,376
	Medical staff - Other	£374	£217	£863		£1,454
	Non Clinical Staff	£147	£515	£308		£969
	Nursing & Midwifery	£804	£4,642	£2,922		£8,368
	Other Clinical Staff	£58	£563	£467		£1,088
	Healthcare Assistants			£299		£299
	Vacancy – Other			£9,893		£9,893
Pay Total		**£2,766**	**£7,139**	**£18,071**	**£0**	**£27,976**
Non pay	Blood	£235	£115			£350
	Clinical Supplies	£426	£3,773	£3,001		£7,200
	Drugs	£397	£775	£529		£1,700
	Establishment Expenses	£137				£137
	Lease	£45				£45
	Other Expenditure	£482	£5,212	£1,711		£7,405
Non pay Total		**£1,722**	**£9,874**	**£5,241**	**£0**	**£16,837**
Income	Income from Activities	£431	£1,520	£251		£2,202
	Income from Operations	£160	£862	£438		£1,460
Income Total		**£591**	**£2,382**	**£689**	**£0**	**£3,662**
Unidentified					**£4,525**	**£4,525**
Grand Total		**£5,078**	**£19,395**	**£24,001**	**£4,525**	**£53,000**
		10%	**37%**	**45%**	**9%**	**100%**

- £28.0m of plans relate to workforce cost reductions (53%)
- £16.8m of plans relate to non-pay cost reductions (32%)
- £3.7m of plans relate to income generation (7%)
- 47% / £24.5m of identified schemes are categorised as maturity level 1 or 2
- 45% / £24.0m of identified schemes are categorised as maturity level 3
- 9% / £4.5m are unidentified and categorised as level 4

Appendix 3 - Board Assurance Framework- Provider Assurance

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has systematically reviewed and assured the operational, workforce and financial plans for 2025/26 that form the basis of the organisation's submissions to NHS England.	YES	Approach and scenarios discussed and agreed at Finance Committee (FDEC) January 2025, detailed review undertaken at Private Board on 11th March. Final approval delegated to FDEC with all components of operating plan approved on 25th March.
The Board has reviewed its quality and finance governance arrangements, and put in place a clinically led process to support prioritisation decisions.	YES	The plan has been developed and delivered through the Planning and Delivery Group, involving Divisional Clinical Chairs and the Executive Committee, with CMO and CNO engagement within UHBW's corporate governance and in bespoke clinical review sessions over the course of the process.
Prioritisation decisions were reviewed by the Board, including explicit consideration of the principles set out in planning guidance.	YES	Planning guidance and the key principles were shared with the Board. All prioritisation decisions have been made in conjunction with Divisions and Executives, with the prioritisation proposals presented to the Board.

A robust quality and equality impact assessment (QEIA) informed development of the organisation's plan and has been reviewed by the Board.	YES	QEIA process refreshed in March 2024. Operational for a year now and working in line with NHSE principles for local prioritisation. Quarterly reporting is to Clinical Quality Group with opportunity for escalation into the Quality and Outcomes Committee as required. Detailed QEIA will continue to be undertaken on CIP schemes over the course of the financial year.
The organisation's plan was developed with appropriate input from and engagement with system partners.	YES	Operational delivery groups for urgent, elective and children's care, HCIGs for community and acute, MH and Children's. Tertiary Services Programme Board.
Plan content and delivery		
The Board has systematically reviewed and is assured that it has plans in place address the key opportunities to meet the national priorities for the NHS in 2025/26. This includes the actions against the national delivery plan 'checklists' and the use of benchmarking to identify unwarranted variation / improvement opportunities.	YES	National productivity information has been used to inform our planning priorities and decisions. Approach and application to performance and savings delivery shared with Board, including a detailed review of the response to the NHSE Productivity Pack.
The Board is assured that all possible realistic in-year productivity and efficiency opportunities have been considered and are reflected across the organisation's operational, workforce and financial plans.	YES	As above
The Board is assured that any key risks to quality linked to the organisation's plan have been identified and appropriate mitigations are in place.	YES	The management of risks and quality issues has been core to UHBW's planning approach, informed our decision making and been embedded into all components of the final plan.

The Board is assured of the deliverability of the organisation's operational, workforce and financial plans. This includes appropriate profiling and triangulation of plan delivery, and mitigations against key delivery challenges and risks.	YES	Full triangulation of plan between finance, performance and workforce has been completed. The risks to the delivery of the plan have been articulated. Delivery of the plan will be contingent on system delivery of critical interrelated components, most prominently achievement of 15% NCTR.

Appendix 4 – 2025/26 Health inequalities priorities

Priority focus	Guidance	2025/26 UHBW Priorities and approach
Data insights and sharing	**Reforming Elective Care:** · *demonstrable improvements in the completeness and accuracy of coding and recording practices, including ethnicity and housing status coding, by using relevant SNOMED codes*	· Ethnicity recording – continue to aim for 80%+ of RTT waiting list. · Exploring with ICB/NBT a consistent approach to sharing and recording of data on housing status
Elective waiting times	**Reforming Elective Care:** · *undertake quarterly reviews of local waiting list data (children and young people and adults) to better understand areas of inequality, looking at deprivation and ethnicity and using wider Core20PLUS5 approaches* · *embed health inequalities data into performance reporting with a quarterly review at board level*	· Inequalities Performance dashboard available to all specialties and Clinical Divisions for their review. Quartey Board reporting in place · Divisions reporting Health Inequalities data and actions through Division Assurance Reports at Health Equity Delivery Group. To consider Health Inequalities deep dives at Divisional Reviews.
Outpatient access	**Reforming Elective Care:** · *develop and monitor action plans to reduce inequalities in access and quality of Care*	· All Divisions will work on reducing DNAs in services with the largest disparity with DNAs for IMD 1 and 2 and Global Majority groups, relative to overall DNA rates (i.e. Reduce DNAs and narrow the gap)
Prevention	**System priorities:** · Tackling Tobacco Dependency (TTD) in maternity and inpatient settings (system ambition to reduce smoking prevalence below 5% by 2030) · Healthy weight declaration being finalized	· Roll out and embed admissions forms with smoking status, Very Brief Advice and referral to TTD · Commit to Healthy Weight Declaration and develop action plan

Lead Governor Activity Report

Reporting period: 21/11/2024 – 13/05/2025

1. Purpose

This report is for information. It sets out the Lead Governor's attendance at events and engagement with Trust colleagues, system partners, and others during the reporting period.

2. Background

The Lead Governor has undertaken to regularly update his fellow Governors, detailing relevant engagements he has undertaken.

3. Lead Governor and Trust Chair Meetings

Ben Argo and Joint Chair Ingrid Barker have a regular one to one. These conversations have highlighted:

a. The Joint Chair's site visits and learning of the operation of both Trusts
b. Development of the Hospital Group model and single managed services
c. The Joint Chair's activity and engagement with the Integrated Care Partnership Board
d. Involvement and collaboration with NBT's Patient Participation Forum
e. Digital transformation
f. The new Elective Care Centre and Community Diagnostic Hubs
g. Governor elections and Trust membership
h. Group Board recruitment and appointment process

4. Activity as Lead Governor

Since the last Council of Governors in November 2024, updates to share with the wider Council of Governors include:

a. I have attended many of the regular meetings that Governors are invited to, including:
    - Governor/NED Engagement Sessions in December, March, and April.
    - the Trust board meetings in public in January, March and May.
    - the hospital group's board-in-common in April and May.
    - Governor Development Seminars in January, February, and April. The April Seminar included a site tour of the Bristol Dental Hospital.
    - Quality Focus Groups in January, March, and May.
    - Governor's Strategy Groups in March and May.
    - the Extraordinary Council of Governors meeting in April.

b. I have met regularly with the Corporate Governance team to get introduced to the new role of lead governor, feed back the views of Governors on important matters, and obtain advice on how I can support my fellow Governors in my new role.
c. I have met regularly with the Deputy Lead Governor, Martin Rose. We have found our discussions helpful as a sounding board.
d. Linking with other Trusts:

- Following on from the Governor Development Seminar on 9th April, having listened to feedback from Governors, I linked up with Membership teams at Kettering General Hospital NHS Foundation Trust. The team were very helpful and I hope Governors found their input at the Council of Governors meeting on 23rd April.
- I have linked up with Chris Witham, Lead Governor for Gloucestershire Health and Care NHS Foundation Trust. Chris is an experienced Lead Governor and we have committed to meet regularly as part of measures to support me in my role as Lead Governor for UHBW.

e. I have regularly attended the Accessible Information and Communication (AIC) Steering Group, alongside fellow governor Rob Edwards. This group oversees the implementation of the Accessible Information Standard. Papers from this group are received by Governors at the Quality Focus Group.
f. In the run up to Governor elections, I attended membership drop-in sessions in Patchway and Yate. I also visited UWE's Glenside Campus in a bid to drive up membership numbers among students from the School of Health and Social Wellbeing.
g. I joined the shortlisting panel for the Full-Hearted Care Awards.
h. I have undertaken two solo site visits, which I have found eye opening. During these site visits, I was able to focus attention on accessibility barriers for patients, carers and staff.
    - I toured level five of Bristol Royal Hospital for Children with the Deputy Director of Nursing. We walked around Bluebell Ward, Sunflower Ward, other neurosciences services and the in-house school. We primarily discussed and reviewed accessibility arrangements for staff with limited mobility, mental health conditions (e.g. PTSD), and autism.
    - I toured the emergency departments at both the Bristol Royal Hospital for Children and the Bristol Royal Infirmary with the Ambulatory Emergency Care Lead. We discussed and reviewed new adaptations for children and adults with learning disabilities or autism.

5. Activity outside UHBW

Outside the Trust, I have been involved in several key activities:

a. Took part in workstreams with system partners, including GPs, Avon and Wiltshire Mental Health Partnership NHS Trust, and BNSSG Integrated Care Board, to transform the Primary Care Liaison Service across the region.
b. Continued my work with Avon and Wiltshire Mental Health Partnership NHS Trust on the implementation of the Accessible Information Standard and other involvement work.
c. Attended BNSSG ICB's workshop on the NHS Ten Year Plan in Fishponds, Bristol.
d. Observed North Bristol NHS Trust's Learning Disability and Autism Steering Group.
e. Presented a Patient Story to the Board of Directors in Public of Avon and Wiltshire Mental Health Partnership NHS Trust.
f. Taken part in an advisory group on prescribing of medications in autistic people- looking at trends, inequalities and outcomes in relation to mental and physical health medications with the University of Bristol.

6. Items for the attention of Governors

I have found the board-in-common meetings particularly insightful. I would encourage my fellow Governors to make time to either attend in person or watch the videos back online while they are on YouTube. As we go through this phase of appointing joint NEDs, being able to scrutinise the performance of our NEDs and focus on our goal of holding them to account individually and collectively for the performance of the board.

I hope in my first six months as Lead Governor I have demonstrated my willingness to work with both fellow Governors and the Trust. It is my intention to foster a growing culture of transparency and collaboration between Governors and NEDs.

I look forward to welcoming our newly elected Governors to their role come 1st June. If I think back to three years ago when I was first elected, our then Lead Governor was instrumental in me finding my feet. I intend to pay that forward, by being open and approachable for all Governors.

Finally, can I express my thanks to Carole Dacombe, Tom Frewin, John Sibley, and Libby Thompson for their services as Governors.

7. Summary and recommendations

The Council of Governors is asked to note the contents of this report.

Ben Argo
Lead Governor and Public Governor for South Gloucestershire

Report To:	Council of Governors		
Date of Meeting:	Wednesday 21st May 2025		
Report Title:	Governor Activity and Membership Forward Look		
Report Author:	Emily Judd, Corporate Governance Manager		
Report Sponsor:	Eric Sanders, Joint Chief Corporate Governance Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	This report provides a summary of governor activity since the last Council of Governors meeting in November 2024, to provide assurance that governors are carrying out their statutory duties, particularly their duty to hold the Chair and Non-Executive Directors to account.		

Key Points to Note *(Including any previous decisions taken)*

It includes an activity summary for the three main groups through which the governors carry out most of their work (the Governors' Strategy Group, the Quality Focus Group and the Membership and Constitution Group), and any other governor activity in the period.

Strategic and Group Model Alignment

This report and its recommendations align with the Trust's 'Experience of Care' Strategic Improvement Priority.

Risks and Opportunities

None

Recommendation

This report is for **Information**

The Council of Governors is asked to note the report.

History of the paper (details of where paper has <u>previously</u> been received)

N/A

Appendices:	None

Governor Activity Report and Membership Forward Look

1. Purpose

1.1 This report provides a summary of governor activity since the last Council of Governors meeting, to provide assurance that governors are carrying out their statutory duties, particularly their duty to hold the Chair and Non-Executive Directors (NEDs) to account.

2. Background

2.1 This report includes an activity summary for the main groups through which the governors carry out most of their work and any other governor activity in the period.

3. Governor Activity

3.1 Since the last Council of Governors meeting on 21st November 2024:

3.1.1 One Governor has stood down from their role as Public Governor for South Gloucestershire. This position was added to the election campaign held earlier in 2025.

4. Governor Meetings

4.1 Quality Focus Group

4.1.1 There have been three meetings of the Quality Focus Group since the last report. Agenda items included updates from the Quality and Outcomes Committee Chair and the People Committee Chair, as well as an update on Pro-equity, Communications and the National Staff Survey Results. There were also Trust Priority spotlights on Timely Care and Our People.

4.2 Governors' Strategy Group

4.2.1 There have been two meetings of the Governors' Strategy Group since the last report. Agenda items included updates from the Finance, Digital and Estates Committee Chair, as well as an update on the Estates Strategy, the Hospital Group Model, PLACE Assessments from 2024 and the Information Sharing Charter Survey – Patient engagement.

4.3 Membership and Constitution Group

4.3.1 There was one meeting of the Membership and Constitution Group since the last meeting. This meeting discussed the annual Representation of members, a Membership Strategy Update, Governor Elections and heard from the Audit Committee Chair.

4.3.2 Further to a meeting of the Governors, it was agreed to amalgamate all items usually discussed within the Membership and Constitution Group into the Quality Focus Group and Governors Strategy Group meetings. To ensure Governors receive the same number of meetings and time dedicated to those meetings, the Governors Strategy Group will now meet every other month.

4.4 Nominations and Appointments Committee

4.4.1 There has been one meeting of the Nominations and Appointments Committee (NOMCO) since the last report. Agenda items included the NED Activity Reports, plans for NED Recruitment in line with the Hospital Group, and the Group Chair and NED Appraisal processes for 2025.

4.4.2 During the Extraordinary Council of Governors meeting in Private on 23rd April 2025, the Council of Governors approved the extension of the Terms of office for Sue Balcombe, Marc Griffiths and Roy Shubhabrata until 31 August 2025.

5. Other Governor Activity

5.1 Governor and Non-executive Director Engagement Sessions

5.1.1 Governors joined the Non-Executive Directors for an engagement session in December 2024, March 2025 and April 2025. Questions were asked around the implementation of Martha's Rule,

Post-discharge treatment and access, sharing of information between providers, the Hospital Group Model, the Paediatric Bone Marrow Transplant service, No Criteria to Reside, Mobility and access to Hospitals, Use of space in the Dental Hospital, Progress on the Trust Priorities, NED Performance and Workforce Fatigue.

5.1.2 New 'Session Topic' reports have been created and uploaded to the Convene Paperless Board Portal for Governors and Non-executive Directors to track conversations held in this area.

5.2 **Governor Development Seminars**

5.2.1 During February's Development Seminar, the Governors heard about the work that had been done in relation to the Annual Operating Plan for 2025/26, and the development of the Hospital Group and engaging the Governors in discussions over the changes to the Trust constitution, the Summary Benefits case and the Group name.

5.2.2 In April's Governor Development Seminar, Governors were invited to be part of the Annual Quality Statement, heard from the Bristol and Weston Hospitals Charity about their new strategy and received another update on the development of the Hospital Group. After a conversation around the Governors meetings in 2025/26, the Governors were given a tour of the Bristol Dental Hospital.

5.3 **Public Board Meetings**

5.3.1 There have been four Public Board Meetings since the last Council of Governors meeting. A number of Governors have attended these meetings in person and watched the recordings added to the Trust Website.

5.3.2 From April 2025, all Public Board meetings have met in common with North Bristol NHS Trust (NBT).

5.4 **Staff Governor Meeting**

5.4.1 In March 2025, the Staff Governors met with Emma Wood, Chief People Officer. Discussions were held around the Annual Operating Plan for 2025/26 and the constraints placed on NHS Trusts to stay within budget.

5.5 **Induction Marketplace**

5.5.1 Staff Governors have attended recent UHBW Staff Induction marketplaces in Bristol and Weston; a space for new starters joining the Trust to hear more about the additional roles people undertake within the Trust and how they can get involved. Moving forward, this visibility will ensure that staff know of another route to escalate concerns and good news stories and ensure their voice is heard at Board-level when decisions are being made.

6. Governor Elections

6.1 Governor Elections were held from 3rd February – 17th April 2025. During this time, there was a Nominations period (from 3rd February – 3rd March) and an election period (from 24th March – 17th April). Results were declared on 22nd April and new Governor terms start on 1st June.

6.2 There were 15 seats up for election in this period, however during the election period one Governor stood down from his role and so an additional seat was available in the Public – South Gloucestershire constituency. The seats for election were:

- Staff – Nursing and Midwifery – 2 seats
- Staff – Other Clinical Healthcare Professions – 1 seat
- Staff – Medical and Dental – 1 seat
- Public, Rest of England and Wales – 2 seats
- Public, Bristol – 7 seats
- Public, South Gloucestershire – 2 seats

6.3 There were eight Governors who were finishing their terms of office, of which six were able to stand for another term. All six Governors stood for re-election.

6.4 In total, 25 nominations were received across all constituencies. Seats in the Staff – Nursing and Midwifery and Staff – Medical and Dental Constituencies were elected unopposed, but all other constituencies went to ballot.

6.5 There were 662 votes cast across all ballots, from a total of 5,455 eligible voters (12.14% turnout). The results were:

- Bristol: John Chablo (re-elected), Robert Edwards (re-elected), Martin Rose (re-elected), Chloë Somers, Wendy Hurn, Paul Wheeler and Phil Smith
- Rest of England and Wales: Mark Patteson (re-elected) and Carolyne Crowe
- South Gloucestershire: Ben Argo (re-elected), David Chandler and Paul Cousins*
- Staff – Other Clinical Healthcare: Esther Obafemi
- Staff – Medical and Dental: Megan Crofts (uncontested)
- Staff – Nursing and Midwifery: Remi George and Rachel Harkness (uncontested)

6.6 *During the election period, Tony Tanner stood down from his role and so the third candidate was offered this seat.

7. Membership and Governors Forward Look

7.1 Focus will now turn to inducting new Governors into the Trust and providing them with the skills and knowledge to fulfil their roles. Some current Governors have offered to 'buddy' new Governors so there is an additional source of support, and a full induction seminar is planned to provide new Governors with information about their new roles.

7.2 A Governors Self-Assessment Questionnaire has been provided to all Governors to give feedback on the role and effectiveness of the Council of Governors, and will provide the Corporate Governance Team with actions to help support the Council of Governors to perform their duties.

7.3 Governors will be invited to take part in the next round of NED Recruitment.

7.4 The Governors will meet with NEDs in June 2025 for their next engagement session.

7.5 The Governors will meet for their next focus groups in July 2025.

8. Summary and Recommendations

8.1 This report is for **Information**.

The Council of Governors is asked to note the report.

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Council of Governors		
Date of Meeting:	Wednesday 21st May 2025		
Report Title:	Amendment of the Constitution		
Report Author:	Mark Pender, Head of Corporate Governance		
Report Sponsor:	Eric Sanders, Joint Chief Corporate Governance Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	The Council of Governors is asked to approve the amended Standing Orders Annexes 4 and 5 of the Trust's Constitution.		

Key Points to Note *(Including any previous decisions taken)*

1. A thorough and robust review of the UHBW Constitution, and of NBT's Standing Orders, has been completed to support the implementation of the Group. The review has been supported by Hill Dickinson LLP.

2. The aim of the review, alongside making sure that decision-making and levels of delegation are consistent, is to ensure that the documents meet current best practice, current legislative requirements and are streamlined. It was noted that over time, the complexity of the documents had grown significantly without necessarily adding extra value.

3. As a result of this review, the Standing Orders of the Council of Governors (Annex 4 to the Constitution) and the Standing Orders of the Board of Directors (Annex 5 to the Constitution) have been amended. Key changes/updates include:

   - Adopting consistent definitions
   - Alignment of notice periods for calling meetings of the Board(s)
   - Recognition that decisions are rarely taken by vote, and that consensus decisions are sought in the first instance.
   - Streamlining wording on "declarations of interest", with reference to the current NHSE guidance on this topic (avoiding the risk that the SOs fall out of date as the guidance is updated).

4. Governors received a presentation on the proposed changes from Hill Dickenson at their development seminar held in February 2025.

5. The amended documents are attached as appendixes 1 and 2 to this report. No other changes to the Constitution are proposed at the current time, although this is being kept under review as the Bristol NHS Group develops.

6. The Board of Directors considered these amendments at its public meeting held in common with the NBT Board of Directors on 8 April 2025 and recommended their approval to the Council of Governors.

Strategic and Group Model Alignment	
The alignment of the Trusts governance is a key enabler to ensuring that the Group, and particularly the decision making of the Trusts, can work as efficiently and effectively as possible, and within a consistent framework.	
Risks and Opportunities	
This represents a significant opportunity to align the Trusts decision making and to remove non-value adding content. The changes mean that colleagues, when referring the documents, will have confidence that the same rules apply in both Trusts, and where they fifer these are highlighted. The risk of not doing this, is that decision making may be misaligned resulting in different decisions or delays to decision making.	
Recommendation	
This report is for **Approval.** **The Council of Governors is asked to approve the proposed amended Standing Orders of the Council of Governors (Annex 4 to the Constitution) and Standing Orders of the Board of Directors (Annex 5 to the Constitution).**	
History of the paper (details of where paper has previously been received)	
Meeting of the Board of Directors of UHBW and NBT held in common	8 April 2025
Appendices:	*Appendix 1 – Standing Orders of the Council of Governors* *Appendix 2 – Standing Orders of the Board of Directors*

ANNEX 4: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

INTERPRETATION AND DEFINITIONS

1.1 In these Standing Orders (SOs), the provisions relating to Interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning and in addition:

2006 ACT	means the National Health Services Act 2006.
ACCOUNTING OFFICER	means the officer with responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matter, in accordance with the 2006 Act.
APPOINTED GOVERNORS	means the Governors who are appointed in accordance with the Constitution.
CHIEF EXECUTIVE OFFICER	means the chief officer of the Trust and the Accounting Officer and holds the role of Joint Chief Executive of both University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust.
COMMITTEE	means a committee or sub-committee appointed by the Trust.
COUNCIL OF GOVERNORS	means the council comprising the Elected Governors and the Appointed Governors.
DIRECTORS	means the Executive Directors and the Non-Executive Directors.
ELECTED GOVERNORS	means the Governors who are elected in accordance with the Constitution.
EXECUTIVE DIRECTOR	means is an officer of the Trust.
NON-EXECUTIVE DIRECTOR	means a person who is appointed to the Board of Directors who is not an Executive Director.
SOs	means Standing Orders.
STAFF CONSTITUENCY	means the staff constituency constituted in accordance with the Constitution.

MEETINGS OF THE COUNCIL OF GOVERNORS

Calling Meetings:

1.2 Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least fourteen days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Trust's website. Notice shall be presumed to have been served two days after posting and one day after being sent out via email or portal. The Secretary shall ensure that within the meeting cycle of the Council of

Governors, general meetings are called at appropriate times to consider matters as required by the 2006 Act and the Constitution.

1.3 If the Chair fails to call a meeting of the Council of Governors after a requisition for that purpose, signed by at least one-third of the whole number of the Council of Governors has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them at the Trust's Headquarters, such one third or more members of the Council of Governors may forthwith call a meeting.

1.4 **Admission of the Public and the Press**– The meetings of the Council of Governors shall be open to members of the public and press unless the Council of Governors decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Council of Governors following the exclusion of members of the public and/or press shall be confidential to the members of the Council of Governors. Governors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

1.5 In the event that the public and press are admitted to all or part of a meeting by reason of SO item 1.4 above, the Chair (or Vice Chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Council of Governors resolving "that in the interests of public order the meeting adjourn for (*the period to be specified*) to enable the Board to complete business without the presence of the public".

1.6 The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Council of Governor meetings.

1.7 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Council of Governors. Such permission shall be granted only upon resolution of the Trust.

1.8 The Council of Governors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

1.9 **Chair of Meetings** – The Chair of the Trust, or in their absence, the Vice Chair, is to preside at meetings of the Council of Governors.

1.10 The Vice Chair may preside at meetings of the Council of Governors in the following circumstances:

1.10.1 When there is a need for someone to have the authority to chair any meeting of the Council of Governors when the Chair is not present.

1.10.2 On those occasions when the Council of Governors is considering matters relating to Non-Executive Directors and it would be inappropriate for the Chair to preside.

1.10.3 When the remuneration, allowance and other terms and conditions of the Chair are being considered.

1.10.4 When the appointment of the Chair is being considered, should the current Chair be a candidate for re-appointment.

1.10.5 On occasions when the Chair declares a pecuniary interest that prevents them from taking part in the consideration or discussion of a matter before the Council of Governors.

1.11 **Setting the Agenda –** The Council of Governors may determine that certain matters shall appear on every agenda for a meeting of the Council of Governors and shall be addressed prior to any other business being conducted.

1.12 **Agenda** – A Governor desiring a matter to be included on an agenda shall specify the question or issue to be included by request in writing to the Chair or Secretary at least five working days before Notice of the meeting is given. Requests made less than five working days before the Notice is given may be included on the agenda at the discretion of the Chair. Agendas will normally be sent to members of the Council of Governors five working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three working days before the meeting, save in emergency.

1.13 **Notices of Motion** – A Governor desiring to move or amend a motion shall send a written notice thereof at least five working days before the meeting to the Chair or Secretary, who shall insert in the agenda for the meeting all notices so received subject to the Notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without Notice on any business mentioned on the agenda, subject to the Chair's discretion.

1.14 **Withdrawal of Motion or Amendments** – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

1.15 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall be in writing by the Governor who gives it and also four other Governors. When any such motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chair to propose a motion to the same effect within six months; however the Chair may do so if they consider it appropriate.

1.16 **Motions** – The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

1.17 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

1.17.1 An amendment to the motion.

1.17.2 The adjournment of the discussion or the meeting.

1.17.3 That the meeting proceed to the next business.

1.17.4 That the motion be now put.

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

1.18 **Chair's Ruling** – Statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

1.19 Save as permitted by law, at any meeting the person presiding shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive).

1.20 **Voting** – Save as otherwise provided in the Constitution and/or the 2006 Act, if the Chair so determines or if a Governor requests, a question at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a casting vote.

1.21 All questions put to the vote shall, at the discretion of the person presiding, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

1.22 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

1.23 If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

1.24 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

1.25 **Minutes** – The Minutes of the proceedings of a matter shall be drawn up and submitted for agreement at the next ensuing meeting.

1.26 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

1.27 **Suspension of Standing Orders** – Except where this would contravene any statutory provision, or any provision of the Constitution, any one or more of the SOs may be suspended at any meeting provided that at least two thirds of the Council of Governors are present, including one Public Governor and one Staff Governor, and that a majority of those present vote in favour of suspension.

1.28 A decision to suspend SOs shall be recorded in the minutes of the meeting.

1.29 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Governors.

1.30 No formal business may be transacted while SOs are suspended.

1.31 **Record of Attendance** – the names of the Governors present at the meeting shall be recorded in the minutes.

1.32 **Quorum** – A meeting of the Council of Governors shall be quorate and quoracy shall require that there shall be present at the meeting not less than 50% of all Governors and of those not less than 51% shall be Elected Governors (excluding those Governors representing the Staff Constituency).

1.33 A Governor who has declared a non-pecuniary interest in any matter may participate in the discussion and consideration of the matter but may not vote in respect of it: in these circumstances the Governor will count towards the quorum of the meeting. If a Governor has declared a pecuniary interest in any matter, the Governor must leave the meeting room, and will not count towards the quorum of the meeting, during the consideration, discussion and voting on the matter. If a quorum is then not available for the discussion and/or the passing or a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

1.34 Subject to SOs in relation to interests, any Director or their nominated representatives shall have the right to attend meetings of the Council of Governors and, subject to the overall control of the Chair, to speak to any item under consideration.

COMMITTEES

1.35 The Council of Governors shall exercise its functions in general meeting and shall not delegate the exercise of any function or any power in relation to any function to a committee.

DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

1.36 **Declaration of Interests** – in accordance with the Constitution, Governors are required to declare formally any direct or indirect pecuniary interest and any other interest which is relevant and material to the business of the Trust. The responsibility for declaring an interest is solely that of the Governor concerned.

1.37 A Governor must declare to the Secretary:

1.37.1 any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, and

1.37.2 any interests which are relevant and material to the business of the Trust.

1.38 Such a declaration shall be made by completing and signing a form, as prescribed by the Secretary from time to time setting out any interests required to be declared in accordance with the Constitution or these SOs and delivering it to the Secretary within 28 days of a Governor's election or appointment or otherwise within seven days of becoming aware of the existence of a relevant or material interest. The Secretary shall amend the Register of Interests upon receipt of notification within three working days.

1.39 If a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter and, if they have declared a pecuniary interest, they shall not take part in the consideration or discussion of the matter. The provisions of this paragraph are subject to paragraph

1.40 Interests are as defined in NHSE's Managing conflicts of interest in the NHS guidance.

1.41 Any travelling or other expenses or allowances payable to a Governor in accordance with this Constitution shall not be treated as a pecuniary interest.

1.42 Subject to any other provision of this Constitution, a Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

1.42.1 they, or a nominee of theirs, is a director of a company or other body not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

1.42.2 they are a partner, associate or employee of any person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the same.

1.43 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

1.43.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

1.43.2 of an interest in any company, body, or person with which they are connected as mentioned in paragraphs 4.2, 4.5 and 4.7, which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

1.44 Where a Governor:

1.44.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

1.44.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

1.44.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

1.45 the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty discloses their interest.

1.46 In the case of persons living together the interest of one partner or spouse shall, if known to the other, be deemed for the purposes of these SOs to be also an interest of the other.

1.47 If Governors have any doubt about the relevance of an interest, this should be discussed with the Corporate Governance Team.

1.48 **Register of Interests –** the Corporate Governance Team shall record any declarations of interest made in a Register of Interests kept by the Trust in accordance with paragraph 36 of the Constitution. Any interest declared at a meeting shall also be recorded in the minutes of the meeting.

1.49 The register will be available for inspection by members of the public free of charge at all reasonable times. A person who requests it is to be provided with a copy or extract from the register. If the person requesting a copy or extract is not a member of the Trust, then a reasonable charge may be made for doing so.

STANDARDS OF BUSINESS CONDUCT

1.50 **Policy –** in relation to their conduct as a Governor of the Trust, each Governor must comply with the Code of Conduct for Governors. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Governors are expected to be impartial and honest in the conduct of official business.

1.51 **Interest of Governors in Contracts** – if it comes to the knowledge of a Governor that a contract in which they have any pecuniary interest not being a contract to which they are themselves a party, has been, or is proposed to be, entered into by the Trust, they will at once give notice in writing to the Corporate Governance Team of the fact that that they are interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

1.52 A Governor shall not solicit for any person any appointment in the Trust.

REMUNERATION

1.53 Governors are not to receive remuneration.

PAYMENT OF EXPENSES TO GOVERNORS

1.54 The Trust will pay travelling expenses to Governors at the prevalent NHS Public Transport rate for attendance at General Meetings of the Governors, or any other business authorised by the Corporate Governance Team as being under the auspices of the Council of Governors.

1.55 Expenses will be authorised and reimbursed through the Director of Corporate Governance's office on receipt of a completed and signed expenses form provided by the Corporate Governance Team.

1.56 A summary of expenses paid to Governors will be published in the Trust's Annual Report.

MISCELLANEOUS

1.57 **Review of Standing Orders** – These Standing Orders shall be reviewed annually by the Council of Governors and any requirements for amendments must be approved by both the Board of Directors and the Council of Governors.

1.58 **Vice Chair** – In relation to any matter concerning the Council of Governors or a Governor outside of a meeting of the Council of Governors which arises, the Vice Chair may exercise such power as the Chair would have in those circumstances.

1.59 **Notice** – Any written notice required by these SOs shall be deemed to have been given on the day the notice was sent to the recipient.

1.60 **Confidentiality** – A Governor shall not disclose any matter reported to the Council of Governors notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors shall resolve that it is confidential.

COUNCIL OF GOVERNORS: NOMINATIONS AND APPOINTMENTS COMMITTEE

1.61 The Chair and other Non-Executive Directors shall be appointed following a process of open competition conducted in accordance with a policy to be agreed by the Council of Governors.

1.62 The Council of Governors shall establish a committee of its members to be called the Nominations and Appointments Committee ("the Committee") to discharge those functions in relation to the selection of the Chair and Non-Executive Directors described in Terms of Reference to be approved by the Council of Governors.

UHBW CONSTITUTION ANNEX 5 STANDING ORDERS DIRECTORS

JANUARY 2025

Note:

This is an updated version of UHBW's Standing Orders, which forms part of UHBW's Constitution.

NBT's Standing Orders are in the same format and the numbering is aligned in both NBT's and UHBW's documents. UHBW-specific terms appear at the end of sections.

ANNEX 5: STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

INTRODUCTION

University Hospitals Bristol and Weston NHS Foundation Trust (the Trust) is a public benefit corporation established under the National Health Service Act 2006.

These Standing Orders form part of the Trust's Constitution in accordance with the 2006 Act.

1 INTERPRETATIONS AND DEFINITIONS

1.1 Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive).

1.2 For convenience, and unless the context otherwise requires, the terms and expressions contained within the Interpretations and Definitions section of the Constitution at page 4 are incorporated and are deemed to have been repeated here verbatim for the purposes of interpreting words contained in this Annex 5 and in addition:

2006 ACT	means the National Health Services Act 2006.
2022 ACT	means the Health and Care Act 2022.
ACCOUNTING OFFICER	means the officer with responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matter, in accordance with the 2006 Act.
AUDIT COMMITTEE	means a committee whose functions are concerned with providing the Trust Board with a means of independent and objective review and monitoring financial systems and information, quality and clinical effectiveness, compliance with law, guidance and codes of conduct, effectiveness of risk management, the processes of governance and the delivery of the Board assurance framework.
CHIEF EXECUTIVE OFFICER	is the chief officer of the Trust and the Accounting Officer and holds the role of Joint Chief Executive of both University Hospitals Bristol and Weston NHS Foundation Trust and North Bristol NHS Trust.

COMMISSIONING	means the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
COMMITTEE	means a committee or sub-committee appointed by the Trust
COMMITTEE MEMBERS	shall be persons formally appointed by the Trust to sit on or to chair specific committees.
CONTRACTING AND PROCURING	means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
DIRECTORS	means the Executive Directors and the Non-Executive Directors
EXECUTIVE DIRECTOR	means is an officer of the Trust.
FUNDS HELD ON TRUST	means those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Schedule 6, paragraph 8 of the 2006 Act. Such funds may or may not be charitable.
GROUP	means the hospital group established by the Trust and North Bristol Trust.
HOSPITAL MANAGING DIRECTOR	means the Executive Director who provides day-to-day leadership and line management of the executive team, reporting to the Chief Executive Officer.
NHS ENGLAND	means the body which is responsible for the oversight of NHS Foundation Trusts.
NOMINATED OFFICER	means an Officer charged with the responsibility for discharging specific tasks within Standing Orders and standing financial instructions.
NON-EXECUTIVE DIRECTOR	means a person who is appointed to the Board of Directors who is not an Executive Director.
OFFICER	means an employee of the Trust or any other person holding a paid appointment or office with the Trust.
SFIs	means Standing Financial Instructions
SOs	means Standing Orders
VOLUNTARY ORGANISATION	means a body, other than a public or local authority, the activities of which are not carried on for profit.

2 **THE BOARD**

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be held in the name of the Trust as corporate trustee.

2.3 The power of the Trust shall be exercised in public or private session as provided for in SO item 4.

2.4 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the Schedule of Matters reserved to the Board and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3 MEMBERSHIP OF THE BOARD

3.1 The terms of the Trust's Constitution shall apply.

4 MEETINGS OF THE BOARD

4.1 **Admission of the Public and the Press** – The meetings of the Board of Directors shall be open to members of the public and press unless the Board decides otherwise in relation to all of the meeting for reasons of confidentiality, or on other proper grounds, or for other special reasons. Matters to be dealt with by the Board following the exclusion of members of the public and/or press shall be confidential to the members of the Board. Directors and any employees of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust.

4.2 In the event that the public and press are admitted to all or part of a Board meeting by reason of SO item 4.1 above, the Chair (or Vice Chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and the public will be required to withdraw upon the Board resolving "that in the interests of public order the meeting adjourn for (*the period to be specified*) to enable the Board to complete business without the presence of the public".

4.3 The Board of Directors may agree further provisions in respect of the admission of the public and the press, to be set out in a policy.

4.4 **Observers at Board Meetings** – The Trust may make such arrangements from time to time as it sees fit with regards to the extending of invitations to observers to attend and address any of the Board meetings.

4.4.1 The Trust may appoint Associate Non-Executive Directors to the Board of Directors on such terms as the Board of Directors may direct. Associate Non-Executive Directors) will attend Board of Director meetings and relevant Committee meetings at the discretion of the Chair and will play an active role in such meetings by providing advice and appropriate challenge across the range of Trust healthcare services and supporting business areas. For the avoidance of doubt, Associate Non-Executive Directors are not formally appointed as members of the Board of Directors and, should circumstances arise, will not be eligible to vote.

4.5 Nothing in these Standing Orders shall be construed as permitting the introduction by the public or press representatives of recording, transmitting, video or small apparatus into meetings of the Board or Committees. Such permission shall be granted only upon resolution of the Trust.

4.6 **Calling of Meetings** – Ordinary meetings of the Board shall be held at such times and places as the Board determines.

4.7 The Chair of the Trust may call a meeting of the Board at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of Directors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them at the Trust's Headquarters, such one third or more Directors may forthwith call a meeting.

4.8 **Notice of Meetings** – Before each meeting of the Board, a written notice of the meeting, specifying the business proposed to be transacted at it shall be delivered to every Director, or

sent by post to the usual place of residence of such Director or sent electronically to the usual e-mail address of the director, or circulated via an agreed online board paper portal, so as to be available to them at least three working days before the meeting.

4.9 Want of service of the notice on any Director shall not affect the validity of a meeting.

4.10 In the case of a meeting called by Directors in default of the Chair, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice, or emergency motions permitted under SO item 4.20.1.

4.11 Agendas will normally be sent to members of the Board five working days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three working days before the meeting, save in emergency. Failure to serve such a notice on more than three Directors will invalidate the meeting. Notice shall be presumed to have been served two days after posting and one day after being sent out via email or portal.

4.12 Before any meeting of the Board which is to be held in public, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least three working days before the meeting.

4.13 **Setting the Agenda** – The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).

4.14 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least five working days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than five working days before a meeting may be included on the agenda at the discretion of the Chair.

4.15 **Chair of Meeting** – At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and they are present, shall preside. If the Chair and Vice Chair are absent, such Non-Executive as the Directors present shall choose shall preside.

4.16 If the Chair is absent temporarily on the grounds of a declared conflict of interest the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

4.17 **Notices of Motion** – A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least five working days before the meeting to the Chief Executive, who shall ensure that it is brought to the immediate attention of the Chair. The Chief Executive shall insert in the agenda for the meeting all notices so received, subject to the notice being permissible under the appropriate regulations. Subject to SO item 4.20.1, this paragraph shall not prevent any motion being moved during the meeting without notice on any business mentioned on the agenda.

4.18 **Withdrawal of Motion or Amendments** – A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

4.19 **Motion to Rescind a Resolution** – Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall be made in writing by the Director who gives it and four other Board Directors and, before considering any such motion, the Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if they

consider it appropriate. This Standing Order item 4.19 shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

4.20 **Motions** – A motion may be proposed by the Chair or any Director present at the meeting. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

Emergency Motions

4.20.1 Subject to the agreement of the Chair and SO item 4.21 below, a Director may give written notice of an emergency motion after the issue of the notice of meeting and agenda (by reason of SO item 4.8 and SO item 4.11), up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. At the Chair's discretion, the emergency motion shall be declared to the Board at the commencement of the business of the meeting as an additional item included on the agenda. The Chair's decision to include the item shall be final.

4.21 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

4.21.1 an amendment to the motion.

4.21.2 the adjournment of the discussion or the meeting.

4.21.3 that the meeting proceeds to the next business*.

4.21.4 the appointment of an ad hoc committee to deal with a

specific item of business.

4.21.5 that the motion be now put*.

4.21.6 that a Director be not further heard*.

4.21.7 that the public be excluded pursuant to SO item 4.1,

and in the case of sub-paragraphs denoted by (*) above, to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote.

4.22 No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion. If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

4.23 The Chair may (at their discretion) refuse to admit any motion of which notice was not given in accordance with SO item 4.17, other than a motion relating to:

4.23.1 the reception of a report.

4.23.2 consideration of any item of business before the Trust

Board.

4.23.3 the accuracy of minutes.

4.23.4 that the Board proceed to next business.

4.23.5 that the Board adjourn.

4.23.6 that the question be now put.

4.24 **Chair's Ruling** – Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the

material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matter shall be final.

4.25 **Voting** – The Board shall aim to make decisions through discussion and by consensus. It is not a requirement for all decisions to be subject to a vote. The Chair of the meeting at which any particular decision is to be taken shall be responsible for determining whether a vote is required and what form this will take. Where the Chair determines that a vote should take place, the decision put to a vote shall be determined by a majority of the votes of the Chair and Directors present and voting on the question and, in the case of the number of votes for and against being equal, the Chair of the meeting (or any other person presiding in accordance with the terms of these Standing Orders) shall have a second or casting vote.

4.26 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if the Chair so directs, or it is proposed and seconded by any of the Directors present.

4.27 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.28 If a Director so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

4.29 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

4.30 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

4.31 Where necessary, a Director may be counted as present when available constantly for discussions through an audio or video link and may take part in voting on an open basis.

4.32 **Minutes** – The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

4.33 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.34 Minutes shall be circulated in accordance with Director wishes. Where providing a record of a meeting in public the minutes shall be made available to the public.

4.35 **Joint Directors** – Where the Office of a Director is shared jointly by more than one person:

4.35.1 either or both of those persons may attend or take part in meetings of the Board.

4.35.2 if both are present at a meeting, they should cast one vote if they agree.

4.35.3 in the case of disagreements, no vote should be cast.

4.35.4 the presence of either or both of those persons should count as the presence of one person for the purposes of SO item 4.42 (Quorum).

4.36 **Suspension of Standing Orders** – Except where it would contravene any statutory provision or any provision in the Constitution or any direction made by the Secretary of State for Health and Social Care or NHSE, any one or more of the Standing Orders may be suspended at any

meeting, provided that at least two-thirds of the Board are present, including one Executive Director and one Non-Executive Director, and at least two-thirds of those present vote in favour of suspension.

4.37 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.38 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and Directors of the Board.

4.39 No formal business may be transacted while Standing Orders are suspended.

4.40 The Audit Committee shall review every decision to suspend Standing Orders.

4.41 **Record of Attendance** – The names of the Chair and Directors present at the meeting shall be recorded in the minutes. If a director is not present for the entirety of the meeting, the minutes shall record the items that were considered whilst they were present.

4.42 **Quorum** – No business shall be transacted at a meeting unless at least one half of the whole number of the voting Chair and Directors appointed are present (including at least two Non-Executive Directors and one Executive Director, and a majority of Non-Executive Directors).

4.43 An Officer in attendance for an Executive Director but without formal acting-up status may not count towards the quorum.

4.44 If the Chair or Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Order 7 or 8) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least one Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board considers the recommendations of the Remuneration and Nominations Committee).

5 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 Subject to the Constitution, or any relevant statutory provision and any directions as may be given by the Secretary of State for Health and Social Care, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions in each case subject below to such restrictions and conditions as the Trust thinks fit:

5.1.1 By a committee or sub-committee.

5.1.2 Appointed by virtue of Standing Order item 6.1 or 6.2 below, or by an Officer of the Trust.

5.1.3 By another body, subject to Standing Order item 5.2 below.

5.2 Where a function is delegated to a third party, the Trust has responsibility to ensure that the proper delegation is in place. Upon delegation to committees, sub committees or Officers or third parties, the Trust retains full responsibility.

5.3 **Emergency Powers** – The powers which the Board has retained to itself within these Standing Orders (Standing Order item 2.4) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board in public or private session (as appropriate) for ratification.

5.4 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, or joint-committees, which it has formally constituted. The constitution and terms of reference of these committees,

or sub-committees, or joint committees and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.5 **Delegation to Officers** – Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or joint-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate Officers to undertake the remaining functions for which they will still retain an accountability to the Trust.

5.6 **Scheme of Delegation:** The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board as indicated above.

5.7 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Chief Financial Officer to provide information and advise the Board in accordance with statutory or NHS England requirements. Outside these requirements, the roles of the Chief Financial Officer shall be accountable to the Chief Executive for operational matters.

5.8 The arrangements made by the Board as set out in the Schedule of Matters reserved to the Board and Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

5.9 **Overriding Standing Orders** – If for any reason these Standing Orders 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 next formal meeting of the Board for action or ratification. All Directors of the Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6 COMMITTEES

6.1 Subject to the Constitution, (and to any guidance issued by the Department of Health and Social Care or by NHS England), the Trust may appoint committees of the Trust, or together with one or more other bodies as defined in the 2022 Act, appoint joint committees.

6.2 A committee or joint committee appointed under SO item 6.1 may, subject to such directions as may be given by the Trust or other health service bodies in question, appoint sub-committees consisting wholly or partly of members of the committee or joint committee (whether or not they are members of the Trust or other health service bodies in question); or wholly of persons who are not members of the Trust or other health service bodies or the committee of the Trust or other health service bodies in question.

6.3 The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees, joint committees and sub-committees established by the Trust. In which case the term “Chair” is to be read as a reference to the Chair of the committee, joint committee or sub-committee as the context permits, and the term “member” is to be read as a reference to a member of the committee also as the context permits. There is no requirement to hold meetings of committees, joint committees and sub-committees established by the Trust in public.

Each such committee, joint committee and sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any applicable legislation and regulation or direction. Such terms of reference shall have effect as if incorporated into the Standing Orders.

6.4 The Board of Directors may appoint committees consisting wholly or partly of persons who are not Executive Directors or Non-Executive Directors of the Trust for any purpose that is calculated or likely to contribute or assist it in the exercise of its powers. It may delegate powers to such committees only if the membership consists wholly of Directors.

6.5 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

6.6 The Board shall approve the appointments to each of the committees, joint committees and sub-committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither Directors nor Officers, shall be appointed to a committee, joint committee or sub-committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

6.7 Where the Board is required to appoint persons to a committee, joint committee or sub-committee and/or to undertake statutory functions, and where such appointments are to operate independently of the Board, such appointment shall be made in accordance with the Constitution, the Terms of Reference and any applicable regulations and directions.

6.8 The Trust Board of Directors shall establish an Audit Committee and Remuneration and Nomination Committee, as standing Committees of the Trust Board of Directors. In addition, the Trust Board of Directors shall establish such other Committees as it deems necessary and appropriate from time to time.

7 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

7.1 **Declaration of Interests** – The Constitution, the 2006 Act, the Code of Governance for NHS provider trusts and the Managing conflicts of interest in the NHS guidance, as updated or superseded from time to time, require the Board Directors to declare interests which are relevant and material to the NHS board of which they are a Director. All existing Board Directors and other decision-making staff should declare such interests. Any Board Directors appointed subsequently should do so on appointment.

7.2 Interests are as defined in NHSE's Managing conflicts of interest in the NHS guidance.

7.3 At the time Board Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring and recorded in the minutes of that meeting.

7.4 Board Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Board's Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

7.5 If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or the Director of Corporate Governance. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.6 **Register of Interests** – The Chief Executive will ensure that a Register of Interests is established to record formal declarations of interests of Board Directors. In particular, the register will include details of all directorships and other relevant and material interests which have been declared by both Executive and Non-Executive Directors, as defined in Standing Order item 7.1.

7.7 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding 12 months will be incorporated.

7.8 The Register will be available to the public in accordance with paragraph 36 and 37 of the Constitution.

7.9 All senior managers and clinicians have a duty to ensure that declaration of interests are made which could materially affect the outcome of decisions made by them. Where in doubt, all senior managers and clinicians should contact the Corporate Governance Team for clarification.

7.10 With the exception of the requirement to report interests in the Annual Report (Standing Order 7.4), this Standing Order also applies in full to any committee or sub-committee or group of the

Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a Director).

8 DISABILITY OF CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

8.1 Subject to the following provisions of this Standing Order, if the Chair or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting or as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

8.2 The Board may exclude the Chair or a Director of the Board from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest, is under consideration.

8.3 Any remuneration, compensation or allowances payable to the Chair or a Director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

8.4 For the purpose of this Standing Order the Chair or a Director shall be treated, subject to SO item 8.5, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

8.4.1 they, or a nominee of theirs, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

8.4.2 they are a partner/associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

8.4.3 and in the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

8.5 The Chair or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

8.5.1 of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

8.5.2 of an interest in any company, body or person with which they are connected as mentioned in SO item 8.4 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

8.6 Where the Chair or a Director has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

8.7 This SO item 8 applies to a committee or sub-committee and to a joint committee as it applies to the Trust and applies to a Director of any such committee or sub-committee (whether or not he is also a Director of the Trust) as it applies to a Director of the Trust.

9 STANDARDS OF BUSINESS CONDUCT POLICY

9.1 Staff should comply with national guidance concerning standard of business conduct including as applicable NHS England's "Standards of Business Conduct for NHS Staff", as may be updated or superseded from time to time.

9.2 **Interests of staff** - All staff shall declare any relevant and material interest, including those described in Standing Order 7. The declaration should be made on appointment to the Executive Director, clinical director, or senior manager to whom they are accountable. If the interest is acquired or recognised subsequently, a declaration should be made via the Trust's online declarations of interest system in line with the Declarations of Interest Policy. The system will then add the interest to the Trust's Register of Interests.

9.3 **Interest of Officers in Contracts** – If it comes to the knowledge of an Officer of the Trust that a contract in which they have any pecuniary interest not being a contract to which they themselves are a party, has been, or is proposed to be, entered into by the Trust they shall, at once, give notice in writing to the Chief Executive or the Director of Corporate Governance of the fact that they are interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

9.4 An Officer should also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

9.5 The Trust requires interests, employment or relationships declared, to be entered in a register of interests of staff.

9.6 Gifts and hospitality shall only be accepted in accordance with the Trust's declarations of interest policy. Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value.

9.7 **Canvassing of and Recommendations by, Directors in Relation to Appointments** – Canvassing of Directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of Standing Order item 9 shall be included in application forms or otherwise brought to the attention of candidates.

9.8 A Director of the Board shall not solicit for any person any

appointment under the Trust or recommend any person for such appointment, but this paragraph of this Standing Order item 9 shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

9.9 **Relatives of Directors or Officers** – Candidates for any staff appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

9.10 The Chair and every Director and Officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

9.11 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office in the Trust.

9.12 Where the relationship to a Director of the Trust is disclosed, the Standing Order headed `Disability of Chair and Directors in proceedings on account of pecuniary interest' (SO item 8) shall apply.

10 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

10.1 **Custody of Seal** – The Common Seal of the Trust shall be kept by the Chief Executive or designated Officer in a secure place.

10.2 **Sealing of Documents** – The seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee thereof, or where the Board has delegated its powers. Where it is necessary that a document be sealed, the seal shall be affixed in the presence of two Directors; OR, one Director and the Director of Corporate Governance; OR two senior managers (not being from the originating department) duly authorised by the Chief Executive, and shall be attested by them.

10.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Financial Officer (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

10.4 **Register of Sealing** – An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all applications of the Trust seal shall be made to the Board at least quarterly. (The report shall contain details of the seal number, a description of the document and the date of sealing).

11 SIGNATURE OF DOCUMENTS

11.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

11.2 The Chief Executive or nominated Officer(s) shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority.

11.3 Unless there is a requirement for sealing, the Chief Executive or nominated officers shall also be authorised, by resolution of the Board, to execute any agreement or other document (the subject matter of which has been approved by the Board or any committee, sub-committee or standing committee with delegated authority) as a deed on behalf of the Trust by signing in the physical presence of an attesting witness. Before any deed relating to building, engineering, property, or capital is executed as a deed in this way, it must be approved and signed by the Chief Financial Officer (or an Officer nominated by him) and authorised and countersigned by the Chief Executive (or an Officer nominated by him who shall not be within the originating directorate).

11.4 Unless there is a specific requirement for a physical seal or wet ink signature, any signature under SO Item 11.1, 11.2 or 11.3 above may be provided in electronic form and shall not be invalid on this basis.

12 MISCELLANEOUS

12.1 **Standing Orders to be given to Directors and Officers** – It is the duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within Standing Orders and standing financial instructions. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies where appropriate of Standing Orders.

12.2 **Documents having the standing of Standing Orders** – standing financial instructions (including provisions as to tendering and contract procedures, disposals and in-house services), Schedule of Matters reserved to the Board and Scheme of Delegation, the Policy on the Register of Interests, Gifts and Hospitality and the Staff Disciplinary and Appeals Procedures

document shall be read in conjunction with the Standing Orders. The Board may also, from time to time, agree and approve policy statements/procedures which will apply to all, or specific groups of staff employed by the Trust.

12.3 **Review of Standing Orders** – Standing Orders shall be reviewed annually by the Board and any requirements for amendments must be directed to both the Board of Directors and the Council of Governors. The requirement for review extends to all documents having the effect as if incorporated in Standing Orders.

12.4 The Board may confirm contracts to purchase from a voluntary organisation or a local authority using appropriate powers under the 2006 Act and shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with this Act.

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Council of Governors		
Date of Meeting:	Wednesday 21st May 2025		
Report Title:	Business Cycle and Terms of Reference for Governor Meetings		
Report Author:	Emily Judd, Corporate Governance Manager		
Report Sponsor:	Eric Sanders, Joint Chief Corporate Governance Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X		
	This report provides Governors with a new proposed Business Cycle and Terms of Reference for all meetings of the Council of Governors for the financial year 2025/26		

Key Points to Note *(Including any previous decisions taken)*

At a recent Development Seminar, Governors discussed the business planners for their Focus Group meetings and agreed to amalgamate all items usually discussed within the Membership and Constitution Group into the Quality Focus Group and Governors Strategy Group meetings.

This paper reflects those changes and also seeks approval for the next financial year's Council of Governor and Governor Development Seminar Business Planners.

Strategic and Group Model Alignment

This report and its recommendations align with the Trust's 'Experience of Care' Strategic Priority.

Risks and Opportunities

None

Recommendation

This report is for **Approval**

The Council of Governors is asked to Approve:

1. The Focus Group Terms of Reference
2. The Focus Group Business Planner
3. The Governor Development Seminar Business Planner
4. The Council of Governors Business Planner

History of the paper (details of where paper has <u>previously</u> been received)

N/A

Appendices:	1. The Focus Group Terms of Reference 2. The Focus Group Business Planner 3. The Governor Development Seminar Business Planner 4. The Council of Governors Business Planner

Focus Groups Business Cycle and Terms of Reference

1. Purpose

1.1 This report provides Governors with a new proposed Business Cycle and Terms of Reference for their Focus Groups and for the Council of Governors for the financial year 2025/26.

2. Background

2.1 Governors agreed within their Governor Development Seminar on Thursday 17th April to amalgamate all items usually discussed within the Membership and Constitution Group into the Quality Focus Group and Governors Strategy Group meetings.

2.2 To ensure Governors receive the same number of meetings and time dedicated to those meetings, the Governors Strategy Group will now meet every other month.

3. Focus Group Terms of Reference

3.1 The Focus Group Terms of Reference has been updated to reflect the changes agreed to move to two focus groups and their remits, plus changes to the frequency of these meetings, which will meet bi-monthly.

4. Focus Group Business Planner

4.1 The Focus Group Business Planner has been updated to include the items from the Membership and Constitution Group within the respective meetings.

4.2 Some meetings may need to be extended for 30 minutes to allow additional discussion time when agendas are full.

5. Governor Development Seminar Business Cycle

5.1 A new Governor Development Seminar Business planner has been created to acknowledge the general themes that will be discussed in each meeting.

6. Council of Governors Business Planner

6.1 An updated Council of Governors business cycle has been included. There have been no changes to the proposed items, although the addition of a Governor Tour before or after the meeting has been indicated for two dates in-year.

7. Summary and Recommendations

7.1 This report is for **Approval**.

7.2 The Council of Governors is asked to Approve:

- The Focus Group Terms of Reference
- The Focus Group Business Planner
- The Governor Development Seminar Business Planner
- The Council of Governors Business Planner

Governor Focus Groups ToR

University Hospitals Bristol and Weston NHS Foundation Trust

Purpose

- The purpose of the Focus Groups is to facilitate engagement with the Trust Board and governors on matters of constitution, membership, strategy and planning (including significant transactions), people, quality and performance monitoring as part of the annual cycle of business.

Duties

- Governors Strategy Group
  - Engagement with Governors to develop the Annual Plan;
  - Engagement with Governors on both the short- and long-term strategic plans of the Trust;
  - Engagement with Governors on capital projects and significant transactions as they arise;
  - Reflections upon updates from the Trust's Finance and Estates Committee.
  - Reflections upon updates from the Trust's Audit Committee.
  - Engagement with Governors in drafting Constitutional changes;
  - Assessment of the public, patient and staff membership profile to ensure a representative membership;
  - Engagement of Governors on communications and engagement activities for Foundation Trust members;
  - Oversight of the Governor Elections as and when required;
  - Ownership and oversight of the Trust's Membership Engagement Strategy, to include recommendations for updates to this working strategy as required;

- Quality Focus Group
  - Regular support to enable Governors to understand and interpret the Board Performance Report to enable governors to hold the Non-Executive Directors to account;
  - Regular support to enable governors to understand and interpret reported progress on the Trust's Priotities;
  - Reflections upon updates from the Trust's Quality and Outcomes Committee and People Committee;
  - Provide input into the Trust's Quality Report and provide the statement for inclusion in the report on behalf of the Council of Governors.

Delegated Authority

- None directly delegated to the group.

Membership

- Focus groups are chaired by a nominated Governor, the Governor Group Chair. In circumstances where it is not possible for the Governor Group Chair to attend, their deputy or another Governor may Chair the meeting.
- There is no fixed membership for the groups; they are open to all Governors to attend. This is to allow for equitable access to any of the focus groups by any Governor.

Administration

- The minimum number of Governors required for any meetings of the focus groups to be considered a valid consultation or engagement activity is any four (4) governors and at least one (1) Trust representative.
- Both Focus Groups will meet bi-monthly.
- Secretariat support will be provided by The Corporate Governance Team

- Approval Date:
- Review Date:

Quality	Lead	May-25	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26
Quality and Outcomes Committee Chairs' Reports	Non-executive Director						
Integrated Quality and Performance Report	To note in QOC Chair item						
People Committee Chairs' Report	Non-executive Director						
Governors' Log of Communications	Corporate Governance Manager						
Review of Patient First Strategic Priority Spotlight	Lead for each objective	Our People	Patient Safety	Our Resources	Experience of Care	Timely Care	Innovate and Improve
Staff Engagement/Organisational Development update (including staff survey results and regular reports on Diversity and Inclusion)	OD team						
Quality Account statement and Report	Associate Director of Quality and Compliance						
Lay Representative meeting updates	Nominated governor	EoC and HEDG		EoC and HEDG	AIS	EoC and HEDG	AIS
Education Strategy	Associate Director of Education			6 monthly update			6 monthly update
Communications update	Director of Communications		6 monthly update			6 monthly update	
National inpatient survey results	Head of Experience of Care and Inclusion						
Spotlight session	Lead for item						

Strategy	Lead	May-25	Sep-25	Nov-25	Mar-26
~~Review of progress against the Trust's Patient First Strategic Priorities~~	~~Deputy Director of Improvement and Innovation~~				
Partnership updates (ICS, Healthier Together, Acute Collaborative Partnership Board, etc.)	Director of Business Development and Improvement				
Finance and Digital Committee Chair's Report	Non-executive Director				
Strategic capital investments update	Strategic Capital Programme Director				
Estates Update	Director of Facilities and Estates				
Sustainability Update	Head of Sustainability				
Digital Strategy Update	Chief Digital Information Officer				
Arts and Culture Programme Update	Arts and Culture Manager				
Operational Plan (TBC depending on national requirements)	Director of Business Development and Improvement and Chief Financial Officer				

Membership and Constitution Group	Lead	Jul-25	Jan-26
Membership Strategy – update on progress	Corporate Governance Manager		
Governor elections	Corporate Governance Manager		
Audit Committee Chair's Report	Non-executive Director		
~~Media Update~~	~~Corporate Governance Manager~~		
Governor Self-Assessment Survey	Corporate Governance Manager		
Three-yearly Membership Survey	Corporate Governance Manager		2025
Annual Members Meeting Plan	Corporate Governance Manager		
Health Matters events programme	Corporate Governance Manager		
Lead governor role review	Corporate Governance Manager		
Review of the Trust Constitution, Governor Code of Conduct	Corporate Governance Manager		
Youth Involvement Group update	Youth Involvement Group Governors		
Focus Group Terms of Reference and Business Cycle review	Corporate Governance Manager		
Annual Membership Representation Report	Corporate Governance Manager		

Quality Focus Group	Lead	May-25	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26
Quality and Outcomes Committee Chairs' Reports	Non-executive Director						
Integrated Quality and Performance Report	To note in QOC Chair item						
People Committee Chairs' Report	Non-executive Director						
Governors' Log of Communications	Corporate Governance Manager						
Review of Patient First Strategic Priority Spotlight	Lead for each objective	Our People	Patient Safety	Our Resources	Experience of Care	Timely Care	Innovate and Improve
Staff Engagement/Organisational Development update (including staff survey results and regular reports on Diversity and Inclusion)	OD team						
Quality Account statement and Report	Associate Director of Quality and Compliance						
Lay Representative meeting updates	Nominated governor	EoC and HEDG		EoC and HEDG	AIS	EoC and HEDG	AIS
Education Strategy	Associate Director of Education			6 monthly update			6 monthly update
Communications update	Director of Communications		6 monthly update			6 monthly update	
National inpatient survey results	Head of Experience of Care and Inclusion						
Lead governor role review	Corporate Governance Manager						
Youth Involvement Group update	Youth Involvement Group Governors						
Focus Group Terms of Reference and Business Cycle review	Corporate Governance Manager						

This will not be extended and you will still have 6 meetings per year, however where an agenda is full we would extend a meeting by 30-mins i.e. Nov/Jan*

Strategy Focus group	Lead	May-25	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26
Partnership updates (ICS, Healthier Together, Acute Collaborative Partnership Board, etc.)	Director of Business Development and Improvement						
Finance and Digital Committee Chair's Report	Non-executive Director						
Strategic capital investments update	Strategic Capital Programme Director						
Estates Update	Director of Facilities and Estates						
Sustainability Update	Head of Sustainability						
Digital Strategy Update	Chief Digital Information Officer						
Arts and Culture Programme Update	Arts and Culture Manager						
Operational Plan (TBC depending on national requirements)	Director of Business Development and Improvement and Chief Financial Officer						
Membership Strategy – update on progress and Membership Representation Report	Corporate Governance Manager						
Governor Elections	Corporate Governance Manager						
Audit Committee Chair's Report	Non-executive Director						
Annual Governor Self-Assessment Survey	Corporate Governance Manager						
Three-yearly Membership Survey	Corporate Governance Manager		2025				
Annual Members Meeting Plan	Corporate Governance Manager						
Health Matters events programme	Corporate Governance Manager						
Review of the Trust Constitution, Governor Code of Conduct	Corporate Governance Manager						
Focus Group Terms of Reference and Business Cycle review	Corporate Governance Manager						

We have increased Strategy meeting frequency from 4 times per year to 6 times per year and removed the M&C Group

Governor Development Seminar Business Cycle 2025/26

Item	Lead	Apr-25	Jun-25	Oct-25	Feb-26
Hospital Group Developments	Group Chair				
System Partner Developments	Director of Business Development and Improvement				
Induction for new Governors	Corporate Governance team				
Freedom to Speak Up Updates	Freedom to Speak up Guardian				
Items of Interest spotlight	Various				
Governor roles in NED Recruitment	Joint Chief Corporate Governance Officer				
External Auditor role	External Auditor				
Convene Training/other system training	Training Teams				
Essential Training	Various			IG/Fire	IPC/EDI
Governor Development	Corporate Governance team				
Membership Engagement	Corporate Governance team				
Tour	Various				

COUNCIL OF GOVERNORS - ANNUAL BUSINESS CYCLE 2025-26							
	Sponsor	**Author**	**Wednesday 21 May**	**Tuesday 22 July**	**Annual Members' Meeting - Tuesday 16 September 2024 (18:00-20:00)**	**Tuesday 18 November**	**Thursday 22 January**
Chair's Welcome and Apologies	Chair	Chair					
Declarations of Interest	Chair	Chair					
Minutes and matters arising from previous meetings	Chair	Chair					
Chief Executive's Report	Chief Executive	Chief Executive					
Chair's Update	Chair	Chair					
Theme for the month	Chair	NEDs	Finance and Digital	People		Quality	Audit
Governor's Questions from Public Board	Chair	Chair					
Nominations & Appointments Committee Report	Chair	Chair					
Lead Governor's Report	Lead Governor	Lead Governor					
Governor and Membership Forward Look	Director of Corporate Governance	Corporate Governance Manager/ Focus Group Chairs					
Governors' Log of Communications - six month view	Chair	Governors					
Foundation Trust Members' Questions	Chair	FT Members					
Annual Cycle of Business for Council of Governors meetings	Director of Corporate Governance	Corporate Governance Manager					
Annual Plan	Chief Executive	Chief Executive					
Council of Governors Register of Interests	Director of Corporate Governance	Corporate Governance Manager					
Membership Strategy Update	Director of Corporate Governance	Corporate Governance Manager		6-monthly update			6-monthly update
Appointment of Lead Governor	Director of Corporate Governance	Corporate Governance Manager					
Foundation Trust Constitution review (Ad hoc as required)	Chair	Director of Corporate Governance	As Required	As Required		As Required	As Required
Terms of Reference for Governor Focus Groups	Director of Corporate Governance	Corporate Governance Manager					
Election and Appointment of Governors	Director of Corporate Governance	Corporate Governance Manager					
Youth Involvement Group Report	YIG Governors	YIG Governors					
Appointment/Re-appointment of Non-executive Directors/Chair (ad hoc as necessary)	Director of Corporate Governance	Corporate Governance Manager	As Required	As Required		As Required	As Required
Presentation of the Annual Report and Accounts (including External Auditor's Opinion on the Annual Report and Accounts)	Chief Executive and Director of Finance	Chief Executive and Director of Finance					
Governors' Annual Report of Governor and Membership Activity	Lead Governor	Corporate Governance Manager					
Governors Meeting Dates for next Financial Year	Director of Corporate Governance	Corporate Governance Manager					
Update on Mergers/Acquisitions/Reconfiguration/ Significant Transactions - ad hoc as necessary	Chief Executive	Chief Executive	As Required	As Required		As Required	As Required
Appointment/Re-appointment of the Trust's External Auditors (ad hoc as necessary)	Director of Corporate Governance	Director of Corporate Governance	As Required	As Required		As Required	As Required
Major Capital Projects - ad hoc as necessary	Chief Executive	Chief Executive	As Required	As Required		As Required	As Required
Governor Tour	N/A	N/A		Tour location TBC		Tour location TBC	

University Hospitals Bristol and Weston NHS Foundation Trust

Report To:	Council of Governors		
Date of Meeting:	Wednesday 21st November 2025		
Report Title:	Governors Log of Communications		
Report Author:	Emily Judd, Corporate Governance Manager		
Report Sponsor:	Eric Sanders, Director of Corporate Governance		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	To update the Council of Governors on the communications with Governors since the last meeting of the Council of Governors.		

Key Points to Note *(Including any previous decisions taken)*

Since the previous Council of Governors meeting held in public on 21 November 2024:

- Nine questions have been added to the log.
- Four questions have been closed on the log.
- Three questions are outstanding on the log.
- Two questions are with the Governor, awaiting the outcome of a separate meeting to discuss the questions raised. These relate to access to the Bristol Hospitals and John Rose met with Andy Jeanes, Director of Estates and Facilities to discuss in more detail on Tuesday 13th May.

Strategic and Group Model Alignment

N/A

Risks and Opportunities

N/A

Recommendation

This report is for **Information**
The Council of Governors is asked to note the updates to the log

History of the paper (details of where paper has <u>previously</u> been received)

N/A

Appendices:	Log attached separately

Governors questions reference number	Date Question Raised	Governor Name	Governor Constituency	Description	Executive Lead	Date Response Due	Response	Status	Secretariat Notes
300	27/11/2024	Martin Rose		I recently experienced a situation where one of my clinicians could not access some test results as they had not requested them. Can the Trust indicate if there are future plans for our systems to join together with primary care so all clinicians can see the entire medical record of one patient, including access to patient test results?	Chief Information Digital Officer	25/12/2024	There are currently several ways that Clinicians can access test results that they have not requested themselves. To view test results in ICE our results reporting system, the clinician can use a system called ICE OpenNet to access ALL results held at UHBW and NBT laboratories regardless of the originating requester (including primary care). The full functionality of this solution is a fairly recent development but is widely available across the whole Trust. Another option is to use the Connecting Care shared record system, which takes a direct feed from the UHBW and NBT Labs and shows all results that have been completed. This system is widely used and has been available for many years. In addition, test results are usually available for each patient to access themselves within the NHS App. Use this link to get started; https://www.nhs.uk › nhs-app › nhs-app-help-and-support It may be the case that the result information was available but was not accessed because of a potential gap in knowledge of ...	Closed	02/01/25 - Chased Neil Darvill 11/03/2025 - Eric Sanders confirmed Emma Mooney has signed off this response.

301	24/12/2024	Rob Edwards		Further to a recent Governor Tour where we visited the Radiopharmacy team, the Governors would like to understand if there were any plans to relocate this group to a larger space more suited to their needs and team size?	Chief Financial Officer	21/01/2025	Radiopharmacy is nationally recognised as a significant concern due to the vital nature of the work it undertakes, together with the vulnerability of workforce capacity and physical estates in which they operate. The UHBW service is no exception to that, and our MHRA licensed unit also supports other Trusts within the South West and beyond. An outline business case has been agreed within BNSSG for a new pharmacy aseptic unit which includes an option for a new Radiopharmacy. This new unit requires national funding, and at present there are no clear plans within NHS England for that funding to include Radiopharmacy. UHBW are therefore looking to undertake a feasibility assessment and create a plan for a potential new stand alone radiopharmacy to replace the existing unit.	Closed	02/01/25 - the Governor tour showed the space for the Radiopharmacy team as a portacabin behind the Estates building, with a concealed entrance. The space inside the building was very small and housed a large number of people within the small space and this greatly concerned the Governors due to the work that was required to be completed by the team and the expansion that was expected. This question has been raised by one Governor, but is a group decision to raise. 11/03/25 - Eric Sanders confirmed Emma Mooney has approved this response.
302	16/01/2025	Ben Argo		Could you please provide the completion rates for the Oliver McGowan training at University Hospitals Bristol and Weston (UHBW), specifically for Level 1 and Level 2 training programs?	Chief People Officer	13/02/2025	Our current completion rates for e-learning are at 75%, Level 1 at 14.4% and Level 2 at 19.6%. In terms of improving compliance, the HRBPs receive a report on all Stat man compliance and work with their division and sub specialities to increase where compliance is low. There is also a System (ICB) working group which is looking to help with compliance - especially capacity for the face to face elements which is limited and will likely mean many organisations are not at the desired compliance levels.	Closed	12/02/25 - chased Comms for review of response. 11/03/25 - Eric Sanders confirmed Emma Mooney has approved response.

303	06/03/2025	John Rose		I wish to ask UHBW to review their perceptions and responsibilities associated with patients' travel arrangements to UHBW's Bristol hospital premises, particularly those with mobility issues. Is there any scope for existing hospital car parks to be dedicated to patients in need of blue badge parking? I am also interested to know what representations UHBW have made to Bristol City Council regarding the safety and usefulness of the construction works ongoing outside of the main entrance to the BRI hospital, intended to improve Upper Maudlin Street. Related to both questions, what are UHBW's plans on using satellite locations for outpatient clinics?	Chief Financial Officer	09/04/2025	An offer has been made for John to join the Director of Estates and Facilities to walk the site and discuss this question.	Awaiting Governor reponse	

304	10/03/2025	Martin Rose		Further to news articles and subsequent letters in The Times about antisemitic behaviour in some NHS Trusts, is any data held on religious hatred incidents at UHBW and what is being done to tackle any known instances of these incidents if they are reported?	Chief People Officer	09/04/2025	The Trust records incidents of abuse including racial abuse in our incident management system. Such abuse from patients or the public is reviewed by line managers and our Health and Safety team and incidents reported to the Managing Aggression and Violence Committee each quarter. Protocols to manage incidents and support staff affected are in place. Patients can be issued warning letters and have treatment withdrawn. Staff can be offered well being support and our violence reduction team offer additional support including preparing cases for the police to encourage prosecutions. There is one record of antisemitic abuse on our reporting system. The patient was managed under our protocols and the staff member offered well being support. The case was closed. We also record incidents which occur between staff and there have been no reports of antisemitic abuse.	Closed	17/03/2025 - Response received by Chief People Officer and sent to Comms. 28/04/25 - Chased Comms for sign off 06/05/25 - Chased Comms for sign off

305	25/03/2025	Martin Rose		Recently, there was a consultation process about stopping all traffic up and down Park Street. Bristol City Council have passed it through, it now goes to WECA, when the newly elected Mayor takes his or her place. Did UHBW input it's views? The prospect of Park Street being closed to traffic leads the alternative route past our hospitals. If the board did partake in the consultation are you able to share what was shared with BCC?	Chief Financial Officer	27/05/2025		Assigned to Executive Lead	13/05/25 - Trust Sec missed question on log and has not chased, so an extension to this response has been granted.
306	28/03/2025	John Rose		Patients of all ages coming to UHBW often have poor mobility and travel to the Hospitals can be incredibly difficult when in this position. What is the most common age range of patients visiting outpatient settings at our hospitals, and what provision is being made to ensure patients can be dropped off and collected by taxis and other vehicles at all hospital sites in a stress-free manner (including seating for waiting)?	Chief Financial Officer	30/04/2025	An offer has been made for John to join the Director of Estates and Facilities to walk the site and discuss this question.	Awaiting Governor reponse	

307	17/04/2025	Libby Thompson, John Rose		1. What is the process for obtaining consent from a patient for a student to be present in their consultation or treatment, and what guidance and training is given to staff to ensure that patient choice is respected in relation to student involvement? 2. Under what circumstances is it appropriate for a patient be asked to sign a consent form for the wrong procedure? 3. What guidance are staff given to manage consent for a specific procedure, when there are no consent forms left for that specific procedure?	Chief Medical Officer	15/05/2025		Assigned to Executive Lead	
308	08/05/2025	Martin Rose, Ben Argo		We would like to seek assurances that the Governors' Log of Communications will return as a standing agenda item to meetings of the Board of Directors. Prior to April 2025, it was routine for the Governors' Log to be presented for information at every meeting of the Board in public. This mechanism allowed the public to view the questions that governors ask of the Board. It also allowed non-executive directors to familiarise themselves with the questions that governors have asked; and seek assurance from executive directors on topics where they felt necessary. We believe this forms an important part of the governance process, as it allows the views of governors (and therefore members) to be communicated to the board as a whole.	Chief Executive Officer	05/06/2025		Assigned to Executive Lead	