# Trust Board Meeting in Public

**Thursday 30 January 2020**
**10.00 – 12:40**
**Seminar Room 5, Learning and Research Centre, Southmead Hospital**

**A G E N D A**

| No. | Item | Purpose | Lead | Paper | Time |
|---|---|---|---|---|---|
| **OPENING BUSINESS** | | | | | |
| 1. | Welcome and Apologies for Absence:<br>Tim Gregory | Information | Chair | Verbal | 10:00 |
| 2. | Declarations of Interest | Information | Chair | Verbal | 10:02 |
| 3. | Patient Story | Information | Director of Nursing & Quality | Verbal | 10:05 |
| 4. | Minutes of the Public Trust Board Meeting Held on 28 November 2019 | Approval | Chair | Enc. | 10:25 |
| 5. | Action Chart from Previous Meetings | Discussion | Trust Secretary | Enc. | 10:27 |
| 6. | Matters Arising from Previous Meeting | Information | Chair | Verbal | 10:30 |
| 7. | Chair's Business | Information | Chair | Verbal | 10:35 |
| 8. | Chief Executive's Report | Information | Chief Executive | Enc. | 10:45 |
| **QUALITY** | | | | | |
| 9. | Board director walk-arounds | Discussion | Trust Secretary | Enc. | 10.55 |
| 10. | Quality & Risk Management Committee upward report<br>10.1. Safety Culture Survey pilot results | Information | NED Chair | Enc. | 11:05 |
| 11. | Patient & Carer Experience Committee upward report | Information | NED Chair | Enc. | 11:15 |
| **PERFORMANCE AND FINANCE** | | | | | |
| 12. | North Bristol Trust Five Year Strategy 2019- 2024 | Approval | Medical Director | Enc. | 11.25 |
| 13. | Integrated performance report | Discussion | Chief Executive | Enc. | 11.40 |
| 14. | Audit Committee Upward report<br>14.1. Standing Orders & Standing Financial Instructions | Information<br>Approval | NED Chair | Enc | 12:05 |
| **PEOPLE & IMT** | | | | | |
| 15. | People & Digital Committee Upward Report | Discussion | NED Chair | Verbal | 12.25 |
| **CLOSING BUSINESS** | | | | | |
| 16. | Any Other Business | Information | Chair | Verbal | 12:35 |
| 17. | Questions from the Public in Relation to Agenda Items | Information | Chair | Verbal | - |
| 22. | Date of Next Meeting: Thursday 29 March 2020, 10.00 a.m. Seminar Room 5, Learning | | | | |

| No. | Item | Purpose | Lead | Paper | Time |
|---|---|---|---|---|---|
| | & Research Building, Southmead Hospital | | | | |
| | *Resolution: Exclusion of the Press and Public. It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, Section 1(2), the press and members of the public be excluded from further items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.* | | | | |

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NHS North Bristol NHS Trust

## Trust Board Declarations of Interest

| Name | Role | Interest Declared |
|---|---|---|
| Ms Michele Romaine | Chair (from 1 July 2018) | • Nothing to declare. |
| Mr Kelvin Blake | Non-Executive Director (from 1 February 2019) | • Non-Executive Director of Weston Area Health Trust.<br>• Non-Executive Director of BRISDOC who provide GP services to North Bristol NHS Trust.<br>• Trustee, Second Step. Provide mental health services for the Bristol North Somerset and South Gloucestershire area.<br>• Trustee, West of England Centre for Integrated Living. Provide a range of services to disabled people living in the Bristol, North Somerset and South Gloucestershire area.<br>• Lay Member of the Avon & Somerset Advisory Committee. The Committee is responsible for forming interview panels for the appointment of magistrates.<br>• Director, Bristol Chamber of Commerce and Initiative.<br>• Member of the Labour Party. |
| Ms Jaki Davis | Non-Executive Director | • Trustee of the Cheltenham Trust.<br>• Trustees of the Friends of the Wilson Museum and Art Gallery in Cheltenham. |
| Mr John Everitt | Non-Executive Director | • Councillor, Newton St Loe Parish Council.<br>• Member of Bath Abbey Appeal Committee.<br>• Daughter works for NBT. |
| Professor John Iredale | Non-Executive Director | • Pro-Vice Chancellor of University of Bristol.<br>• Advisor to Novartis on liver disease.<br>• Member of Medical Research Council.<br>• Trustee of:<br>  ○ British Heart Foundation<br>  ○ Children's Liver Disease Foundation<br>  ○ Foundation for Liver Research<br>• Chair of the governing board, CRUK Beatson Institute. |
| Mr Tim Gregory | Non-Executive Director | • Son-in-law works for NBT. |

| Name | Role | Interest Declared |
|---|---|---|
| Mr Robert Mould | Non-Executive Director | • Non-Executive Director of Weston Area Health Trust.<br>• Member of Bristol Mediation.<br>• Daughter works for NBT. |
| Ms Andrea Young | Chief Executive | • Nothing to declare. |
| Ms Evelyn Barker | Chief Operating Officer & Deputy Chief Executive | • Nothing to declare. |
| Ms Helen Blanchard | Interim Director of Nursing and Quality (from 2 July 2018 to 7 November 2019) Director of Nursing and Quality (from 8 November 2019) | • Nothing to declare. |
| Dr Chris Burton | Medical Director | • Wife works for NBT. |
| Mr Neil Darvill | Director of Information Management and Technology (non-voting position) | • Wife works as a senior manager for Avon and Wiltshire Partnership Mental Health Trust. |
| Ms Jacqui Marshall | Director of People and Transformation (non-voting position) | • Nothing to declare. |
| Mrs Catherine Phillips | Director of Finance | • Nothing to declare. |
| Mr Simon Wood | Director of Estates, Facilities and Capital Planning (non-voting position) | • Nothing to declare. |

# DRAFT Minutes of the Public Trust Board Meeting held on Thursday 28 November 2019 at 10.00am Seminar Room 5, Learning & Research Building, Southmead Hospital

**Present:**

| | | | |
|---|---|---|---|
| Michele Romaine | Chair | Helen Blanchard | Director of Nursing & Quality |
| Kelvin Blake | Non-Executive Director | Evelyn Barker | Chief Operating Officer |
| John Everitt | Non-Executive Director | | |
| Tim Gregory | Non-Executive Director | Dr Chris Burton | Medical Director |
| Jaki Meekings-Davis | Non-Executive Director | Neil Darvill | Director of Informatics |
| | | Catherine Phillips | Director of Finance |
| Prof John Iredale | Non-Executive Director | Jacqui Marshall | Director of People & Transformation |
| Rob Mould | Non-Executive Director | | |

**In Attendance:**

| | | | |
|---|---|---|---|
| Xavier Bell | Director of Corporate Governance & Trust Secretary | Stephen Lightbown | Director of Communications |
| | | Andrew Jeanes | Director of Operational Facilities |
| Isobel Clements | Corporate Governance Officer | | |

**Presenters:**

| | | | |
|---|---|---|---|
| Kacie Gibson* | Deputy Antenatal and new-born Screening Coordinator/ Foetal Medicine Midwife | Dr Hadi Waheed* | Registrar |
| | | Sarah Chalkey** | Deputy Head of Nursing/ Lead Nurse ASCR |
| Brenda Dowie* | Lead Chaplain, Department of Spiritual Care | Sarah Lidgett** | Clinical matron, Medicine |
| | | Sue Mallett** | Clinical matron, NMSK |
| Dr Jane Mears* | Consultant Gynaecologist & Obstetrician | Dr Kathryn Holder*** | Consultant Anaesthetist, Guardian of Safe Junior Doctor Working |
| Lauren Cole* | Bereavement Midwife | | |

*Attended for up to and during minute no.04, **Attended for up to and during minute no.09, *** Attended for minute no.19 only.

**Observers:** Ten members of staff / public attended.

**Apologies:**

| | |
|---|---|
| Andrea Young | Chief Executive |
| Simon Wood | Director of Estates, Facilities & Capital Planning |

**TBC/19/11/01 Welcome** **Action**

The Chair welcomed everyone to the public meeting of the Board and noted the high number of public and staff in attendance.

**TBC/19/11/02 Apologies For Absence and Welcome**

The Board noted that apologies for absence had been received from Andrea Young, Chief Executive and Simon Wood, Director of Estate & Facilities.

**TBC/19/11/03 Declarations of Interest**

There were no declarations of interest declared nor updates to the Trust Board register of interests as currently published on the NBT website and annexed to the papers.

**TBC/19/11/04 Patient Story / Staff Story**

Dr Jane Mears read out a letter of thanks received by Andrea Young, Chief Executive, from parents, Sam and Dan, describing their experience after learning that their baby boy's heart had stopped

beating at 18 weeks gestation.

They praised NBT for its carefully planned process, care, compassion and the respect the staff gave to them and their baby Harry. This included services provided by NBT which were not provided by all Trusts such as funeral and burial for babies who die between 13 and 40weeks gestation and a memory box to take home.

Those mentioned in the letter had been thanked personally by Andrea Young and the Board also added their thanks.

Key observations and questions from the Trust Board and staff involved who were in attendance were as follows:

- The bereavement midwife role and the multi-disciplinary team was invaluable to provide the best care and support for patients, family and fellow staff;
- It was noted second trimester pregnancy loss was not uncommon on the Cotswold Ward, a gynaecology ward, and therefore co-location with maternity was key;
- It was noted that 20-weeks' gestation elicited one to one midwife care, whereas at 20-weeks and below, patients are cared for on Cotswold ward which has a higher staff to patient;
- It was noted that a large amount of staff time and effort was required to provide a service that helps reduce negative impact on patient's long-term mental health;
- Staff present confirmed that although the work was emotionally challenging, staff felt positive that they are able to provide individualised care for patients and families;
- The importance of treating the whole family/couple was noted.

**RESOLVED thanked on behalf of the Trust Board for sharing the story and staff thanked for all they did and continue to do.**

**TBC/19/11/05 Minutes of the previous Public Trust Board Meeting**

**RESOLVED that the minutes of the public meeting held on 26 September 2019 be approved as a true and correct record.**

**TBC/18/11/06 Action Log and Matters Arising from the Previous Meeting**

The below actions were clarified:

- A proposal regarding the non-executive walk-arounds would be brought to December/ January Trust Board;
- Risk Management Committee action to be brought to January's Trust Board.

**RESOLVED that the updates to the Action Log be received and approved.**

**TBC/19/11/07 Chair's Business**

The Chair provided an update on the following:

- Andrea Young, Chief Executive, had received an Honorary Doctorate awarded by the University of West England (UWE). The

Chair noted this was a fantastic achievement Helen Blanchard, Director of Nursing and Quality was congratulated on her substantive appointment and formally welcomed as a member of Trust Board.

**RESOLVED that the Chair's verbal update be noted.**

**TBC/19/11/08 Chief Executive's Report**

The Board considered the Chief Executive's report, presented by Evelyn Barker, Chief Operating Officer and Deputy Chief Executive in Andrea Young's absence. The following points were highlighted:

- NBT had received a visit from Health Education England which was successful;
- NBT was recognised by UWE for its excellence especially regarding student approval ratings and Emergency Medicine at the Trust was recognised as outstanding by the General Medical Council. NBT was also recognised as the largest placement provider in the South West and had been asked for further placements to be made available. John Iredale, NED, stated NBT was a fantastic partner to University of Bristol as well as UWE;
- NBT, University Hospitals Bristol (UHB) and Weston Area Heath Trust (WAHT) were aiming to become an Academic Health Science Network (AHSN) (interview process in February). It was noted this was positive cross-working in building the Bristol 'brand'. John Iredale, noted the AHSN label would give the Trust leverage nationally and with key authorities such as Local Government;
- New national pension guidance issued varied slight from the pension scheme Trust Board had previously approved.
- NBT's Chair and Chief Executive signed off BNSSG's Long-Term Plan for submission to NHSI at the most recent STP Partnership Board in line with delegated authority from the Board.

**RESOLVED that the Chief Executive's report be noted and the pension issue to be discussed at People & Digital Committee in December.**

**TBC/19/11/09 Pressure injury improvement programme**

Helen Blanchard, Director of Nursing & Quality introduced Sarah Chalkey, Deputy Head of Nursing/ Lead Nurse ASCR, Sarah Lidgett, Clinical Matron (Medicine) and Sue Mallett, Clinical Matron (NMSK) who presented the achievements to date and the planned next steps of the pressure injury improvement programme (PIIP).

The PIIP stemmed from an action from the Board after presentation of a paper that evidenced a raised incidence of pressure injuries (PI) in the Trust. The PIIP focussed on three main areas to reduce incidents of PIs: (i) Documentation; (ii) education & training; and (iii) monitoring & assurance.

<u>Key comments and questions from the Board:</u>

- John Everitt, NED, acknowledged the impressive dedication to the

PIIP but queried what targets would be used to monitor progress. It was confirmed that compliance targets and competency training would be detailed on Lorenzo with the overall target being a reduction in PI. Additionally, in future the PIIP hoped to encourage comparability across services within BNSSG;

- It was confirmed the Trust had had positive feedback on Trust-wide PI training and was also working with UWE pre-registered and in-training nurses to ensure PIs were at the forefront of clinical training;
- It was confirmed that a process was in place for ensuring patients had the correct PI care on discharge. This process included incorporating photos of PIs in the care summary for community teams;
- It was clarified that PI incidences were lower on patient-mobile wards such as Elgar and highest on high dependency wards;
- It was noted work was ongoing to gain comparator data of specific wards for example, ICU had a high incidence of PIs within the Trust but data from other Trusts had been requested for a benchmarking exercise;
- The Board were assured a PI risk assessment to identify PIs or risks of PI was completed within six hours of admission.

**RESOLVED:**

- **The Board were assured on the activity and progress of the Pressure Injury Incident group since July 2019;**
- **Presenters were thanked for their attendance and for their clear view on how to tackle PI incidence across the Trust.**

**TBC/19/11/10 Patient & Carer Experience Committee upward report**

Rob Mould, NED, presented the Patient & Carers Experience Committee (P&CEC) upward report and described escalations to the Board as follows:

- Assess the organisation's disability confidence and accelerate work on information accessibility (prioritising Accessible Information Standards business cases);
- Support a clear methodology for learning from complaints and PALS pilot;
- Action P&CEC if further deep-dives into Quality Elements of the IPR need further investigation.

Key comments from the discussion were as follows:

- NBT was confirmed as compliant for accessibility standards and the CCG had acknowledged the Trust was furthering its work around this especially regarding learning difficulties and autism. However, it was noted assurance could be greater for other disabilities;
- P&CEC had useful insight from a visually impaired patient who attended November's meeting;
- P&CEC would receive a further update on patient transport issues in



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May 2020.

**RESOLVED:**

- **Received and noted the P&CEC upward report;**
- **Agreed to increased reporting of accessibility standards work at NBT to Board in 2020/21;** **XB**
- **Tasked P&CEC committee with overseeing the Disability Confident scheme's NBT self-assessment after scoping of resource required.** **XB**

**TBC/19/11/11** **Complaints annual report**

Helen Blanchard presented the Complaints Annual Report for information. The report was described as predominately quantitative but a commitment had been made as part of the Quality Strategy that learning from complaints would be triangulated with feedback received from the Family & Friends Test (FFT) and local surveys.

Key comments from the discussion that ensued were as follows:

- Tim Gregory, NED, highlighted that moving to electronic feedback in day-care and the chemotherapy centre had elicited a drop in the number of patient responses received. Tim Gregory requested continuation of alternative and broader feedback opportunities. Helen Blanchard advised that the Trust was looking at collecting feedback differently which complemented changes to the FFT due in April 2020. This process was confirmed to be owned by P&CEC.
- It was noted that the number of complaints to the Trust overall had risen. The Board noted the positive aspects of this as the following: it suggested increased engagement with patients; it provided further learning opportunities and it allowed more opportunities for the Trust to 'turn around' a complaint into a positive interaction as the way in which complaints are dealt with was key to bettering the patient experience and perceptions of the Trust;
- It was further noted that compliments in general are not reported at the same rate as complaints;
- The Trust was commended on the improvement in timeliness of complaint responses;
- It was confirmed that all of the Trust's responses to complaints were signed off by an Executive Director and most often by the Chief Executive;
- It was suggested that more could be done to follow-up responses to complaints i.e. a phone call to check if the complainant was satisfied with the response. The Chair noted support for this process which could be provided by PALS.

**RESOLVED:**

- **Noted the complaints annual report;**
- **Requested that future complaints reports contained additional information about patient satisfaction with complaint responses.**



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**TBC/19/11/12 Quality & Risk Management Committee Upward Report**

Professor John Iredale, NED and chair of the QRMC commended the QRMC Upward report to the Board for assurance with no issues to escalate but key approvals requested.

**RESOLVED:**

- **Approved the revised wording for BAF SIR14;**
- **Noted the positive 14 day turn-around time for cervical screening (99.28% compared to the national average 52%);**
- **Approved the QRMC's revised Terms of Reference;**
- **Approved the revised 7day services audit for submission to regulators.**

**TBC/19/11/13 Six-monthly safer staffing report**

Helen Blanchard presented the six-monthly safer staffing report which outlined the progress to date and further actions planned to ensure staffing levels were safe to meet the needs of patients, were effectively managed, and were being published in accordance with the national quality standards. Key points were as follows:

- All adult patient areas were assessed for staffing levels bar NICU and ICU which had their own, specific staffing standards.
- Regarding maternity, the Trust was commissioning a separate Birth-rate Plus review (including Cossham) which would be brought back to Board for assurance when completed.
- Overall, the report evidenced that staffing levels were appropriate to meet the requirements of patients;
- Some areas were challenged by numbers of vacancies, sickness and mental health nurses to support patients;
- Increases in staffing recruitment such as international nursing programme would improve staffing levels in the future;
- The Board were assured that staffing levels were reviewed two to three times daily across all inpatient areas to ensure safety and identification of hotspots.

**RESOLVED:**

- **The six-monthly safer staffing report was noted;**
- **It was agreed the safer staffing report would be deep-dived at a future People & Digital Committee;**
- **It was agreed a reflection of the system context should be included in future staffing reports;** **HB**

**TBC/19/11/14 Integrated Performance Report – October 2019**

Evelyn Barker introduced the Integrated Performance Report (IPR) for October 2019 data. Key highlights of the IPR were as follows:

- Third month in a row of strong urgent care performance especially in comparison to local Trusts;
- Reduction in overall waiting list size which was positive especially



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regarding the sustained pressure on the Trust;
- The Trust had planned to achieve the endoscopy target in a shorter timeline than expected due to outsourcing;
- A large spike in demand for CT scanning was highlighted with the Trust investigating options for dealing with this.

Key comments from the Board were as follows:
- Professor John Iredale, NED and also pro-vice chancellor Health & Life Sciences at the University of Bristol, highlighted that the Universities had an under-utilised CT scanner;
- Jaki-Meeking Davies, NED, noted the delay of transfers figures were high. Evelyn Barker confirmed the latest data showed times had improved but that numbers of stranded patients greater than 21 days continued to increase. The Board were assured regular system-wide conversations were taking place regarding this;
- John Everitt, NED, recognised that with the exception of diagnostics, the Trust was on track with revised trajectories;
- The Board were assured the four patients who had breached the 12-hour trolley target had access to an alarm and were cared for in a bed in ED with regular monitoring for hydration, pain and food. Additionally, Datix reports were undertaken for each breach;
- Catherine Phillips, Director of Finance, highlighted the Trust was behind plan but predicting to meet its control total. John Everitt, NED and F&PC chair, confirmed the Trust was predicting to meet outturn but that there was a significant number of risks to achieving the difficult target.

**RESOLVED that:**

- **The IPR be noted;**
- **Board concerns be acknowledged and fed into Urgent Care Oversight Board discussions;**
- **Further discussions offline to be had regarding University of Bristol's CT scanner;** **EB/JI**
- **Further peer comparison requested regarding meeting of targets.**

**TBC/19/11/15 Month 6 2019/20 corporate objectives update**

Catherine Phillips presented the month six 2019/20 corporate objectives which had been updated from the IPR and the F&PC. It was noted that the Trust's position was more positive than the red indicators within the report suggested.

**RESOLVED:**

- **Noted the Month 6 2019/20 corporate objectives update;**
- **Requested F&PC to deep-dive the objectives and risk mitigations in February 2020;**
- **Prioritisation of the Trust's objectives to be completed and** **CP**



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**denoted within future reports.**

**TBC/19/11/16 Freedom to speak up 6-monthly report**

Xavier Bell, Director of Corporate Governance and Trust Secretary, presented the Freedom to speak up (FTSU) 6-monthly report and highlighted the following points to the Board:

- The number of concerns reported to FTSU had increased to the national average in the last six months though it was noted Q1 and Q2 did not currently have comparative data;
- It was noted that no staff who had raised a concern felt they had experience detriment. This was a reduction since the previous annual FTSU report;
- Future reports would include triangulation of data such as happy app and staff survey results;
- From CQC feedback, FTSU had further incorporated Staff Side Union colleagues into policy reviews and meetings;
- It was noted NBT's FTSU scheme had good involvement from junior doctors;
- Guardian well-being was supported through training, well-attended quarterly FTSU meetings and Xavier Bell as lead.

There was discussion around how other Trusts created and ran FTSU within their Trusts. Xavier Bell described variance nationally as some Trusts employed a dedicated FTSU Guardian and others had multiple volunteer FTSU Guardians who meet regularly.

**RESOLVED:**

- **Agreed a self-review tool for FTSU be confirmed at a future Board seminar workshop;**
- **Noted the FTSU report with agreement that visibility to Board was important;**
- **Agreed to a FTSU internal audit in 2020/21;** **XB**
- **FTSU Guardians were thanked for volunteering their time.**

**TBC/19/11/17 Any Other Business (AOB)**

No other business was raised.

**TBC/19/11/18 Questions from the Public in Relation to Agenda Items**

A member of the public raised three questions on the topic of refugees accessing healthcare:

'1. How will North Bristol NHS Trust monitor cases of harm and distress resulting from the implementation of the charging regime - and make this information publicly available?

2. How are patients who are charged for or denied care supported so that the bills they receive do not do irreparable financial damage and drive them to avoid accessing further care?

3. How are the costs, charges and income generated being evaluated by the Trust on an on-going basis to ensure that the implementation of the policy can be justified?'

The Board thanked the member of public for their questions and confirmed a full, written response would be communicated in due course. Board members further provided assurance that the Trust

would always provide urgent treatment to someone who needed it. It was also noted that the Trust were acting in line with National Government policy.

**RESOLVED to provide a full written response to the questions provided by the member of public.** **XB**

**TBC/19/11/19 Annual guardian of safe working (junior doctors) report**

Chris Burton introduced Dr Kathryn Holder whose role as guardian of safe working was created as part of the junior doctors contract, 2016.

Dr Kathryn Holder noted the following:

- At the Junior Doctor Forum, availability and choice of food during anti-social hours shifts was highlighted as a key concern;
- A review of junior contract hours had stipulated a reduction of weekend working frequency from 1 in 2 to 1 in 3 and doctors should receive rotas with 6-8 weeks-notice;
- Since writing the report, vacant appointments in Trust junior-doctors staffing had reduced to three;
- The Board was assured that the Trust was on track to be compliant in February 2020 for the 1 in 3 weekend rotas in ITU and for 72-hour week maximums.

Rob Mould, NED, also highlighted the lack of hot food facilities for patients and visitors to Southmead Hospital. Andrew Jeanes, Director of Operational Facilities, confirmed the Trust was in conversations with The Hospital Company (PFI provider) and hoped provision of a new food outlet including hot food would be available in 2020.

**RESOLVED**

- **Noted the annual guardian of safe working report;**
- **Requested a discussion/ workshop with shift staff to provide potential options for out-of-hours food;** **AJ/KH**
- **Kathryn Holder to continue to attend People & Digital Committee quarterly.**

**TBC/19/11/20 Date of Next Meeting**

The next public meeting of the Board was scheduled to take place on 30 January 2020 at 10.00am, Southmead Hospital.

The meeting concluded at 12.15pm

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**North Bristol NHS Trust** **Trust Board - Public Committee Action Log**

# Trust Board - Public ACTION LOG

| | | | |
|---|---|---|---|
| Closed | Action completed and can be filtered out | Amber | Status not updated/completed and/or the deadline passed. |
| Blue | Completed and will be removed from chart for next iteration. A = On current meeting agenda. | Red | Status not updated/completed and/or deadline passed by more than one month. |
| Green | Status updated and on track within timescale. | | |

| Meeting Date | Agenda Item | Minute Ref | Action No. | Agreed Action | Owner | Deadline for completion of action | Item for Future Board Meeting? | Status/ RAG | Info/ Update | Date action was closed/ updated |
|---|---|---|---|---|---|---|---|---|---|---|
| 30/05/2019 | Quality and Risk Management Committee Report | TBC/19/5/11 | 2 | Review format of Exec / Non-Exec Walkrounds | Helen Blanchard Director of Nursing & Quality | Aug-19 | Yes, 29/08/2019 | A | On January public trust Board agenda | 28/11/2019 |
| 28/11/2019 | IPR – October 2019 | TBC/19/11/14 | 14 | Further discussions offline to be had regarding University of Bristol's CT scanner | Evelyn Barker, COO & John Everitt, NED | TBC | No | Open | Andrew Pearce is facilities manager at the Universities | 23/01/2020 |
| 28/11/2019 | Questions from the Public in Relation to Agenda Items | TBC/19/11/18 | 18 | Provide a full written response to the questions provided by the member of public | Xavier Bell, Director of Governance | Jan-20 | No | Complete | A response was provided in December 2019 | 22/01/2020 |

NHS North Bristol NHS Trust

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| **Report To:** | Trust Board Meeting | | **Agenda Item:** | 8.0 |
| **Date of Meeting:** | 30 January 2020 | | | |
| **Report Title:** | Chief Executive's Briefing | | | |
| **Report Author & Job Title** | Xavier Bell, Director of Corporate Governance & Trust Secretary | | | |
| **Executive/Non-executive Sponsor (presenting)** | Andrea Young, Chief Executive | | | |
| **Purpose:** | **Approval/Decision** | **Review** | **To Receive for Assurance** | **To Receive for Information** |
| | | | | **X** |
| **Recommendation:** | The Trust Board is asked to receive and note the content of the briefing. | | | |
| **Report History:** | The Chief Executive's briefing is a standing agenda item on all Board agenda. | | | |
| **Next Steps:** | Next steps in relation to any of the issues highlighted in the Report are shown in the body of the report. | | | |

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| **Executive Summary** |
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| The report sets out information on recent updates from our regulators, changes in senior leadership within the Trust, and other items of importance to the Board. |



*This document could be made public under the Freedom of Information Act 2000.*
*Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.*

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|---|---|
| **Strategic Theme/Corporate Objective Links** | **Be one of the safest trusts in the UK**<br><br>**Play our part in delivering a successful health and care system** |
| **Board Assurance Framework/Trust Risk Register Links** | Does not link to any specific risk. |
| **Other Standard Reference** | N/A |
| **Financial implications** | None identified. |
| **Other Resource Implications** | No other resource implications associated with this report. |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | None noted. |

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| **Appendices:** | Appendix 1 – Flu Vaccination Figures – 16 January 2020<br>Appendix 2 – Transforming health through innovation: Integrating the NHS and academia (Summary) |





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## 1. Purpose

To present for information an update on local and national issues impacting on the Trust.

## 2. Background

The Trust Board should receive a report from the Chief Executive to each meeting detailing important changes or issues in the external environment. This includes guidance and policy actions which have been received from the wider regulatory and policy system, quality and financial risks in the health economy.

## 3. New clinical performance standards

Recent media reports have highlighted that there is likely to be a change to emergency department performance standards, including the current A&E 4 hour wait standard. A number of Trusts nationally have been piloting new clinical standards since they were first recommended in a review led by NHS England's national medical director in March 2019.

At the time of writing this report, providers have not received any formal notification that standards will change in 2020/21; however annual planning guidance is expected to be released in late January 2020 which may provide further information on changes and a timeframe of implementation.



## 4. Local Members of Parliament

Trust Board will be aware that the recent national election (December 2019) did not result in any changes to local Members of Parliament in Bristol or South Gloucestershire.

The Right Honourable Chris Skidmore, MP for Kingswood, currently holds the Government post of Minister of State (Department for Business, Energy and Industrial Strategy) (Universities and Science) (Joint with the Department for Education).

Luke Hall, MP for Thornbury and Yate, currently holds the Government post of Parliamentary Under-Secretary (Housing, Communities and Local Government).

## 5. Academy of Medical Sciences new report

The Academy of Medical Sciences has published a new report "Transforming health through innovation: Integrating the NHS and Academia". The report calls for better integration of academic and clinical activity and career pathways. Across the two Bristol Trusts there is a considerable volume of research activity, with NBT increasingly performing well in research income and activity. Executives from the two Trusts and the Universities will consider how we can build on the current platform.

A summary of the report is attached at *Appendix 2*.



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**6. Out of hospital care**

Changes to the GP contract in the context of establishing Primary Care Networks are currently out for consultation with NHS England due to respond before the start of the new financial year. Staffing shortages, similar to those experienced in the hospital sector are being highlighted as creating difficulties in meeting some of the contract standards, particularly those concerned with medication reviews in nursing homes, and the development of anticipatory care. We await the outcome of the consultation to determine pace of change in building primary care networks and localities.

More encouragingly Sirona as the new community provider have appointed Executive Directors to support integration in each of the six localities in Bristol, North Somerset and South Gloucestershire. A presentation on their vision and progress with implementation was shared with TMT this week.

**7. Protecting NHS staff**

We welcome the announcement by NHS England and Improvement that a new joint agreement has been signed with the Crown Prosecution service to ensure there is effective investigation and prosecution of cases where emergency workers are the victims of crime and physical violence. This puts strength behind the current legislation "Assaults on Emergency Workers (offences) Act". The new agreement is effective from 6 January 2020.

Our most recent staff survey suggests a worsening picture for staff experiencing physical violence at work at NBT, so action in this area nationally and locally remains a top priority.

**8. Thornbury outpatients facility**

The new Thornbury outpatient unit opened its doors on 23 December 2019. This involved the relocation of various outpatient services from the Thornbury Hospital site to a precinct in the centre of Thornbury. This has allowed the old site to be closed, while still retaining a local service for the residents of Thornbury.

There are four outpatient rooms in the new unit which currently support gynaecology, colorectal, respiratory medicine and audiology outpatient appointments, as well as community midwifery activity. So far there has been positive user feedback and a good demand for the services offered at the new site.

**9. System planning 2020/21**

Following submission of the system long term plan in November 2019, focus has now shifted to developing an implementation plan for 2020/21. Regulators have now confirmed revenue support for the Weston transaction, and alongside this there is



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an expectation that the BNSSG system plan for 2020/21 will achieve a financial trajectory agreed with regulators.

Currently a number of system partners are reporting a variance from this trajectory which totals £29M. Work is underway at executive level to try and close this gap.

**10. Consultant appointments**

In quarter 3 of 2019/20 the Trust appointed eight new consultants across several key specialties:

| Name: | Specialty: | Appointed from: |
|---|---|---|
| Anthony Cox | Diagnostic/Interventional Neuroradiology | October 2019 |
| Fleur Talbot | Diabetes & Endocrinology | October 2019 |
| Helen Johnston | Anaesthetics | November 2019 |
| Thomas Mayes | Medicine for Older People | November 2019 |
| Chih Wong | Cardiology | November 2019 |
| Jay Nath | Renal Transplant Surgery | December 2019 |
| Sananda Halder | AbdominoPelvic Radiology | December 2019 |
| Zoe Jones | Acute Medicine | December 2019 |

Trust Board is invited to welcome these critical members of staff to the Trust – we wish them well in their career at NBT.

**11. Flu vaccinations**

The 2019/20 seasonal flu vaccination campaign continues and will run until the end of February 2020. The vaccination programme includes 84 peer vaccinators along with 45 hours per week bank shifts to ensure a wide coverage across the Southmead site and satellite units.

The national requirement, linked to the flu vaccine CQUIN is that 80% of frontline healthcare workers receive a vaccination. As at 16 January 2020 the Trust has achieved 80.7% of all frontline staff vaccinated. A further breakdown is provided in *Appendix 1*.

**12. Use of the Trust Seal**

Trust Board should note that the following contracts have been executed on behalf of the Trust under seal, in accordance with the Standing Orders and Scheme of Delegated Authority:



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| Contract: | Date sealed: |
|---|---|
| Cribbs Causeway (Lease) | 19/09/2019 |
| Construction contract - refurbishment of BCRM building to facilitate move outpatients & imaging | 19/09/2019 |
| Shirehampton Health Centre – Licence to underlet (Community Midwifery) | 19/09/2019 |
| Residential accommodation for overseas nurses, Bristol (Lease) | 02/10/2019 |
| Residential accommodation for overseas nurses, Bristol (Lease) | 21/10/2019 |
| Licence for alterations, Beckspool Road, Frenchay (BIRU) | 21/10/2019 |
| • East Trees Health Centre (Lease)<br>• VWV Lease<br>• Statutory Declaration | 03/10/2019 |
| JCT Intermediate Building Contract – Phase 2 Pathology Programme | 12/11/2019 |
| Residential Lease, Bristol | 20/11/2019 |
| Hope Farm, Thornbury – Overage Agreement (Deed of Covenant) | 27/11/2019 |
| Hope Farm, Thornbury, Deed of Priority | 27/11/2019 |
| Sale of Land (Frenchay) | 18/12/2019 |
| Retail Leases at Southmead Hospital (Licence for works) | 19/12/2019 |



## 13. Recommendation

The Trust Board is recommended to receive the report for information.



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NHS North Bristol NHS Trust

| | | | | |
|---|---|---|---|---|
| **Report To:** | Trust Board Meeting | | **Agenda Item:** | 8.0 |
| **Date of Meeting:** | 30 January 2020 | | | |
| **Report Title:** | Board Director walk arounds | | | |
| **Report Author & Job Title** | Xavier Bell, Director of Corporate Governance & Trust Secretary | | | |
| **Executive/Non-executive Sponsor (presenting)** | Xavier Bell, Director of Corporate Governance & Trust Secretary | | | |
| **Purpose:** | **Approval/Decision** | **Review** | **To Receive for Assurance** | **To Receive for Information** |
| | **X** | | | |
| **Recommendation:** | The Trust Board is asked to discuss and approve the proposed approach to Board Director walk-arounds. | | | |
| **Report History:** | This paper provides a response to an action arising from the May Trust Board meeting asking for a proposal for Board Director walk-arounds. | | | |
| **Next Steps:** | Next steps in relation to any of the issues highlighted in the Report are shown in the body of the report. | | | |

9

| **Executive Summary** |
|---|
| The series of slides (*Appendix 1*) sets out a proposal for Board Director walk-arounds at North Bristol Trust. These slides will be presented at the Board meeting, and the Board is invited to consider and discuss the proposal. Approval is sought for the recommended option. |



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| | |
|---|---|
| **Strategic Theme/Corporate Objective Links** | **Be one of the safest trusts in the UK** |
| **Board Assurance Framework/Trust Risk Register Links** | N/A |
| **Other Standard Reference** | N/A |
| **Financial implications** | None identified. |
| **Other Resource Implications** | No other resource implications associated with this report. |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | None noted. |

| | |
|---|---|
| **Appendices:** | Appendix 1 – Board Director walk-around slides<br>Appendix 2 – Board Director walk-around template |





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NHS
North Bristol
NHS Trust

# Board Director Walk-arounds

## *Purpose & Process – for discussion*

Exceptional healthcare, personally delivered

NHS
North Bristol
NHS Trust

# Purpose:

- **Visibility of Board Members**
- **Engagement with front-line staff**
- **Insight and exposure for Non-Executives**
- **Coaching & conversations**

**NOT:**

- **Recording actions / "rescuing"**
- **A safety audit *(note that Ward Accreditation is planned for 2020)***

# Process:

North Bristol NHS Trust

**Annual Board seminar/discussion covering:**

- Purpose & Process
- Senior front-line staff to be involved – sharing their experience of, and what they get out of the process
- Board discussion on priority areas for visits
- Culminates in a 12 month schedule of visits for Execs and NEDs
- "self-rostered" – option to step in to cover absence

# For discussion:

NHS North Bristol NHS Trust

| Option 1: (Recommended) NED & Exec undertaking visits together | Option 2: Separate visits |
|---|---|
| Opportunity for NEDs & Execs to spend time together | Less "VIPs" descending on a location at once |
| Exec able to navigate and provide introductions if required | NED opportunity to have discussions/triangulate without Execs present |

- **Proposed frequency is quarterly for Executives, and twice yearly for Non-Executive Directors**
- **Suggest that whatever conclusion is reached, new NEDs accompany an Exec for first few visits**

# Process *(continued):*

North Bristol NHS Trust

**Visits & Outcomes:**

- Directors take their own notes
- Simplified template, consistent across both Execs and NEDs
- Opportunity for senior manager to accompany NED, but not a requirement
- PA/Admin to ensure ward manager meet's Director on arrival
- Notes shared with Xavier Bell & Su Monk
- Visit numbers and themes reported to QRMC

NHS North Bristol NHS Trust

# Board Director Walk-arounds

| | |
|---|---|
| Ward / Clinical Area | |
| Date & Time | |
| Executive/Non-Executive | |

| Individuals spoken to (please only use patient's first name or initial, and staff member's role): |
|---|
| e.g. ward housekeeper |
| Patient M |
| |
| |

**Director's Observations**

| Good practice I heard about: | Concerns heard: |
|---|---|
| | |

| *Director Impression (indicate):* | | | | |
|---|---|---|---|---|
| Staff morale | | | | ** |
| Patient experience | | | | ** |
| Physical environment | | | | ** |
| Overall impression | | | | ** |
| | **HELP… - indicates serious safety concern, requires immediate feedback to relevant Director | | | |

9

NHS North Bristol NHS Trust

**Discussions with Staff**

**Prompts…**

- *How's it going today?*
- *Do you like working on this ward/in this team?*
- *Is it a supportive environment?*
- *Do you know about the staff wellbeing offerings?*
- *Did you feel enabled to provide the best care for your patients this week?*
- *What are you proud of this week?*
- *What are your top three concerns?*
- *How does communication between staff either help or hinder safe care on your ward?*
- *How can we help you to undertake activities that improve safety and patient experience?*
- *Did you discuss with your manager any incidents / complaints that have been reported?*
- *Do you know what happened following the reported incident(s) / complaints?*
- *Is there anything you want to ask me? Do you have any ideas or good practice to share?*

**Discussions with Patient and/or Relatives**

**Prompts…**

- *How has your stay with us been?*
- *Do you know when you're leaving hospital?*
- *(If yes) Are you confident the arrangements are in place?*
- *(If no) Do you know what you are waiting for?*
- *Is there anything the staff have been doing really well?*
- *Is there anything we could do better?*



Please now:

- Complete this form and share it with Su Monk & Xavier Bell

| | | | | |
|---|---|---|---|---|
| **Report To:** | Trust Board | | **Agenda Item:** | 10 |
| **Date of Meeting:** | 23 January 2020 | | | |
| **Report Title:** | Quality & Risk Management Committee Report | | | |
| **Report Author & Job Title** | Xavier Bell, Director of Corporate Governance & Trust Secretary | | | |
| **Executive/Non-executive Sponsor (presenting)** | Professor John Iredale, Quality and Risk Management Committee Chair, Non-executive Director | | | |
| **Purpose:** | **Approval/Decision** | **Review** | **To Receive for Assurance** | **To Receive for Information** |
| | | | X | |
| **Recommendation:** | The Trust Board should receive the report for assurance and:<br>• Note in particular the Committee's conclusion that the Trust continues to comply with the CNST maternity standards; and<br>• Consider the emerging NHS patient safety survey and the Trust's patient safety culture work as possible future away-day topics. | | | |
| **Report History:** | The report is a standing item to the Trust Board following each Committee meeting. | | | |
| **Next Steps:** | The next report will be received at the Trust Board in March 2020. | | | |

10

| **Executive Summary** |
|---|
| The report provides a summary of the assurances received and items discussed and debated at the Quality and Risk Management Committee Meeting held on 23 January 2020. |

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| | |
|---|---|
| **Strategic Theme/Corporate Objective Links** | • Be one of the safest trusts in the UK<br>• Treat patients as partners in their care |
| **Board Assurance Framework/Trust Risk Register Links** | Link to BAF risk SIR14 relating to clinical complexity. |
| **Other Standard Reference** | CQC Standards. |
| **Financial implications** | No financial implications identified in the report. |
| **Other Resource Implications** | No other resource implications identified. |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | None identified. |

| | |
|---|---|
| **Appendices:** | Appendix 1: Safety Culture Survey Report – QRMC January 2020 |



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## 1. Purpose

To provide a highlight of the key assurances received, items discussed, and items for the attention of Trust Board from the Quality and Risk Management Committee meeting held on 23 January 2020.

## 2. Background

The Quality and Risk Management Committee is a sub-committee of the Trust Board. It meets bi-monthly and reports to the Board after each meeting. The Committee was established to provide assurance to the Trust Board on the effective management of quality governance and risk management.

## 3. Key assurances received & items discussed

The Committee focused its discussions on the following items:

3.1 Safety culture survey

The Medical Director provided an update on actions being taken by the Trust arising from the Professor Durkin report. It was noted that these actions are progressing appropriately.

The Committee also received a report on the pilot of a safety culture survey in Gynaecology and Pathology. This report included triangulation of safety culture information from a variety of sources, including:

- The Trust's Quality Improvement Programme
- The Perform Academy
- The Trust's staff wellbeing programme
- The Clinical Governance Improvement Programme
- Results from the Trust's recent CQC inspection
- 2018 staff survey results
- 2019 SCOR safety culture survey results in maternity
- The Freedom to Speak Up programme
- The "Just Culture" transformation project, focusing on the management of disciplinary and grievance cases

The safety culture pilot in Gynaecology and Pathology used a version of the Safety Attitudes Questionnaire (SAQ) adapted to be NHS context-specific. Trust Board should be assured that the interim results from the survey are positive; with the only area scoring below the "positive" cut-off were staff perceptions around staffing levels in Pathology.

The various sources set out in the report identified consistent themes of staffing levels and the danger of burnout and how this might impact on safety culture. It acknowledged that the safety culture across the organisation appears to be positive, but with areas that clearly need improvement. Work over coming months to implement the new NHS patient safety culture will help to progress the desired improvements.

A copy of the report received by the Committee is included as *Appendix 1.*

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3.2 Cancer Diagnostics/52ww/A&E 12 hour performance – patient harm deep dive

A deep-dive was undertaken, led by the Chief Operating Officer. Assurance was provided that patients waiting for longer than the agreed standards are reviewed regularly, and that patients approaching treatment deadlines are also subject to a clinical review.

The Committee was also assured that patients on an RTT pathway who wait longer than 52 weeks are usually seen within 56-57 weeks, and that the harm reviews undertaken on each patient have not identified any worse outcomes resulting from the wait.

The Committee asked for additional work to ensure that the clinical review looking at patient harm is standardised and as effective as possible, and also looks at quality and patient experience as well as harm. The Committee will receive quarterly updates on this topic.

3.3 NHS Patient safety strategy overview

The Committee received an update on the new NHS patient safety strategy. The implementation of this strategy over the next three years will involve a focus on patient safety culture and developing a “just culture” in the NHS. The Committee were reassured based on feedback from regulators including the CQC that the Trust will start this work from a position of strength.

The Patient safety strategy will also involve significant changes to incident reporting and investigations, moving to a more thematic and risk-based approach with more board oversight. The Committee will receive further updates as regulators release additional implementation guidelines and the Trust’s patient safety strategy implementation plan progresses.

This item (together with the patient safety survey described above) is recommended to Trust Board as possible Trust Board away-day topics.



3.4 CNST maternity scheme update

The Committee received an update on the Trust’s compliance with the CNST maternity scheme, and was assured that that Trust is continuing to achieve the require standards, with appropriate actions being taken to ensure that this continues. The Committee also reviewed the perinatal morbidity quarterly report.

It was noted that some of the standards may require future investment and support from commissioners. This will continue to be monitored and exception reports will be raised to the Committee as required.

3.5 Other updates:

Updates were also received on the following topics:

- Risk management assurance programme;
- Quality performance report;
- Board Assurance Framework quality risks;
- Patient falls;

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- Internal audit reports (Patient Safety Incident Reporting & Clinical Governance Improvement Programme);
- Serious incidents/Never events;
- Royal College of Surgeons colorectal surgery review (the full written report will be brought to the next Committee meeting);
- Liberty Protection Safeguards (LPS) regulations & Deprivation of Liberty Standards (DOLS) reporting;
- CQC inspection action plan; and
- Sub-committee upward reports.

The Committee did not identify any concerns requiring escalation to Trust Board.

3.6 Committee self-evaluation results

The results of the Committee's self-evaluation questionnaire indicate that members feel that the group was focusing on the important issues and achieving the aims of the Committee as set out in its terms of reference. It was agreed that more clarity would be provided to authors when commissioning deep-dives.

**4. Identification of new risk & items for escalation**

No new risks were identified in the meeting.

**5. Recommendations**

The Trust Board should receive the report for assurance and:

- Note in particular the Committee's conclusion that the Trust continues to comply with the CNST maternity standards; and
- Consider the emerging NHS patient safety survey and the Trust's patient safety culture work as possible future away-day topics.



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ITEM 10.1 - APPENDIX 1

NHS North Bristol NHS Trust

| | | | | |
|---|---|---|---|---|
| **Report To:** | Quality & Risk Management Committee | | **Agenda Item:** | 05.2. |
| **Date of Meeting:** | 23/01/2020 | | | |
| **Report Title:** | Safety Culture | | | |
| **Report Author & Job Title** | Dr Seema Srivastava, Associate Medical Director.<br>Lorraine Motuel Quality Improvement Patient Safety Lead. | | | |
| **Executive/Non-executive Sponsor (presenting)** | Dr Chris Burton, Medical Director | | | |
| **Purpose:** | **Approval/Decision** | **Review** | **To Receive for Assurance** | **To Receive for Information** |
| | | X | X | X |
| **Recommendation:** | The committee is requested to:<br>• Note the interim findings of the current Safety Culture survey in Pathology and Gynaecology.<br>• Note the findings of the Staff Survey, CQC report and other relevant reviews.<br>• Note the approach QSIT has used to develop the survey, create specialty readiness and engagement ahead of survey launch and the collaboration with key corporate teams, Comms, HR, PMO, Clinical Risk, for the analysis and triangulation of information.<br>• Note the requirement for ongoing activities related to the results of this report to continuous to develop a Just Culture in NBT in line with the NHS Patient Safety strategy. | | | |
| **Next Steps:** | As set out in paper; | | | |

**Executive Summary**

This report provides QRMC with an overview of the work on measuring the safety culture in North Bristol Trust (NBT) and the on-going development of a Just Culture. This was one of the five recommendations from the Independent Inquiry carried out by Professor Michael Durkin into the Serious Incident Investigation on the missed diagnosis of cervical cancer in a patient.

| | |
|---|---|
| **Strategic Theme/Corporate Objective Links** | Strategic Themes:<br>• Be one of the safest trusts in the UK<br>• Patients as partners in their care<br>Linked Corporate Objectives 19/20:<br>• Invest in clinical governance for learning and improvement |

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ITEM 10.1 - APPENDIX 1

| | |
|---|---|
| | • Achieve 'Good' CQC rating |
| **Other Resource Implications** | To regularly measure the safety culture across the organisation there are resource implications.<br>• Divisions will be required to release staff from clinical and administrative duties to participate in engagement activities to develop their safety culture vision and strategy.<br>• Time will also be required for analysis and planning to improve safety culture.<br>The Quality and Safety Improvement Team (QSIT) will estimate the time it has taken in pilot areas to carry out the engagement activities and who needs to be involved (for example, PMO, Communications, divisional governance) The pilots in Gynaecology and Pathology should inform the requirements for safety culture work in other specialties and clinical areas. |

## 1. Purpose

In 2017 a Serious Incident was reported in which a diagnosis of cervical cancer was delayed resulting in the death of a patient. The subsequent investigation was criticised and the Trust commissioned Professor Mike Durkin to review the Trusts investigation process. A number of recommendations were made in the Durkin report and the actions against these will be reported to QRMC. One specific recommendation was made where the Trust Board asked for early indications of progress. That recommendation was:

***In order to avoid future examples of poorly conducted safety investigations, the Board of the Trust must reaffirm its commitment to a compassionate and just leadership culture that champions innovation and eradicates fear and blame, whilst ensuring open, efficient and effective investigations when mistakes are identified. To this end strong consideration should be given to formally assessing the Trust's safety culture at regular intervals and acting upon the results, alongside wider information such as that obtained from the Staff Survey.***



Through its quality strategy (draft at QRMC Jan 2020) and response to the national patient safety strategy published in 2019 the Trust demonstrably affirms its commitment to developing a culture that continuously promotes the safety of patients. This report describes work already undertaken to develop that culture as well as additional steps being taken which include piloting a trust safety culture survey and initial feedback from the two pilot clinical areas – Pathology and Gynaecology.

To provide an overview of the insights into the safety culture from recent trust reports and reviews;

- Trustwide Safety Culture Survey Report 2016
- The Care Quality Commission reported finding in August 2019.
- Staff survey results of 2018 (2019 results due February).

ITEM 10.1 - APPENDIX 1

- Results of a Score safety culture survey in maternity as part of a national maternity project (NHS Improvement).
- Freedom to speak up programme.
- Human Resources transformation project of a Just Culture approach in the management of disciplinary and grievance cases.

## 2. Introduction

There are many definitions of what organisational culture is.

Culture can be defined as our values (what is important?), behaviours (the way we do things around here) and beliefs (how things work).

The Southwest Patient Safety Collaborative use simple but clear language in their publication about Safety Culture (2015):

“What does it feel like to come to work?”

“Do I feel valued for my contribution in my team?”

It is widely accepted that good culture in the NHS is crucial to ensure that patients receive high quality care and better outcomes.

NHS Improvement has described in the NHS Patient Safety Strategy (2019) the key ingredients for healthcare organisations that want to be safe: staff who feel psychologically safe; valuing and respecting diversity; a compelling vision; good leadership at all levels; a sense of teamwork; openness and support for learning.

## 3. Trustwide Safety Culture Survey 2016



In 2016 a validated Safety Culture survey called the Safety Attitude Questionnaire (SAQ) was used to measure Safety Culture across the organisation. 984 questionnaires were completed from staff across all divisions (then directorates). The Safety Attitudes Questionnaire (SAQ), developed by the University of Texas is a validated questionnaire for use in healthcare.

The survey consists of 28 questions to determine staff perceptions towards Safety Culture in their local clinical service and teams. Participants used a Likert Scale to rate their perceptions towards safety related statements. The scale scores range from ‘Strongly Disagree’ to ‘Strongly Agree’.

The outputs of the survey include a total Safety Attitude Score described as a percentage, which if over 50%, indicates a positive finding in that domain. Scores less than 50% are considered negative.

In the 2016 survey the trust score was 74%. Positive findings included having regular briefings, encouraging reporting incidents and nursing input being well received.

Less positive domains included perceptions around staffing levels and speaking up if there was a problem in patient care.

A number of activities have taken place since this report to build on a positive Safety Culture.

ITEM 10.1 - APPENDIX 1

**4. Trust activities which have supported building a positive Safety Culture**

There have been a number of ways which we have engaged our staff in positive Safety Culture. These include:

Quality Improvement (QI) Programme

- Creating a comprehensive Patient Safety Programme which engages all professions to be able to play their part in improving the care they deliver to patients, and the services they work within. The programme covers safety on wards, in theatres, emergency care and maternity care (Appendix 2).
- Holding a weekly Hub for anyone with an idea to make positive changes in their services to receive Quality Improvement coaching and technical support.
- Celebrating success with an annual Quality Improvement poster event and showcasing the great work that teams do at the first World Patient Safety day.
- Regular workshops which give staff training in how make positive change and improve their services.
- Supporting the well-established Foundation Year QI programme as well as extending the QI education to Clinical Fellows and other grades of doctors.

In 2019 there were 199 improvement projects registered with 40 of them now in final stages. Examples of projects include:

- The Theatres Simulation Project which enables teams to train together and improve psychological safety.
- Reducing Anxiety for Burns Patients which developed a video to support patients when they are transferred to rehabilitation units.
- The ICU Infographic Project has improved the experience of relatives visiting ICU, and enables them to understand more about the care which is delivered to their family member.
- Positive Incident Management developed in ICU and spread to Medicine. This encourages teams to nominate staff members monthly who have made a positive contribution and celebrate their efforts to provide compassionate care to patients.

This demonstrates that we have a culture of improving, and that our teams feel empowered to take their ideas and develop them into deliverable improvements to help their patients and their own working environment.

Perform Academy

In April 2018 the Trust invested significantly in its teams to develop and deliver the Perform approach with a focus on coaching teams to work well together with structured communication and shared goals to enable patients to get home quicker and improving “flow”. To date 1750 members of NBT staff have attended Perform Bootcamps (over 20% of the organisation). Perform coaches have supported all inpatient wards as well as ICU, Maternity and

MediRooms. In Mendip Ward (Part of Women's and Children's Division) they saw a 10% reduction in length of stay. In ICU there has been a >50% increase in morning transfers out of the Unit.

The appreciative approach of Perform

- encourages teams to identify their vision for an excellent service for patients
- supports the strengthening of team accountability and empowerment and
- celebrates success within teams and more visibly in the organisation

Has all contributed to positive team cultures.

Staff Wellbeing

There has been significant attention to staff health and wellbeing with initiatives such as Schwartz Rounds, Mindfulness, Reflective writing, Mental Health First Aid.

In 2018, 206 staff have accessed one-to-one psychology support, 37 teams have requested support with 6 active sessions currently running, 180 staff members have received training in Mental Health First Aid awareness, with an additional 50 staff who are existing Mental Health First Aiders.

Schwartz Rounds started at NBT in 2017 and take place every six weeks. There have been approximately 47 to 64 attendees at each round with a total of 390 attendees to date. The rounds provide a structured forum where all staff regularly come together to discuss the emotional and social aspects of working in healthcare. Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. Quotes from some of the rounds –"*Great stories, thought provoking*". *"Safe forum for reflection, great to see so many professionals attending and open to reflection".* "*So very pleased that I found the time to attend". "Very powerful and moving content that inspires non-judgemental discussions about subjects people are mostly afraid to discuss otherwise.*



Clinical Governance Improvement Programme

A Trustwide Clinical Governance Improvement Programme (CGIP) was delivered between September 2018 and June 2019. This included revision of the committee infrastructure to bring the board closer to quality assurance and improvement through direct reports to the Quality and Risk Management Board sub-committee. A wide range of quality systems geared towards supporting divisional and specialty leaders as well as 'corporate' quality committees have been reviewed, and where improvements are needed relevant actions have been developed. This programme agreed increased investment of £300K to support quality governance within Clinical Divisions and also a new Patient Advice and Liaison Service to support patients or families/carers raising concerns. It covered 9 different project areas and QRMC received regular reports on progress. The CQC inspection in July 2019 commented very positively on programme delivery. Similarly a KPMG Internal Audit report from December 2019 "Clinical Governance Improvement Programme" has provided a *'Significant Assurance'* rating on its

achievements. Phase 2 of this programme commences January 2020 to drive the benefits further into frontline teams.

## 5. Triangulation of Recent reviews which give insights into Safety Culture

The Care Quality Commission reported finding in August 2019.

In Appendix 3 are a number of relevant findings from the recent CQC inspection report related to patient safety, a learning culture, incident reporting and quality improvement.

Examples of good practice included:

***"Managers debriefed and supported staff after any serious incident. Some staff had received individual feedback and support following incidents and they saw this as a positive experience. The service had a good track record for safety."*** Urgent and emergency services

***"The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons with the whole team and in the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and actioned."*** Women's and Children's Division (Maternity)

The report mentioned one area to strengthen which is the quality of feedback staff receive once they have reported an incident. As part of the Quality Governance Improvement Project (QGIP, phase 2), we expect to see an improvement in staff perception about feedback as this work develops.



Staff survey results of 2018 (2019 results due February)

The staff survey asks six questions related to Safety Culture. In 2018, NBT had a response rate of 41% (national average was 44%) with 3,362 staff members completing the survey.

This data from 2018 shows that there are opportunities to improve staff perceptions of Safety Culture. The data shows NBT as average nationally on all the scores, although there has been an improvement on 4 out of the 6 questions comparing each year.

Our ambitions are to be much better than this and we anticipate the 2019 results following the many actions (some of which have been described in this report) over the last 12 months.

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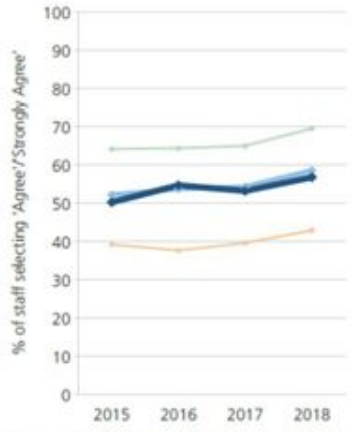
Survey Coordination Centre

**2018 NHS Staff Survey Results > Theme results > Detailed information >** Safety culture 1/2

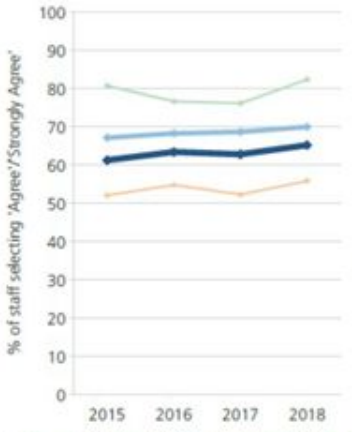
NHS England

**Q17a**
My organisation treats staff who are involved in an error, near miss or incident fairly



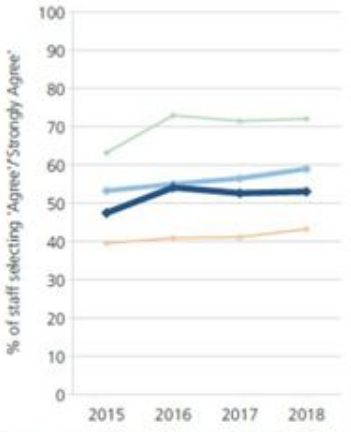

| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| Best | 64.1% | 64.3% | 64.9% | 69.5% |
| Your org | 50.2% | 54.6% | 53.2% | 56.7% |
| Average | 52.1% | 53.7% | 54.3% | 58.5% |
| Worst | 39.1% | 37.6% | 39.5% | 42.8% |

**Q17c**
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again




| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| Best | 80.7% | 76.6% | 76.1% | 82.3% |
| Your org | 61.2% | 63.3% | 62.7% | 65.1% |
| Average | 67.1% | 68.2% | 68.6% | 69.9% |
| Worst | 52.0% | 54.7% | 52.2% | 55.8% |

**Q17d**
We are given feedback about changes made in response to reported errors, near misses and incidents




| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| Best | 63.2% | 72.9% | 71.4% | 72.0% |
| Your org | 47.4% | 54.1% | 52.6% | 53.0% |
| Average | 53.2% | 54.9% | 56.4% | 58.9% |
| Worst | 39.5% | 40.9% | 41.1% | 43.2% |

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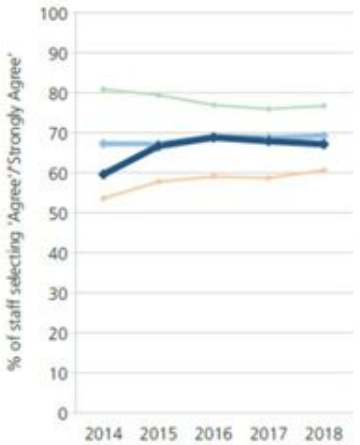
Survey Coordination Centre

**2018 NHS Staff Survey Results > Theme results > Detailed information >** Safety culture 2/2

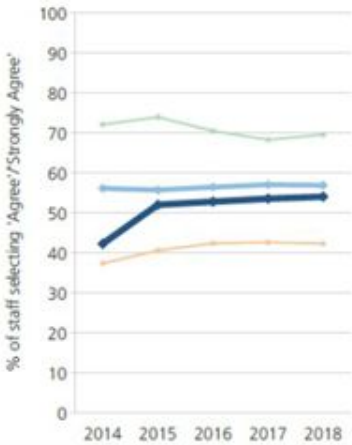
NHS England

**Q18b**
I would feel secure raising concerns about unsafe clinical practice



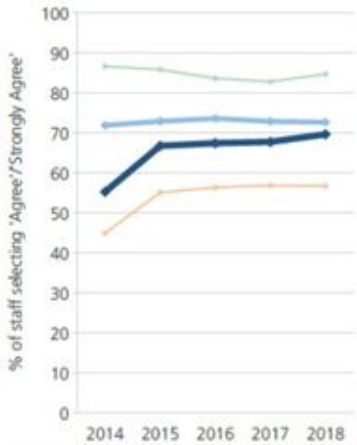

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| Best | 80.8% | 79.4% | 76.9% | 75.9% | 76.7% |
| Your org | 59.5% | 66.7% | 68.8% | 67.9% | 67.1% |
| Average | 67.2% | 67.1% | 69.1% | 68.8% | 69.2% |
| Worst | 53.5% | 57.7% | 59.0% | 58.7% | 60.6% |

**Q18c**
I am confident that my organisation would address my concern




| | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| Best | 72.0% | 73.9% | 70.4% | 68.2% | 69.5% |
| Your org | 42.2% | 52.0% | 52.7% | 53.5% | 54.0% |
| Average | 56.0% | 55.7% | 56.4% | 57.0% | 56.8% |
| Worst | 37.3% | 40.5% | 42.3% | 42.6% | 42.2% |

**Q21b**
My organisation acts on concerns raised by patients / service users




| | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| Best | 86.6% | 85.8% | 83.6% | 82.7% | 84.6% |
| Your org | 55.2% | 66.7% | 67.3% | 67.7% | 69.6% |
| Average | 71.8% | 72.8% | 73.5% | 72.8% | 72.6% |
| Worst | 44.9% | 55.0% | 56.3% | 56.8% | 56.6% |

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Results of the 2019 SCORE safety culture survey in maternity - part of a national maternity project (NHS Improvement).

NBT's maternity unit is part of the national safer births collaborative. The team members in Maternity (which is in the same division as Gynaecology with many staff working in both areas) completed a baseline safety culture survey (SCORE - Safety, Communication, Organisational Reliability and Engagement) at the start of this program. The survey used by the national program is more in depth than the SAQ but requires considerable analysis for it to be useful once completed. 352 staff members responded to the questionnaire with a response rate of 55%.

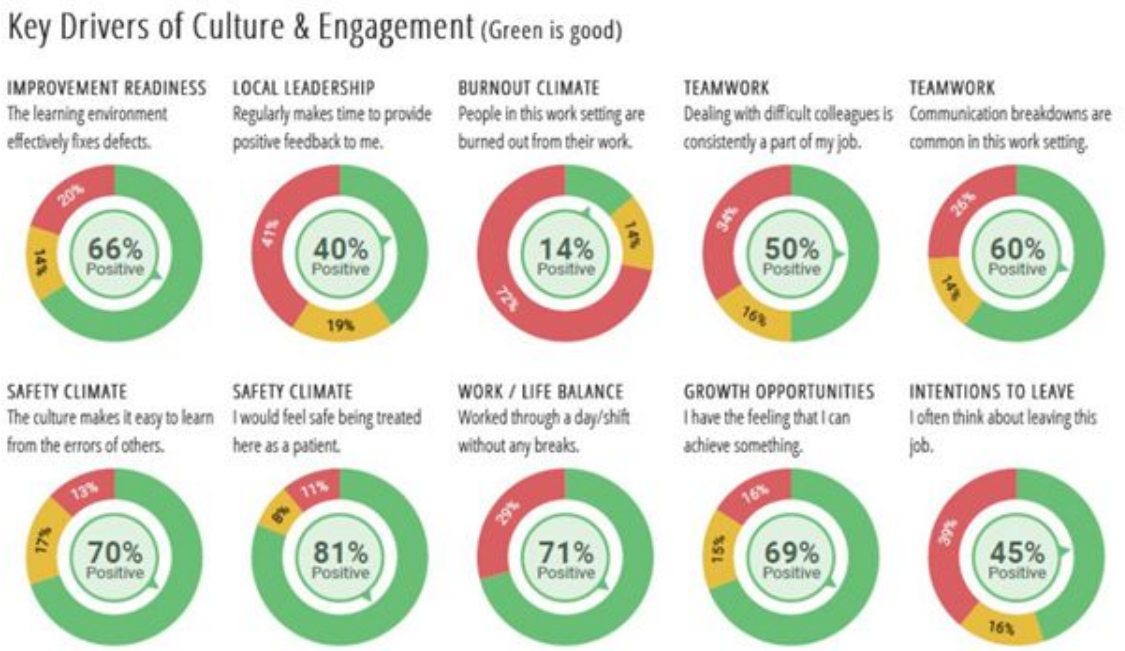
Nationally, the SCORE survey showed that many maternity units had lower scores in the domains of Local Leadership, Burnout and Communication Difficulties domains.

In NBT, the Safety climate questions in SCORE had some of the highest scores with 81% of staff feeling safe to be treated as a patient at NBT (47th centile nationally). Other positive findings:

- 90% said different disciplines/backgrounds work together as a well-coordinated team
- 85% find it easy to ask questions when they do not understand
- 81% felt errors are handled appropriately
- 70% said the culture makes it easy to learn from others
- 79% reported that lessons from other work settings were integrated
- 74% said the learning environment allowed insight into what is done well

Domains which had lower scores were Workload Strain (which was lower than national score at the 30th centile) and Feedback from incidents.





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The results of the SCORE survey were presented in detail at the January Patient Safety & Clinical Risk Committee by the Maternity team and the engagement within the respective teams across the service will be targeted to understand why some teams have scored particularly well consistently and to identify learning in those areas that can be applied elsewhere. For example themes around leadership, management and the impact on staff resilience and retention. A series of focus groups and engagement workshops are now being planned.

Freedom to speak up programme

The Freedom to Speak Up Bi-Annual Report (Appendix 4) was presented to Trust Board in November where the board were asked to review progress with the vision, strategy, action plan and the triangulation with the “Happy app” data. The report concluded that overall, whilst the number of concerns being raised is broadly in line with a national average, there is more work to be done to encourage staff to speak up. Positive comments focused on the fact that in the last quarter, no individuals who raised a concern felt that they suffered any detriment from doing so. It was also noted that unlike many other NHS organisations, NBT has good engagement with junior doctors in the FTSU process via the JD wellbeing champions who are also FTSU guardians.

## 6. Background on 2019/20 Safety Culture Survey in Gynaecology and Pathology

In November 2019 QSIT were asked to present to the Patient Safety Clinical Risk committee (PSCRC), options for measuring the organisation’s safety culture. PSCRC approved our recommendation to work with two clinical services, Gynaecology and Pathology to develop and plan activities to measure, analyse and share themes from a Safety Culture survey. The Committee also approved the use of the Safety Attitudes Questionnaire (SAQ), which was used in 2016. The Quality and Safety Improvement Team used the learning from the survey work in 2016 to consider the approach we would take to enable high levels of engagement with the local leaders of the services and encourage staff to complete the survey. We have adapted the SAQ to make it more NHS context-specific, with permission from the authors to ensure validity remained.



## 7. Progress on 2019/20 Safety Culture Survey

- QSIT and the Communications team have created electronic surveys with service-specific customisation, accessible using an internet web link or a QR code for personal devices to increase completion of the survey.
- QSIT has met with Pathology and Gynaecology senior teams on a number of occasions to scope how their teams will be encouraged to complete the survey and planned how to analyse, share, learn and engage when the results are available. The survey has been live in the two pilot sites during December and early January.
- We have met with colleagues in PMO who are developing a template so that a report can be generated for the two pilot sites which is easy to navigate and share with teams.

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- We have made initial connections with Yorks and Humber Academic Health and Science Network Patient Safety Collaborative, who have used the SAQ for a number of years, so that we can understand how we can expand the safety culture surveys beyond the pilot sites.
- We have triangulated information in conjunction with Clinical Risk and Human Resources teams, from recent organisational reviews where culture has been referenced.

**8. Interim Results of Safety Culture Survey**

In Pathology the survey has been live since December 10th 2019. So far 164 staff have completed the survey. This represents approximately 25% of the workforce. A summary of the interim results can be found in Appendix 5. The survey will be open until 17th January. The current overall Safety Attitude Percentage is 62%. Any score above 50% is deemed positive in the calculations for SAQ.

Initial findings in the Pathology survey show that respondents perceive the service as one which regards patient safety as a priority with appropriate support to deliver their work safely. The initial responses also indicate that we need to do more to improve communication within the service and review with teams how they feel about staffing levels in their areas. The only question to score under 50% was related to perceptions around staffing levels.

In Gynaecology the survey has been live since December 20th 2019. So far 24 staff members have completed the survey. This represents 25% of the workforce. A summary of the interim results can be found in Appendix 6. The survey will be open until 17th January. The current overall Safety Attitude Percentage is 65%.

Initial findings in the Gynaecology survey show that respondents perceive the service as one which regards patient safety as a priority with appropriate support to deliver their work safely. There were no questions scoring under 50%. Perceptions around staffing also appears to be an emerging theme from the interim results.

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## 9. Driver Diagram for current Safety Culture work

## 10. Human Resources transformation project of a Just Culture approach in the management of disciplinary and grievance cases.

The Just Culture approach is being led by the transformation team, it is at a scoping stage with an aim to improve the disciplinary and grievance processes and policies. Learning from the work at Mersey Care Mental Health by the key principles of:

- Free from harm – not from error
- Education v punishment
- Learning v sanction
- Encourages and supports speaking up
- Early conversations aimed at tackling things when they happen and including the person/people involved
- Restorative actions/conversations where possible which aim to put things right Reduction in formal 'cases' - and those that occur are handled efficiently and limit harm

The plan is for the just culture approach to be further developed, with training and testing in agreed pilot areas with agreed KPIs before a change in policy.

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## 11. Recommendations

The Quality & Risk Management Committee is requested to:

- Note the progress made in building positive Safety Culture and the activities in Quality Improvement, Patient Safety, Staff wellbeing and Clinical Governance, which support this.
- Note the findings of the recent CQC review, Staff Survey, Maternity SCORE survey and Freedom to Speak Up report.
- Note the interim findings of the current Safety Culture survey in Pathology and Gynaecology.
- Note the approach QSIT has used to develop the survey, create specialty readiness and engagement ahead of survey launch and the collaboration with key corporate teams, Comms, HR, PMO, Clinical Risk, for the analysis and triangulation of information.
- Note that there will be a more detailed report which will be shared in February with the Services.
- Note the requirement for ongoing activities related to the results of this report to continuous to develop a Just Culture in NBT in line with the NHS Patient Safety strategy.
- Discuss the portfolio of work in place and work being planned, to assure the Board of Safety Culture and recognise the need to develop this further to reach our ambition to be one of the safest healthcare providers in the country.

## 12. References

South West Patient Safety Collaborative SCORE Survey tool
http://www.swscn.org.uk/wp/wp-content/uploads/2015/07/Safety-Culture-information_final_10Feb16.pdf

NHS Patient Safety Strategy, 2019
https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf

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## Appendix 1 Trust wide Safety Culture Survey 2016

### Executive Summary

This is the third Safety Attitude Questionnaire (SAQ) conducted across NBT within the past five years. The questionnaire has been designed to gauge staff safety attitudes to their working environment. The survey is based on the Texas Safety Culture Tool and has been adapted and validated for use in many different clinical environments.

The aim of this survey is to determine staff attitudes towards safety culture in directorates by using the SAQ's 28 safety related questions. Participants used a Likert Scale to rate their attitude towards safety related statements. The scale scores range from 'Strongly Disagree' to 'Strongly Agree'. Its use was prompted by the requirement to monitor staff culture as part of the Trust-wide Quality Strategy.

The survey ran from February 2016 to March 2016 and a total of 984 questionnaires were returned. Of these 140 (14.2%) did not list the directorate the staff were from. These responses have been included in the Trust-wide data, but not included in the directorate breakdowns. The background information provided is as follows:

- Most respondents were from the Medicine directorate(25.5%), closely followed by Core Clinical Services (25.4%) which is not unexpected due to the large number of personnel in these directorates.
- 97.4% had not completed this survey before.
- Most respondents were Registered Nurses with 31.1% responses received.
- 76.3% of respondents were female and 23.7% were male.
- Most respondents had worked at the trust for 13 to 20 years (20.2%).

**The Safety Attitude Percentage for 2016 is 72.4%.** This year's sample was the largest collected with 984 responses received compared to 2013 (153 responses), and 2014 (129). In 2014 we had an overall safety percentage of 55.5% illustrating an almost neutral safety attitude in North Bristol NHS Trust. This has now increased by 16.9% showing a considerable improvement over the last two years.

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## Table 1: Breakdown of Safety Attitude Percentage by Directorate

| Directorate | Number of responses | Safety Attitude Score | Safety Attitude Percentage |
|---|---|---|---|
| TRUSTWIDE | 984 | 22,407/50,214 | 72.4% |
| Core Clinical Services | 211 | 4,340/10,998 | 69.8% |
| Medicine | 215 | 4,834/11,224 | 71.6% |
| Musculo-Skeletal | 57 | 1,295/2,988 | 71.5% |
| Neurosciences | 70 | 1,612/3,640 | 72.3% |
| Renal | 57 | 1,577/2,940 | 77.0% |
| Surgery | 104 | 2,724/5,222 | 76.2% |
| Women's and Children's Health | 94 | 2,408/5,010 | 74.1% |

Although one of the smaller directorates the most positive Safety Attitude percentage was Renal at 77% which is almost 5% higher than the Trust-wide average. Core Clinical Services gave the lowest response at 69.8%, almost 3% lower than the average.

Listed below are the top 5 questions with highly positive and negative responses.

**Highest SAQ Scores**

**1.** (Q11) Briefing personnel before the start of a shift (i.e. to plan for possible contingencies) is important to patient safety. (SAQ Score: 1338/1640, **90.8%**)

**2.** (Q7) It is easy for personnel here to ask questions when there is something that they do not understand. (SAQ Score: 1353/1916, **85.3%**)

**3.** (Q1) Nurse input is received well in this area. (SAQ Score: 1124/1716, **82.8%**)

**4.** (Q22) I know the proper channels to direct questions regarding patient safety in this area. (SAQ Score: 1245/1846, **83.7%**)

**5.** (Q17) I am encouraged by my colleagues to report any patient safety concerns I may have. (SAQ Score: 1238/1840, **83.6%**)

**Lowest SAQ Scores**

**1.** (Q2) In this area it is not difficult to speak up if I perceive a problem with patient care (question inverted therefore negative = positive) (SAQ Score: -946/1840, **24.3%**)

**2.** (Q15) The levels of staffing in this clinical area are sufficient to handle the number of patients. (SAQ Score: -332/1788, **40.7%**)

**3.** (Q24) Hospital management does not knowingly compromise the safety of patients. (SAQ Score: 359/1854, **59.7%**)

**4.** (Q26) Leadership is driving us to be a safety-centred organisation. (SAQ Score: 478/1876, **62.7%**)

**5.** (Q27) My suggestions about safety would be acted on if I expressed them to management. (SAQ Score: 533/1876, **64.2%**)

The responses reflect the overall positive attitude to the importance of patient safety. The majority of personnel believe that briefings before the start of the shift are important, they know the proper channels to direct any questions and encourage one another to report any issues or concerns they may have.

A high percentage of staff believe that the levels of staffing are not sufficient. This follows on from the 2014 report where the highest negative answer was also in regards to the staffing levels. There appears to be some concern surrounding upper management and their attitude to patient safety. The survey questions differ to previous reports, however this was also a concern in 2014 where only 36% of staff felt that the management supported their daily efforts, and 30% of staff felt that management were doing a good job.

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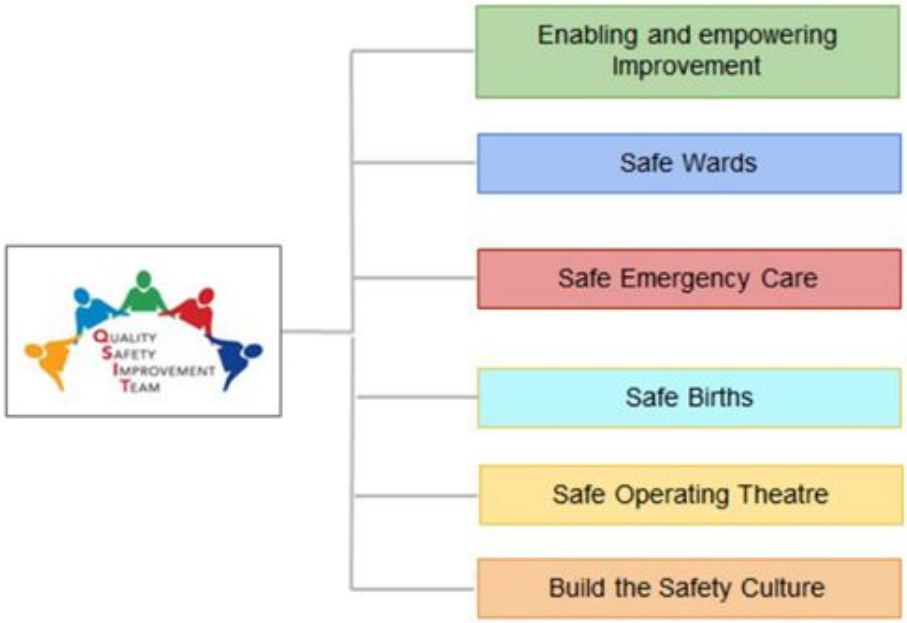
**zsaAppendix 2 Quality and Safety Improvement Programme**

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## Appendix 3 CQC Comments relevant to Culture (from 2019 Report)

| Report | Pg | Service line | Quote |
|---|---|---|---|
| Inspection report | 7 | Trust wide summary | Staff were encouraged to report incidents and there was a good learning culture. |
| Inspection report | 5 | Trust wide summary | Patients were protected from harm. Incidents were reported and well managed when something went wrong.<br>Recruitment and retention of staff was improving. The staff and the organisation was prepared to learn and improve. Staff were well trained, and services were safely staffed most of the time. |
| Inspection report | 14 | Trust wide summary | The leadership team worked well with the clinical leads and encouraged divisions to share learning across the trust.<br>The introduction of service line management had been well implemented and received positively. |
| Evidence appendix | 12 | Trust wide | We reviewed six serious incidents and were able to track duty of candour from the point of reporting through the investigation stages, where patients and families were invited to submit questions for consideration, to conclusion where verbal and written apologies and face to face meetings were offered. All serious incidents were discussed at the clinical risk operational group (CROG) and we were able to see from the minutes of those meetings that duty of candour was a standing agenda item and actions were monitored for each case. We saw examples where questions submitted by patients/relatives had been included in the terms of reference for the root cause analysis investigations, and the completed reports had been shared with them, including any learning, upon conclusion. |
| Inspection report | 15 | Trust wide summary | The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. We saw evidence of learning being shared across the trust and feeding into training and quality improvement. There was a robust learning from deaths procedure in place. |
| Inspection report | 20 | Trust wide summary | Lessons were learned when things went wrong, and staff were confident about reporting incidents |
| Evidence appendix | 27 | Trust wide | The use of LASER (Learning after significant event recommendations) posters were used to cascade learning. Each division had a governance and risk lead who was responsible for facilitating and sharing learning. The trust maintained a central resource of LASER posters and common themes were built into learning events through CROG and workshops. The trust told us learning from incidents fed into the annual safety priorities and quality improvement work and staff were able to provide examples of where changes had occurred in practice as a result of learning. Pharmacy staff felt empowered to raise concerns and report incidents and learning from medicines incidents was shared in huddles and with teams and across the trust. The trust had developed a new patient safety incident report which would be presented quarterly to the QRMC, and included analysis to divisional level, of the previous quarter's incidents along with trends, themes and comparison with national data where available. The trust told us they had more to do in relation to triangulating this data with trends and themes from complaints, mortality |

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| Report | Pg | Service line | Quote |
|---|---|---|---|
| | | | reviews and other intelligence, and had plans to develop this work. |
| Evidence appendix | 36 | Trust wide | Effective systems were in place to identify and learn from unanticipated deaths. The learning from deaths national guidance was published in 2017 and required trusts to publish its policy on learning from deaths, to provide quarterly reports including data and learning points to the trust' public board and to incorporate the reporting into trust quality accounts. The trust was compliant on all of the above and we found the policy and associated processes to be robust. The trust's policy expectation going forward was to screen all deaths, and to undertake a full mortality case review (MCR) on all deaths in the majority of specialities subject to appropriate screening and we found there were supporting tools being used to do this. As of July 2019, the trust scored themselves as 91% compliant against their target. The process in place flagged any cases with an overall score of poor, or very poor and these were automatically escalated for serious incident reporting. We reviewed six cases at random and tracked through two where care issues had been highlighted; in line with trust policy these had been reported as serious incidents and we saw learning and actions arising from these were detailed and shared. |
| Inspection report | 23 | Urgent and emergency services | The service had a good track record on safety, monitored safety performance and managed incidents well. There were well-embedded risk management processes to ensure that incidents, including deaths and unexpected outcomes, were reviewed and learning shared. |
| Inspection report | 25 | Urgent and emergency services | The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.<br>Managers ensured that actions from patient safety alerts were implemented and monitored.<br><br>The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors. |
| Evidence appendix | 59 | Urgent and emergency services | The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.<br><br>Managers investigated incidents thoroughly. Patients and families were involved in these investigations, where appropriate. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. We reviewed the investigation of an unexpected death in the emergency department in March 2018. A root cause analysis was completed, and the findings were shared with family members, |

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| Report | Pg | Service line | Quote |
|---|---|---|---|
| | | | who were invited to meet with clinicians and to ask any questions about their relative's care and treatment.<br><br>Staff told us they received feedback following incidents and lessons were shared with the wider team. Incidents, learning and any relevant safety alerts were, for example, discussed at daily safety briefings, clinical governance meetings and reported in a monthly newsletter.<br><br>In the case of the unexpected death referred to above, although the findings of the investigation did not find omissions or poor practice which contributed to the patient's death, the findings were shared with staff at clinical governance meetings and at safety briefings because the case was rare and there was some learning.<br><br>Managers debriefed and supported staff after any serious incident. Some staff had received individual feedback and support following incidents and they saw this as a positive experience. The service had a good track record for safety. |
| Evidence appendix | 60 | Urgent and emergency services | The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors. The service continually monitored safety performance, which was displayed in the emergency department. The safety thermometer data showed the service achieved 100% harm-free care for the last 12 months. The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month. A suggested date for data collection is given but departments can change this. Data must be submitted within 10 days of the suggested data collection date. Data from the patient safety thermometer showed the trust reported no new pressure ulcers, falls with harm or new urinary tract infections in patients with a catheter from February 2018 to February 2019 within urgent and emergency care. |
| Inspection report | 32 | Medical care | The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. |
| Inspection report | 34 | Medical care | The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.<br>Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. |
| Evidence appendix | 96 | Medical care | Assessing and responding to patient risk Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients |

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| Report | Pg | Service line | Quote |
|---|---|---|---|
| | | | safe. |
| Evidence appendix | 107 | Medical care | Incidents The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. All staff knew what incidents to report, how to report them and reported all incidents they should report. Staff spoken with were clear on the processes they followed to report incidents. They were able to talk to us about the learning which had been shared following incidents on their wards, or within their division. We saw evidence of incident outcomes on wards for staff to follow and learning needed from these. For example, on discharge of one patient a care package had not been re-started when discharged, this resulted in the patient being re-admitted. There were listed actions staff must take to prevent this from happening again. Mortality case note reviews were completed for any incident related to deaths. Senior staff told us incidents involving mortality were investigated and any learning shared with all staff. We were given an example of one incident which involved more than one speciality. Staff received feedback from investigation of incidents, both internal and external to the service. This was shared through safety huddles, team meetings, newsletters and briefings. Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. |
| Inspection report | 13 | Surgery | **(Area for improvement) Provide meaningful feedback as appropriate to staff who report incidents.** |
| Inspection report | 41 | Surgery | The service managed patient safety incidents well and staff were clear on how to report incidents.<br><br>Staff used monitoring results well to improve safety. The service provided care and treatment based on national guidance and evidence-based practice. |
| Inspection report | 42 | Surgery | The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.<br>Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.<br><br>The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.<br><br>Staff did not always receive feedback in response to reporting incidents. |
| Inspection report | 45 | Surgery | **(Should do) Provide meaningful feedback as appropriate to staff who report incidents.** |

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| Report | Pg | Service line | Quote |
|---|---|---|---|
| Evidence appendix | 152 | Surgery | The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured actions from patient safety alerts were implemented and monitored. Staff knew how to report incidents through the electronic reporting system. All staff we asked were able to tell us how the system worked and how they would report an incident. Staff we spoke with on wards said the electronic reporting system worked well. Staff could specify whether they wanted feedback when reporting incidents. Those who had requested this told us they had received meaningful feedback. However, staff we spoke with in theatres said they did not always receive feedback after reporting an incident through the electronic reporting system. Where a reported incident caused moderate or greater harm, these incidents were reviewed by the heads and deputy heads of nursing. A decision was then made as to the appropriate response, including whether to carry out a full investigation. Leaders told us if it was a serious incident, an immediate meeting would be held, and a 72-hour report produced to ensure any identified concerns that might still be ongoing were addressed. Staff were aware of learning from recent incidents. For example, all surgical wards we visited were able to provide consistent examples of learning from incidents across the service and the divisions more generally. Staff were able to describe the lessons learnt from the incident and the steps taken to ensure something similar did not happen again. Senior nurses shared learning from incidents with staff. Staff told us learning from incidents was shared on wards through various channels including safety briefs, team meetings, governance meetings, board and ward rounds, huddles and LASER (Learning After Significant Event Recommendations) posters across the hospital. Staff told us feedback and sharing from incidents had improved since our last inspection. |
| Evidence appendix | 153 | Surgery | Safety thermometer. The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors. There was a slight downward trend in patient harms (improvement), and the trust was now using other measures to record this information. |
| Inspection report | 4 | Maternity | The service managed patient safety incidents well and monitored safety performance |
| Inspection report | 46 | Maternity | The service managed patient safety incidents well and monitored safety performance. The service had enough medical, nursing and midwifery staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. |
| Inspection report | 47 | Maternity | The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons with the whole team and in the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented |

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| Report | Pg | Service line | Quote |
|---|---|---|---|
| | | | and actioned.<br><br>The service used safety monitoring results to improve safety. The service collected safety information. |
| Evidence appendix | 198 | Maternity | Staff used a nationally recognised tool to identify deteriorating women and escalated them appropriately. Staff completed the Modified Early Warning Score for Obstetrics to monitor patients and recognise the deteriorating patient, including those at risk of developing sepsis. Compliance with this process was not audited because there had been no incidents relating to this process and no changes to national guidelines to indicate a new risk. We checked patient records during our inspection and saw these charts were completed correctly |
| Evidence appendix | 199 | Maternity | Staff knew about and dealt with any specific risk issues such as venous thromboembolism, sepsis, falls and pressure ulcers. Sepsis training was provided to all staff within the trust and local maternity induction and during specific annual midwifery training<br><br>Staff shared key information to keep women safe when handing over their care to others. The service completed World Health Organisation surgical safety checklists in maternity surgery. Compliance with this process was not audited because there had been no recent incidents or changes to national guidelines to identify a risk. We observed this process during our inspection and saw the checklist was completed to an exemplary standard. |
| Evidence appendix | 202 | Maternity | The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. All staff knew what incidents to report and how to report them. We saw that the antenatal ward had reported incidents relating to staffing shortages and when they had no capacity to admit women who required induction of labour. Staff reported serious incidents clearly and in line with trust policy. In accordance with the Serious Incident Framework 2015, the trust reported seven serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from March 2018 to April 2019. |
| Evidence appendix | 203 | Maternity | Managers investigated incidents thoroughly. Women and their families were involved in these investigations. Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation when things went wrong. Staff received feedback from the investigation of incidents, both internal and external to the service. For every serious incident investigation, the team produced a poster showing the learning recommendations. For example, there was a poster emphasising the requirement for all women under obstetric-led care to have an obstetric review on admission and an individual plan of care. These posters were displayed in a folder in each clinical area, and staff knew how to refer to this resource. Staff met to discuss the |

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| | | | feedback from investigations and look at improvements to patient care. All learning from incidents was shared at the weekly safety meeting attended by the divisional lead for quality and patient safety, matrons, midwives, and consultants. For example, this meeting incorporated consideration of avoidable causes of harm that can lead to infants born at term being admitted to a neonatal unit. This was a safety project initiated as part of the national maternity transformation programme. There was evidence that changes had been made because of feedback. For example, there was an incident involving a baby who was taken seriously ill immediately post-discharge from the unit. The investigation concluded that communication regarding the signs and symptoms of serious illness after birth needed to be clearer for parents. As a result, the ward now discussed this with families on day one and reminded them on the day of discharge, and parents signed to say they had been given this important information.<br><br>The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff using the maternity dashboard. Safety thermometer data was shared with patients and visitors. 204 Safety thermometer data was displayed on wards for staff and women to see. The trust was unable to provide safety thermometer data for the 12 months preceding our inspection. Leaders continually monitored the safety and effectiveness of the service using data collected via the maternity dashboard and incident reports. This information was shared with staff in the monthly governance reports. |
| Evidence appendix | 225 | Maternity | The service applied Duty of Candour appropriately. The service had processes to ensure they met the duty of candour, including a policy, relevant training and support for staff. Incident investigation reports showed evidence that the duty of candour had been followed. |
| Inspection report | 6 | End of life care | The service managed safety incidents well and learned lessons from them. |
| Inspection report | 53 | End of life care | Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service. |
| Inspection report | 54 | End of life care | The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.<br>Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored. |
| Evidence appendix | 237 | End of life | The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. The management of incidents relating to end of life care was much improved since our last inspection. The trust had procured a different incident reporting system since our last visit, which enabled the user to |

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| Report | Pg | Service line | Quote |
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| | | | identify incidents specifically related to end of life care. All staff knew what incidents to report and how to report them. Additionally, staff were better able to describe the types of incidents that may be classified as related to end of life so we were assured this information was being better captured. We examined the minutes of the end of life group meetings and saw that incidents were discussed and changes or learning agreed and disseminated. Furthermore, the specialist palliative care team were able to view and analyse incidents in real time using the electronic system. We saw examples of where they had been able to make immediate improvements to mitigate risk and feedback in a timely way to those who had reported the incidents. |
| Evidence appendix | 250 | End of life | Learning from and evaluation of end of life care had become truly embedded across the trust since our last inspection. However, this was not seen as an end point, but as a continuous process for improvement that was owned by everyone we met. The work that had been undertaken on the “Purple Butterfly” had been recognised nationally with an award for the palliative care team and complex care ward, and was felt to represent a step change in the delivery of end of life care at the trust. |

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**Appendix 4 Freedom to Speak Up Report 2019**

NHS North Bristol NHS Trust

| | | | | |
|---|---|---|---|---|
| **Report To:** | Trust Board | | **Agenda Item:** | Leave Blank |
| **Date of Meeting:** | 30 May 2019 | | | |
| **Report Title:** | Freedom to Speak Up Bi-Annual Report May 2019 | | | |
| **Report Author & Job Title** | Millie Warrington, Staff Engagement & Wellbeing Consultant | | | |
| **Executive/Non-executive Sponsor (presenting)** | Xavier Bell, Director of Corporate Governance & Trust Secretary | | | |
| **Purpose:** | **Approval/Decision** | **Review** | **To Receive for Assurance** | **To Receive for Information** |
| | | x | | |
| **Recommendation:** | Board are asked to:<br>• Review progress against the FTSU vision, strategy and action plan<br>• Review the FTSU data triangulated against other information<br>• Discuss the report and findings with Guardians | | | |
| **Report History:** | • Vision, Strategy and Action plan developed from Board session on 31 August 2018.<br>• Bi-annual Freedom to Speak Up Board report reviewed at Trust Board on 29 November 2018. | | | |
| **Next Steps:** | • Monitor implementation of vision, strategy and action plan.<br>• Continue to support and promote Freedom to Speak Up at North Bristol NHS Trust | | | |

| **Executive Summary** |
|---|
| Freedom To Speak Up (FTSU) Guardians have been in place at North Bristol NHS Trust (NBT) since November 2017 and the programme has been continually developing over time.<br><br>North Bristol Trust now has a robust and established FTSU approach. We have 13 FTSU Guardians in place, with Guardians holding diverse substantive job roles across the Trust. We are continuing to deliver our Trust-wide and local communications, in order to build and maintain awareness across the Trust.<br><br>This report explores the most recent data around concerns being raised and compares this with the National Average. Whilst NBT is within the average range of numbers of concerns |

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being raised compared to other Trusts, this data also indicates that in recent quarters the number of concerns being raised at NBT has dropped. The data also allows us to compare staff groups, comparing this again with the national average, confirming that whilst NBT are mostly aligned with the national data, we see that the percentage of Nurses raising concerns at NBT is significantly lower than the national average, whereas we have a higher percentage of Allied Healthcare Professionals and Midwives raising concerns than national averages have seen.

This report also triangulates this data with the 2018 NHS Staff Survey results related to speaking up. As previously identified by the People and Digital Committee, there has been a more negative responses to some of these questions compared to national results. Therefore Speaking Up has been set as a Trust-wide staff survey priority for 2019.

The report highlights progress made against the FTSU action plan developed form the Board session in August 2018. Overall, good progress has been made although the data shows that there is a need to improve awareness, visibility and confidence to speak up, particularly amongst our Medical and Nursing workforce.

One of our FTSU Guardians will be present at the Board meeting to share a speaking up story and answer questions about the FTSU process from the Guardian's perspective.

The Board are asked to review the data in the report and note progress made against the action plan.

| | |
|---|---|
| **Strategic Theme/Corporate Objective Links** | Strategic Themes:<br>Be one of the safest trusts in the UK<br>Create an exceptional workforce for the future |
| **Board Assurance Framework/Trust Risk Register Links** | |
| **Other Standard Reference** | Freedom to Speak Up arrangements form part of the CQC Well Led assessment. |
| **Financial implications** | N/A |
| **Other Resource Implications** | N/A |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | EDS2 Objective: Better Health Outcomes<br>EDS2 Objective: Representative and Supported Workforce |

| | |
|---|---|
| **Appendices:** | Appendix 1 – FTSU Vision, Strategy and Action Plan |

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## 1. Purpose

**1.1** The purpose of this report is to update the Board on Freedom To Speak Up (FTSU) activity at North Bristol NHS Trust (NBT) over the past 6 months; providing information on concerns raised; comparing this activity to the national picture; and identifying progress made against our strategy and actions.

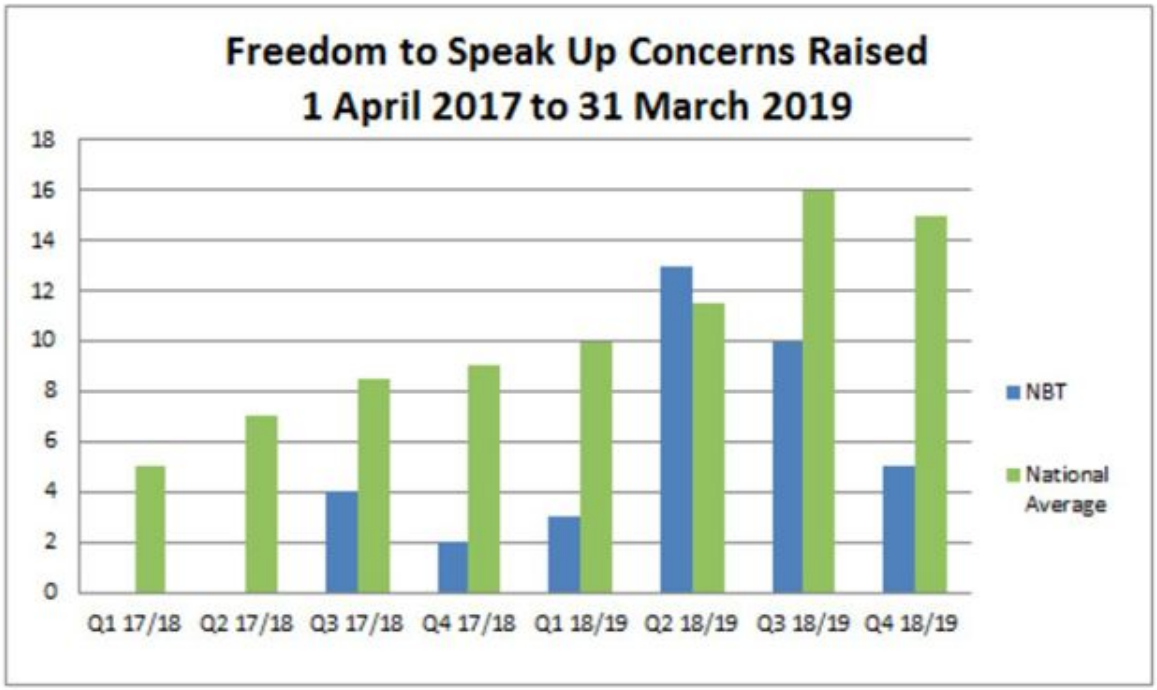
## 2. Background

**2.1** Freedom to Speak Up Guardians have been in role since November 2017. The infrastructure is in place and the number of Freedom to Speak Up Guardians has increased, with 13 current Guardians from diverse roles across the trust, representing the key employee groups and different levels of seniority. Each Division is represented by a minimum of one Guardian – although FTSU Guardians are not limited to addressing concerns within their division and staff are encouraged to contact whichever guardian they would feel most comfortable raising a concern with.

**2.2** The Board undertook the NHS Improvement self-assessment review in August 2018, which led to the creation of a vision, strategy and action plan for FTSU at NBT, which was also discussed and endorsed at the FTSU Guardians' quarterly meeting in December 2018. The vision, strategy and action plan is enclosed as Appendix 1.

## 3. How NBT Compares to the National Picture

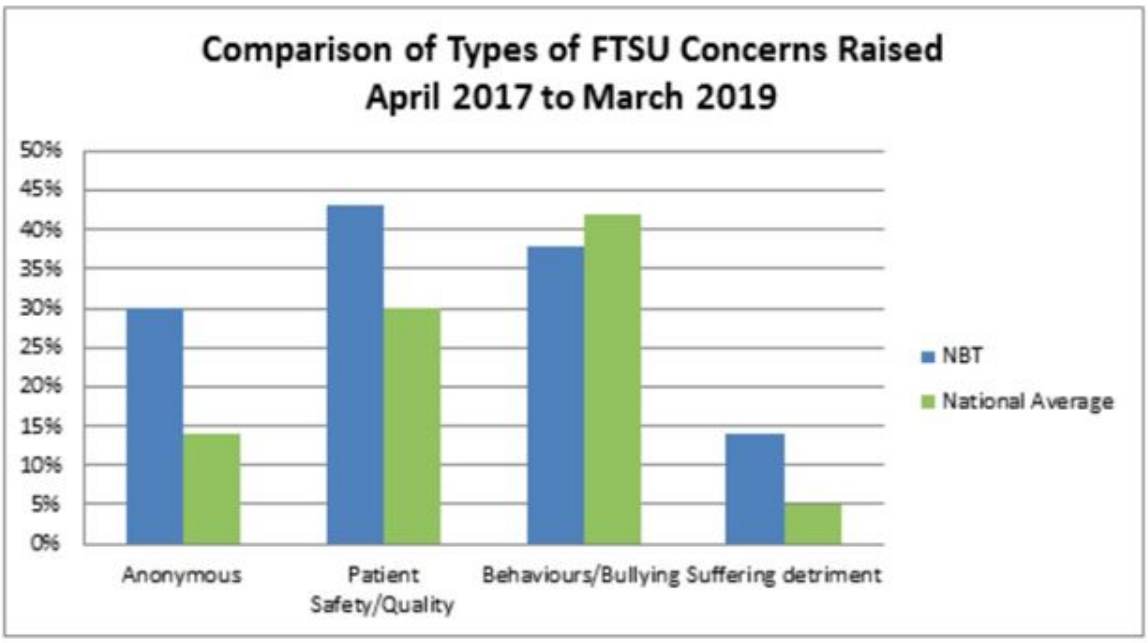
**3.1** Whilst Freedom to Speak Up continues to be developed and embedded at NBT, as it does nationally, we are now in a position to be able to report on the number of concerns raised over an 18 month period since the current model was implemented in November 2017. As National Guardian's Office says, "The absolute number of cases is not necessarily



reflective of the speaking up culture in an organisation"[1]. However, they also note that scenarios where either a lack of cases or an excessive number of cases are being raised would be concerning.

**3.2** The data in the above chart continues to show that overall, since Q3 17/18 when the current FTSU model was launched, NBT has remained broadly within the range of the national average of cases raised. From April 2018 to March 2019 the total number of cases raised was 31 compared to the mean national average of 51. However, the chart above does also appear to indicate a recent pattern of declining numbers of concerns over the last six months, in contrast to the ongoing national pattern of increases in the average number of concerns over time.

**3.3** The chart below compares the breakdown of different types of concerns which have been raised at NBT against the nationally reported data. This tells us that a greater proportion of staff within NBT are raising concerns anonymously than the national average, and with more claiming to have suffered detriment as a result of raising a concern. The proportion of concerns raised at NBT relating to behaviours and bullying are slightly lower than the national average, whilst those relating to patient safety and quality of care is higher than the national average. (NB. A concern may occupy more than one category at a time).




[1] Speaking up in the NHS in England , National Guardian's Office, September 2018

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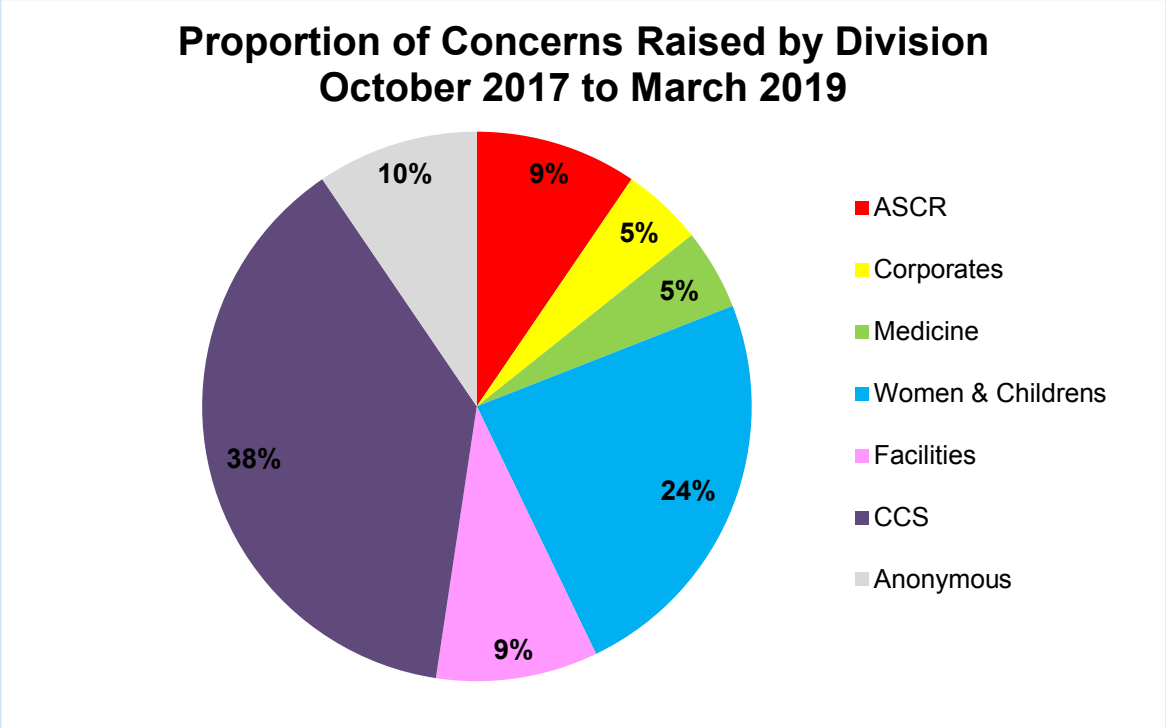
## 4. Triangulation of Speaking Up Data Against Other Data

**4.1** In line with the action plan in Appendix 1, the Guardians records are being collated centrally in order to allow a deeper analysis of the data collected by the Freedom to Speak Up Guardians (such as divisional analysis, thematic analysis, analysis by gender and other characteristics, etc). We currently hold records for 21 of the total 37 concerns, the missing records being those over a year ago. We are continuing to collect these so, whilst a fairly limited deeper analysis is available at present, this will become fuller over time.

**4.2** Initially, the below charts highlight a broad overview of the concerns raised categorised by division. From the below charts it is notable that concerns have been raised across all divisions, with the exception of NMSK. The highest number of concerns are being raised in Women and Children's and Core Clinical Services. It is worth reiterating that a greater proportion of concerns being raised may indicate both that the division has a healthy speaking up culture; and / or that the division has a number of issues that staff are concerned about. In addition, where a concern is raised simultaneously by several staff, this is recorded as several individual concerns.




*NB breakdown by division only available for 21 of 37 concerns

**4.3** Further analysis has also been undertaken into those raising concerns. The table below gives a comparison to national averages of the breakdown of professional groups at NBT raising concerns through FTSU.

**4.4** Whilst NBT is broadly comparable to the national average benchmark proportions, the main anomaly is a significant difference in the number of Nurses speaking up at NBT, with Nurses at NBT falling into one of the lowest categories of professional groups speaking up,

compared to being the highest professional group speaking up nationally. We can also see that in contrast, we have more Midwives and Allied Healthcare Professionals speaking up than the national average. It is recommended that we particularly seek to raise awareness with our nursing groups and we will seek support from the Nursing and Midwifery Workforce Group in doing this.

| Proportion of Concerns Raised by Professional Groups at NBT October 2017 to April 2019 | | |
|---|---|---|
| **Group** | **NBT** | **National Average*** |
| **Nurses** | 5% | 31% |
| **Administrative** | 10% | 16% |
| **Allied Healthcare** | 24% | 13% |
| **Other** | 5% | 11% |
| **Healthcare Assistants** | 10% | 7% |
| **Doctors** | 5% | 6% |
| **Cleaning** | 5% | 5% |
| **Corporate** | 14% | 5% |
| **Midwives** | 19% | 3% |
| **Unknown** | 5% | 2% |
| **Dentists** | 0% | <0.5% |
| **Board** | 0% | <0.5% |

*NB. Latest national data available for comparison is April 2017 to March 2018.



**4.5** It is also possible to use other data available within the Trust to triangulate with the FTSU data, specifically we can look at the national staff attitude survey, which measures staff views in two relevant areas:

- Errors and Incidents, which relate to FTSU concerns of patient safety / quality
- Violence, Bullying and Harassment, which relate to FTSU concerns of Behaviours / Bullying.

**4.6** The below table reflects some of the answers to questions linked to errors and incidents, bullying and harassment and reporting of concerns linked to physical violence, which could fall within Patient Safety or Behaviours and Bullying, from the 2018 Staff Survey. These responses show that overall there has been a consistent drop in positive responses in comparison to North Bristol's 2017 Staff Survey result, and we remain below average in all these questions. This is in contrast to the overall direction of travel seen in the 2018 Staff Survey, where engagement increased, and the majority of questions had a more positive response.

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| 2018 NHS Staff Survey Question | Compared to 2017 | Compared to other trusts |
|---|---|---|
| The last time you experienced physical violence at work, did you or a colleague report it? | -8.22% | -7.58% |
| The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it? | -3.39% | -3.35% |
| The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it? | -0.98% | -1.80% |
| If you were concerned about unsafe clinical practice, would you know how to report it? | -1.36% | -2.34% |
| I would feel secure raising concerns about unsafe clinical practice. | -1.28% | -1.07% |

**4.7** These results were identified by People and Digital Committee as a concern in March 2019 and, as a result, Speaking Up has been made one of 5 key high priority areas of focus for 2019.

**4.8** More positively, there is an encouraging trend of improvement since the 2017 NHS Staff Survey around the action being taken by the organisation to encourage speaking up, , as highlighted in the below table. However, whilst the direction of travel is positive and reflects well on the work being done by FTSU Guardians, we do still sit below average in the responses compared to other Trusts.



| 2018 NHS Staff Survey Question | Compared to 2017 | Compared to other trusts |
|---|---|---|
| My organisation treats staff who are involved in an error, near miss or incident fairly. | 3.12% | 0.31% |
| My organisation encourages us to report errors, near misses or incidents. | 0.91% | -2.04% |
| When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again. | 2.09% | -2.55% |
| We are given feedback about changes made in response to reported errors, near misses and incidents. | 0.02% | -3.70% |

**4.9** In the chart below, the data collected in the 2018 NHS Staff Survey to identify whether there is a concern linked to perceptions of FTSU with any particular staff group. The chart shows the mean average of positive and negative responses to the specific questions relating to FTSU around patient safety, errors, incidents and bullying and harassment and whether concerns have been reported. The highest percentage of negative responses is for Medical and Dental staff, followed by Nursing and Midwifery and Estates and Ancillary.

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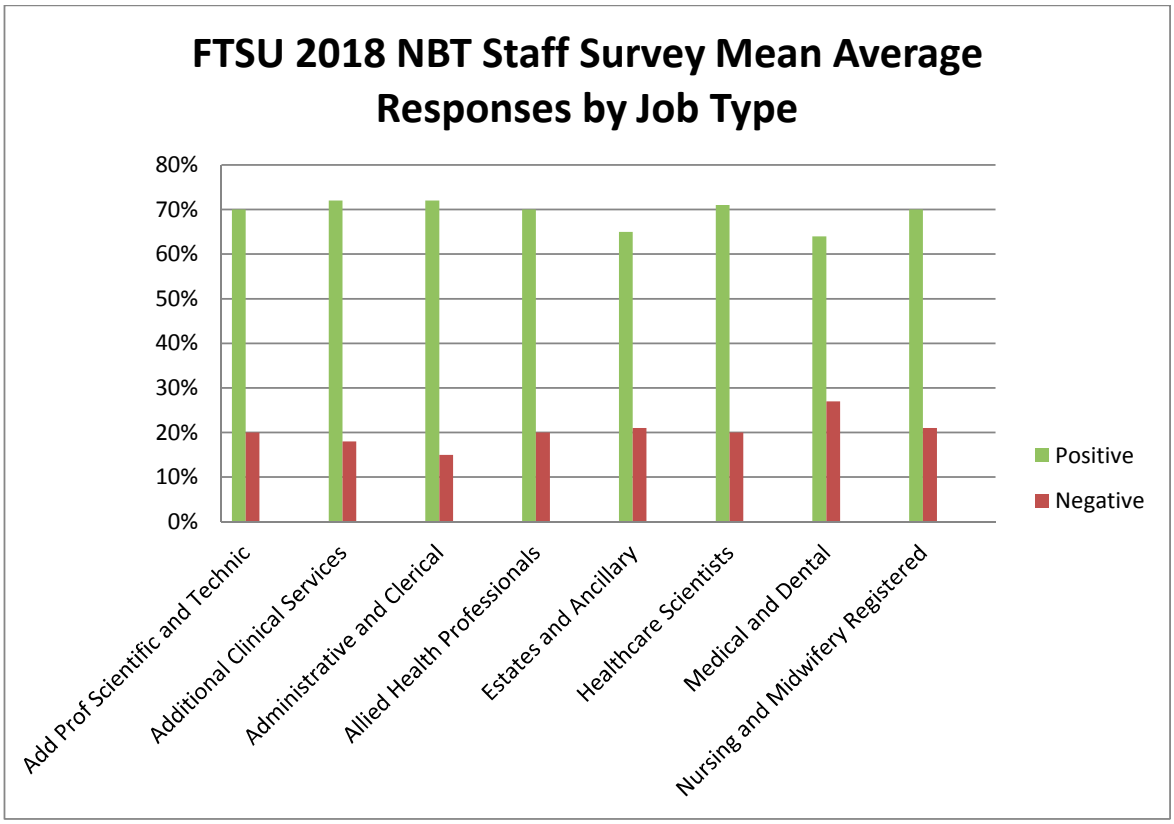


**4.10** A discussion took place at the FTSU Meeting in March 2019 in which it was agreed that a deeper analysis would be carried out to identify which specific staff group within these areas are raising concerns and whether there is any data to support further targeted resolution to the concerns linked to not speaking up. In particular, further analysis is being undertaken into the Medical / Dental responses by our Guardian who is in a Junior Doctor role.

**4.11** The chart below shows mean average responses to the 2018 NHS staff survey questions linked to FTSU. ASCR, Medicine and Facilities all have a higher mean negative response when compared to other divisions and a lower overall positive response rate.

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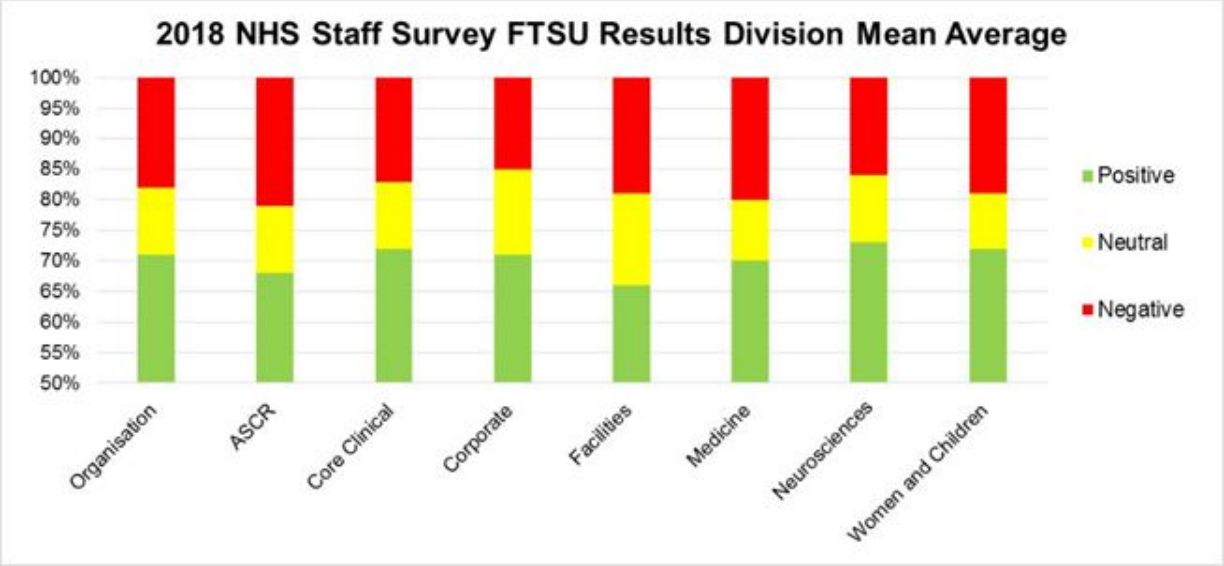


**4.12** In order to understand what the patient safety and quality concerns might be, the Board is encouraged to compare the themes in this report with those arising from the Quality and Risk Management Committee (QRMC), which considers issues arising from Datix; and the Safety and Effectiveness section of the Integrated Performance Report. Suggested indicators to consider might include: occurrence of serious incidents per 1000 bed days; top types of serious incidents reported; safe staffing levels, etc.

**4.13** In summary, when reviewing the triangulated data there appears to be a need to increase visibility and confidence in the FTSU approach across the workforce, but in particular with our Medical, Dental and Nursing workforce.

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## 5. Summary of Findings

**5.1** Overall, whilst the number of concerns being raised is broadly in line with a national average, there is more work to be done to encourage staff to speak up. The combination of a recent apparent downward trend in the number of concerns being raised, together with a deterioration in the staff survey of the reported willingness of staff to speak up, should be addressed.

**5.2** In particular, the Medical and Nursing workforces are highlighted as areas to focus on raising awareness.

**5.3** There are no divisions that show a correlation in particularly high or low numbers of concerns being raised, together with noticeably negative staff survey responses. However, it is notable that Women and Children's and Core Clinical Services have had higher numbers of concerns raised than other divisions. The Guardians who have had these concerns raised with them have been communicating directly with the leadership teams in these areas to address the issues at hand, however it is recommended that this is

monitored over time to consider whether there may be trends arising or indications of cultural issues.

**5.4** Overall, the strategy and action plan for FTSU at NBT still looks appropriate, although an additional focus on communication, awareness raising and championing of speaking up is recommended.

## 6. Communications Update

**6.1** The communications plan to promote FTSU throughout the trust is in place, which includes regular updates through internal communication channels. The Intranet homepage has recently been updated with the FTSU logo to ensure the FTSU Guardians page is easily accessible to all staff in one click; and updated screensavers have been launched which include reference to FTSU at NBT.

**6.2** The FTSU posters have been updated to reflect recent changes to the FTSU Guardians and these have been reissued around the trust.

**6.3** FTSU is now included in the new starter induction and new starters are encouraged to speak up with any concerns and to tell their colleagues about speaking up.

**6.4** The same standard presentation is used by all Guardians to raise awareness in their local areas and following a successful FTSU Roadshow in October 2018, there are plans in place to carry out a second Roadshow with all Guardians to continue to promote FTSU on the different wards and departments.

**6.5** A one page summary about speaking up has been produced for local inductions and issued to all areas and Guardians.

**6.6** Freedom to Speak Up will feature in the Wigwam of Wellbeing as part of the upcoming Festival of Engagement on 29 May.

**6.7** It is recommended that a short update of the Board's considerations of FTSU at each 6 monthly review is shared with staff via the regular Friday 5 communication.

## 7. Vision, Strategy and Action Plan

**7.1** A vision, strategy and action plan for FTSU at NBT was established from the Board development session on 31 August 2018. Part of the recommended strategy is for Board to be monitor progress against the strategy and action plan. An update on the progress of actions is shown below:

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| No | Action | Owner / Date | Progress |
|---|---|---|---|
| **1** | A 6 monthly report to be provided to Board, from November 2018 | Guy Dickson / Rob Mould<br><br>From Nov 2018 | Complete<br>Regular 6 monthly report being shared at Board meetings (Public). |
| **2** | Guardian meetings to cover the recommended items at least quarterly: | Guy Dickson<br><br>From Dec 2018 | Complete<br>Guardian meetings have been held quarterly since November 2017. All items recommended by NHSI are now included as a standard agenda. |
| **3** | Recruit more FTSU Guardians from diverse / vulnerable groups eg BAME. | Guy Dickson | Complete<br>Recent appointments have increased the diversity of the Guardian group to better reflect our staff demography. This will be kept under review. |
| **4** | Non-Executive Director to instigate and lead an auditing approach of concerns raised. | Rob Mould<br><br>Annually beginning 2019 | Ongoing<br>Agenda item for next Guardians meeting on 12 June 2019 |
| **5** | Communication to the Trust as a whole about Freedom to Speak Up: | Guy Dickson / All FTSU Guardians<br><br>Oct 2018 Onward | Ongoing<br>Under review at each quarterly Guardian meeting. |
| **6** | Leadership development framework and programme to be developed to support Freedom to Speak Up principles / behaviours . To be delivered and monitored through the Workforce Committee. | Harriet Attwood<br><br>Nov 2018 onward | Ongoing<br>This work will be taken forward as part of the OneNBT Leadership programme, ensuring that the leadership development aligns with FTSU behaviours. |



**8. Recommendations**

Board are asked to:

- Review progress against the FTSU vision, strategy and action plan
- Review the FTSU data triangulated against other information
- Discuss the report and findings with Guardians

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## Appendix 5 Pathology Safety Culture Survey Results

| Question Text | N Number | SAQ % |
|---|---|---|
| It is easy for staff here to ask questions when there is something that they do not understand | 148 | 77.03% |
| I have received training on quality and safety issues. | 140 | 74.64% |
| Do you feel that the patient is priority when performing testing? | 147 | 74.49% |
| I know the process and people to direct questions regarding patient safety in this pathology discipline. | 137 | 72.63% |
| I am encouraged by my colleagues to report any patient safety concerns I may have. | 132 | 70.27% |
| Pathology management does not knowingly compromise the safety in this discipline. | 139 | 69.96% |
| I would feel safe being treated in North Bristol Trust as a patient. | 141 | 69.15% |
| Serious incidents are handled appropriately here. | 148 | 67.06% |
| I know the first and last names of all the staff I worked with last. | 147 | 65.99% |
| In this pathology discipline it is difficult to discuss errors. | 141 | 64.54% |
| Staff frequently disregard rules or guidelines (e.g. hand-washing, treatment protocols/ clinical pathways, sterile field, etc do not wear appropriate PPE, do not follow SOPs, guidelines etc) that are established for this pathology discipline. | 138 | 63.59% |
| Staff here in my main work area work together as a well-coordinated team. | 147 | 62.07% |
| Staff input is well received in this/ my discipline/ area of work. | 148 | 59.63% |
| My suggestions about safety would be acted upon if I expressed them to management. | 140 | 58.75% |
| The culture in this pathology discipline makes it easy to learn from the errors of others. | 141 | 58.51% |
| I receive appropriate feedback about my performance. | 141 | 57.98% |
| Disagreements in the pathology area are resolved appropriately (i.e not who is right, but what is best for the patient.) | 141 | 56.74% |
| I am frequently unable to express disagreement with the clinical and managerial leads. | 143 | 56.64% |
| This organisation is doing more for patient safety now than it did one year ago. | 125 | 55.60% |
| Leadership is driving us to be a safety-centred organisation. | 140 | 55.18% |
| Decision-making in this/ my pathology discipline utilises input from relevant personnel. (If you work in more than one pathology discipline, please answer for the area you entered as your first choice) | 147 | 54.76% |
| I am satisfied with the quality of collaboration that I experience in other areas of the hospital. | 137 | 52.74% |
| Important issues are well communicated. | 150 | 50.83% |
| The funded levels of staffing in this pathology discipline are sufficient to handle the number of requests received number of patients. | 139 | 33.63% |

ITEM 10.1 - APPENDIX 1

## Appendix 6 Gynaecology Safety Culture Survey Results

| Question Text | N Number | Actual Score | Maximum Score | SAQ % |
|---|---|---|---|---|
| Safety briefings/Huddles are common in this area. | 22 | 24 | 44 | 77.27% |
| I know the process and people to direct questions to regarding patient safety in this gynaecology discipline. | 20 | 20 | 40 | 75.00% |
| It is easy for staff here to ask questions when there is something that they do not understand. | 21 | 20 | 42 | 73.81% |
| Serious incidents are handled appropriately here. | 21 | 20 | 42 | 73.81% |
| I am encouraged by my colleagues to report any patient safety concerns I may have. | 20 | 19 | 40 | 73.75% |
| Important issues are well communicated at shift changes. | 21 | 19 | 42 | 72.62% |
| I would feel safe being treated here as a patient. | 20 | 18 | 40 | 72.50% |
| Staff input is well received in this area of work. | 21 | 18 | 42 | 71.43% |
| Staff frequently disregard rules or guidelines (e.g. hand-washing, treatment protocols/clinical pathways, sterile field, etc.) that are established for this area. | 21 | 17 | 42 | 70.24% |
| In this area, it is difficult to discuss errors. | 20 | 14 | 40 | 67.50% |
| Staff here in my main work area work together as a well-coordinated team. | 21 | 13 | 42 | 65.48% |
| I know the first and last names of all the staff I worked with last. | 21 | 12 | 42 | 64.29% |
| Decision-making in gynaecology utilises input from relevant staff. (If you work in more than one gynaecology discipline, please answer for the area you entered as your first choice) | 21 | 12 | 42 | 64.29% |
| The culture in this gynaecology discipline makes it easy to learn from the errors of others. | 20 | 10 | 40 | 62.50% |
| I am frequently unable to express disagreement with the clinical and managerial leads. | 21 | 10 | 42 | 61.90% |
| Gynaecology management does not knowingly compromise the safety in this discipline. | 20 | 9 | 40 | 61.25% |
| I am satisfied with the quality of collaboration that I experience in this area. | 21 | 8 | 42 | 59.52% |
| Leadership is driving us to be a safety-centred organisation. | 20 | 7 | 40 | 58.75% |
| I have received training on quality and safety issues. | 20 | 7 | 40 | 58.75% |
| I receive appropriate feedback about my performance. | 20 | 7 | 40 | 58.75% |
| My suggestions about safety would be acted upon if I expressed them to management. | 20 | 7 | 40 | 58.75% |
| Disagreements in gynaecology are resolved appropriately (i.e not who is right, but what is best for the patient.) | 21 | 6 | 42 | 57.14% |
| The levels of staffing in this area are sufficient to handle the number of patients. | 20 | 0 | 40 | 50.00% |
| This organisation is doing more for patient safety now than it did one year ago. | 16 | 0 | 32 | 50.00% |

| | | | | |
|---|---|---|---|---|
| **Report To:** | Trust Board | | **Agenda Item:** | 11 |
| **Date of Meeting:** | 30 January 2020 | | | |
| **Report Title:** | Patient & Carer Experience Committee Report | | | |
| **Report Author & Job Title** | Kate Debley, Deputy Trust Secretary | | | |
| **Executive/Non-executive Sponsor (presenting)** | Robert Mould, Chair of the Patient & Carer Experience Committee and non-Executive Director. | | | |
| **Purpose:** | **Approval/Decision** | **Review** | **To Receive for Assurance** | **To Receive for Information** |
| | | | X | |
| **Recommendation:** | The Trust Board is recommended to receive the report for assurance and to:<br>• Note and support the Trust's Learning Disability & Autism Strategy. | | | |
| **Report History:** | The report is a standing item to each Trust Board meeting following a Patient & Carer Experience Committee meeting. | | | |
| **Next Steps:** | The next report to Trust Board will be to the March 2020 meeting. | | | |

11

| **Executive Summary** |
|---|
| The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the Patient & Carer Experience Committee Meeting held on 23 January 2020. |

| | |
|---|---|
| **Strategic Theme/Corporate Objective Links** | Reports received supported the delivery of the following strategic themes and corporate objectives:<br>• Be one of the safest trusts in the UK<br>• Treat patients as partners in their care |
| **Board Assurance Framework/Trust Risk Register Links** | Reports received support the mitigation of the following BAF risks:<br>N/A |

| | |
|---|---|
| **Other Standard Reference** | Care Quality Commission Standards. |
| **Financial implications** | No financial implications as a consequence of this report. |
| **Other Resource Implications** | No other resource implications as a result of this report. |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | No legal implications. |

| | |
|---|---|
| **Appendices:** | Appendix 1 – Learning Disability & Autism Strategy |

## 1. Purpose

To provide a highlight of the key assurances, any escalations to the Board and identification of any new risks from the Patient & Carer Experience Committee meeting held on 23 January 2020.

## 2. Background

The Patient & Carer Committee is a sub-committee of the Trust Board. It meets bi-monthly and reports to the Board after each meeting. The Committee was established to:

- Raise the profile and visibility of patient experience at Trust Board level and provide assurance to the Board;
- Set the strategic direction for patient experience with the purpose of achieving the Trust's strategic aims, including to 'treat patients as partners in their care';
- Monitor development and delivery of a patient experience strategy and carer strategy;
- Be the conduit for effective change and improvement to patient experience, act on feedback to challenge, influence activities that deliver an improved patient experience.

## 3. Key Assurances & items discussed

3.1 The Committee started its meeting with a patient story. This focused on a lady who suffered abuse as a child, which impacted on how she can interact with people as an adult, and how this has impacted the way in which she experiences care at the Hospital. She has agreed an alert that sits on her medical record explaining her need to be asked for, and to give, her explicit consent before any form of physical contact. The story outlined her experiences at the Trust and the opportunities for learning that her engagement with the Trust has presented.

3.2 The Director of Nursing & Quality presented the Trust's Learning Disability and Autism Strategy. This is one of the Trust's quality priorities in 2019/20. This report included the Trust's driver diagram and action plan for improvements in this area. The Committee was assured that good progress was being made in this area, and commended the clear and concise strategy and action plan. This is included at *Appendix 1.*



3.3 The Committee received an update from the patient representative member around how a patient experiences the complaints process in the Trust. This has resulted in a number of recommendations around how to make it easier for patients to provide feedback particularly via the Trust website. A project has been agreed to explore this further.

3.4 An update report was received from the Patient Experience Group. This included an update on the revised Friends & Family Test (FFT), which highlighted that the revised questionnaire will set a new baseline. This means that the Trust will not be able to compare results of the new FFT to those of the revised FTT (from April 2020); however the revised FTT should provide better qualitative data. A report on

how best to use FFT results to provide insight and assurance will be received by the Committee in March 2020.

3.5 The Committee had a very useful discussion about how feedback is received by the Trust from its patients via the patient partnership board. The Committee were assured about the levels of engagement and feedback via the patient partnership board, but it was agreed that the upward report from the Patient Experience Group should be clearer on the specific contributions made by patients.

3.6 The Patient Experience section of the new format Integrated Performance Report was reviewed. This indicated significant performance improvement in the Trust's complaint response compliance and a reduction in formal complaints. It was felt that this correlates with the improved investment in resource and training in clinical divisions and will remain under review.

3.7 A Report on Patient Experience Risks was received and it was agreed that this would become a standing agenda item going forward for all higher scoring Patient Experience risks, with all Patient Experience risks to be reviewed every six months. The Committee reviewed the two Trust level risks and will continue to monitor at the next meeting.

3.8 Having been tasked by the Trust Board to oversee an assessment of the Trust's "Disability Confidence", the Committee received a paper from Jas Kaur, Head of Equality, Diversity & Inclusion, in relation to the plan and scope for this assessment. The Committee noted that Disability Confident is an accreditation generally awarded to employers, and this led to an interesting discussion about what Disability Confidence could mean from a patient perspective. Kelvin Blake, Non-Executive Director, and Jas Kaur will meet to discuss potential next steps and an update will be brought to the Committee in May 2020.

## 4. New risks identified for Trust Board attention

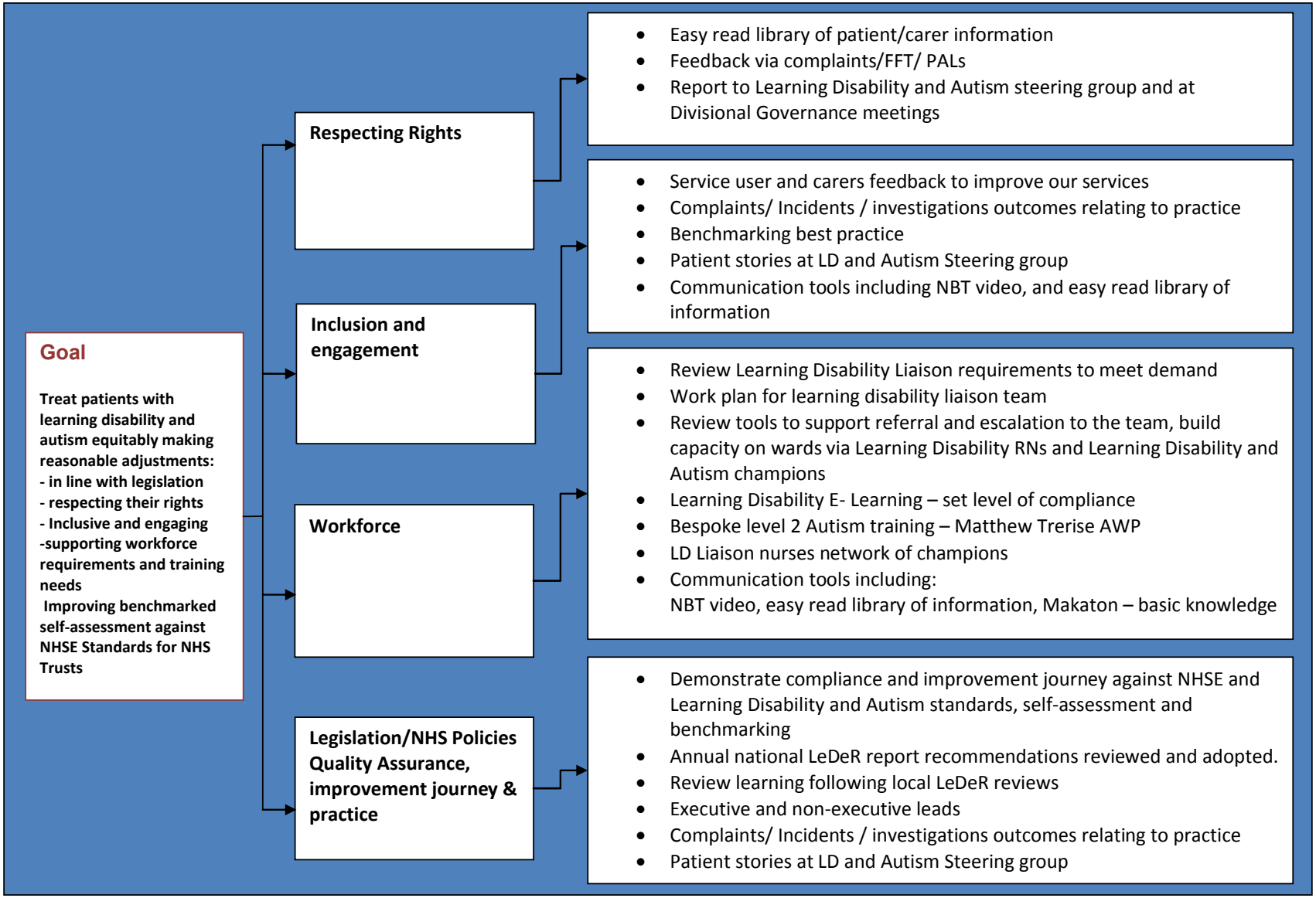
4.1 No new risks were identified requiring Trust Board attention.

## 5. Recommendations

5.1 The Trust Board is recommended to receive the report for assurance and to:

- Note and support the Trust's Learning Disability & Autism Strategy.

# Learning Disability and Autism Standards
# Driver Diagram




*Continued on page 2*

| Secondary Driver Element: | | |
|---|---|---|
| **Secondary Driver Element – Legislation changes / NHS Policies quality assurance, improvement journey & practice** | | |
| **Core Team** | **Name** | **Email** |
| | Sue Jones | |
| | Gill Brook | |
| | Michelle Darch | |
| | Lynda Saddles | |
| | Alan Howe | |
| | | |

| Improvement Component | Component Lead | Testing ( Reporting) | Timeline | Comments |
|---|---|---|---|---|
| **legislation/NHS Policies benchmarking and improvement plan** | Sue Jones | LD strategy to meet and exceed national standards, Driver diagram and improvement actions update to LD and Autism steering group | Ongoing | |
| **Policy, process and documentation** | Gill Brook | Review self-assessment and benchmarking feed into improvement plan | Sept 2019 | |
| | Gill Brook and Sue Jones | 2019/20 Benchmarking:<br>Organisational data<br>Staff Survey<br>Patient Survey | | Surveys November / December<br><br>Organisational data by 17/01/20 |
| | Sue Jones | Develop improvement plans for primary drivers: respecting rights, inclusion and engagement and workforce | | Workshop September 2019<br>Vision and priorities reviewed |
| | Sue Jones and Gill Brook | Review improvement plan and LD nurses work plan further to annual LeDeR review | | To add risk regarding aspiration pneumonia |
| | Sue Jones | Confirm forward plan for LD steering group to meet Terms of Reference | | |
| **Audit of practice** | Sue Jones | • Complaints / incidents / | 6 months | Reports on agenda. Complaints flagging to be resolved by |

| | | | | |
|---|---|---|---|---|
| | Gill Brook | investigations report to LD and Autism steering group, review learning and development opportunities<br>• Use self-assessment and benchmarking to inform action plan<br>• Ensure action plan is informed by local and annual national LeDeR reviews<br>• Work with patients and carers to improve inclusion and engagement | Annual<br><br>Annual | March 2020<br><br>Redo self-assessment<br><br>Invite patient / carer rep to the steering group<br><br>Work with existing patient groups |
| **Assurance of quality & practice** | Sue Jones / Gill Brook / Heads of Nursing | • Patient Stories at LD and Autism steering group and other relevant governance groups | | In place |
| **Quality Improvement** | Sue Jones / LD steering Group | • Workshop to confirm priorities for improvement<br>• Steering group to confirm vision<br>• Improvement plan to include small tests of change, Learning Disability RNs and champions working with patients and carers<br>Align improvement priorities with learning Disability Liaison nurses workplan | | 11 September 2019<br><br>02 October 2019 |

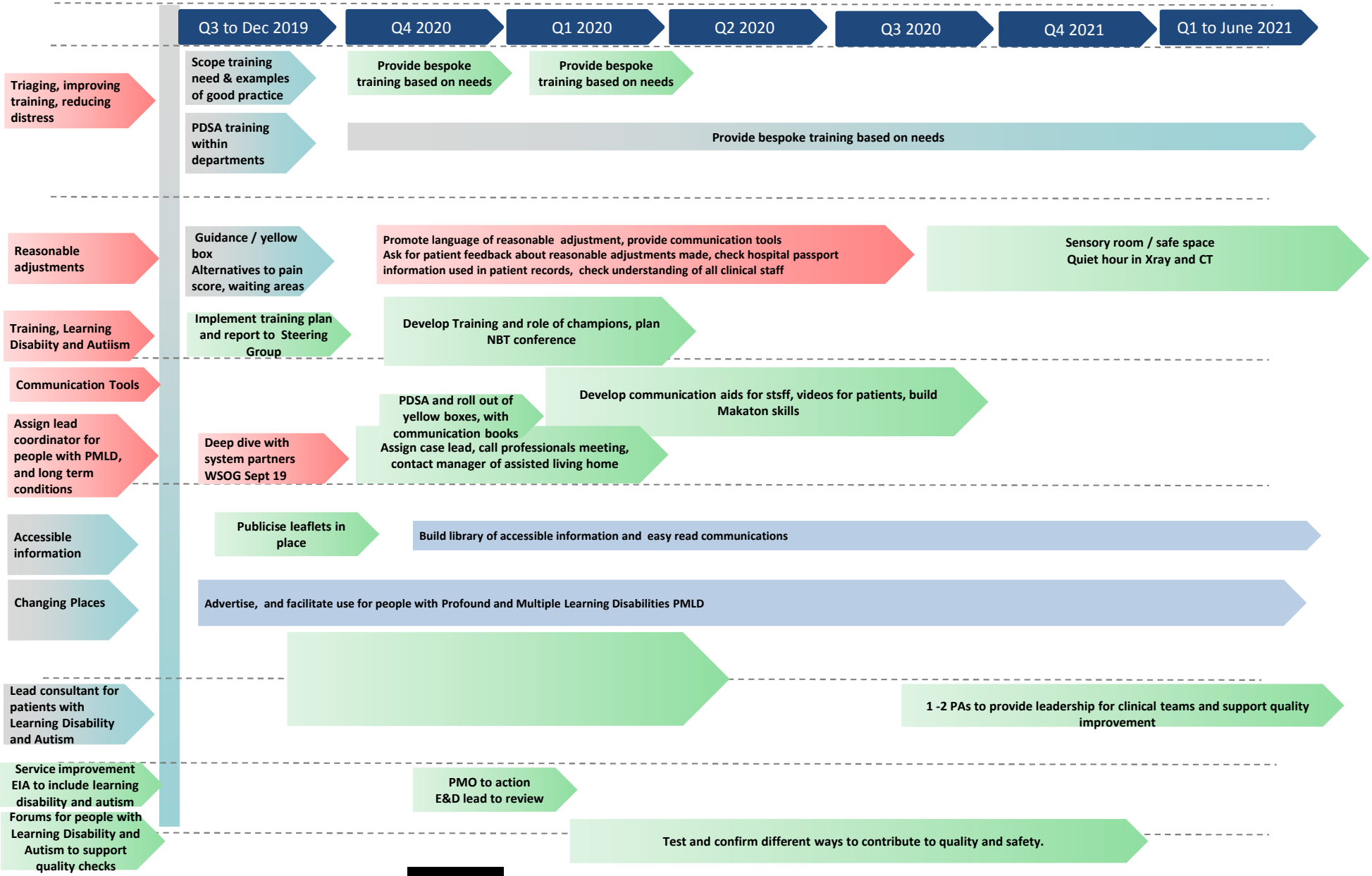
| Secondary Driver Element: | | | | |
|---|---|---|---|---|
| **Secondary Driver Element – Workforce** | | | | |
| | **Name** | **Email** | | |
| | Sue Jones | | | |
| | Alan Howe | | | |
| | Heads of Nursing | | | |
| **Improvement Component** | **Component Lead** | **Testing** | **Timeline** | **Comments** |
| **LD training – Awareness on induction and E-Learning** | Alan Howe<br>Michelle Darch<br>Lynda Saddles | Induction to start September 2019<br>E learning for LD in place, set level of compliance by October 2019 | Sept 2019<br><br>Oct 2019 | |
| **Autism education**<br><br>. | Alan Howe<br>Sue Jones<br>Gill Brook<br><br>Alan Howe | Bespoke training for identified leads / departments, delivered by Matthew Trerise AWP.<br><br>Review training needs and deliver training plan | Ongoing | First training programme for 20 delivered June 2019<br>Bid for additional Autism level 2 training, from 120 to 240 staff 2020/21<br><br>Reporting to LD and Autism Steering Group |
| **LD and Autism communication** | Gill Brook<br>Michelle Darch<br>Lynda Saddles<br>Pete Bramwell | • Develop network of champions and resources for champions<br>• Improve easy read portfolio and access to easy read information<br>• Film and publish video/s | 18-24 months | 73 champions (Oct 19) planning meetings / training and conference 2020<br>Some leaflets available improve library of leaflets by 2021<br><br>Sophie's video 2019, develop service specific videos by 2021 |
| **Designated expertise & capacity within the LD Liaison team and Champions** | Gill Brook<br><br>Lynda Saddles and Michelle Darch | • Liaison team employed by Sirona, review contract and meet regularly with Sirona manager<br>• LD liaison nurses workplan<br>• Development plan and resources for champions | | In place |

| | | | | |
|---|---|---|---|---|
| | Sue Jones | • Identify and communicate with all LD nurses employed as RNs at NBT<br>• Review requirement over 7 days based upon need for skill mix required | | For 2020 contract |

| Secondary Driver Element: | | | | |
|---|---|---|---|---|
| **Secondary Driver Element – Respecting Rights** | | | | |
| | **Name** | **Email** | | |
| | Gill Brook | | | |
| | Michelle Darch / Lynda Sandles | | | |
| | Heads of Nursing | | | |
| **Improvement Component** | **Component Lead** | **Testing** | **Timeline** | **Comments** |
| **Patient/carer information & feedback** | Michelle Darch / Lynda Sandles<br><br>Heads of Nursing | • Develop library of easy read patient information leaflets | 2021 | Library is developing:<br>MCA and DoLs easy read complete |
| | Gill Brook | • Produce reports based upon Complaints, FFT and PALs feedback and complaints<br>• Work with local groups for LD and Autism, develop network of expert patients / carers | March 2020<br><br>ongoing | Case examples only: awaiting mechanism to flag on Datix |

| Secondary Driver Element: | | | | |
|---|---|---|---|---|
| **Secondary Driver Element – Inclusion and Engagement** | | | | |
| | **Name** | **Email** | | |
| | Sue Jones | | | |
| | Michelle Darch / Lynda Sandles | | | |
| | | | | |
| **Improvement Component** | **Component Lead** | **Testing** | **Timeline** | **Comments** |
| Open culture learning and improvement | Sue Jones | • Incidents / investigations outcomes relating to practice reported to Learning Disability and Autism Steering Group | Oct 2019 | In place |
| | Gill Brook / Sue Jones | • Benchmarking best practice | | |
| | Sue Jones<br><br>Michelle Darch / Lynda Sandles Heads of Nursing | • Patient stories at LD and Autism Steering group<br>• Communication tools including Sophie's video, and easy read library of information | April 2019 | In place |

# Learning Disability and Autism Gantt Chart Oct 2019 – June 2021



NHS
North Bristol
NHS Trust

# Learning Disability, Autism or both:
## A plan for improving our care

### Vision
Working in hand in hand with our community health and care partners and carers, we will ensure all people with Learning Disabilities, Autism or both receive high quality and person-centred individualised care, based on excellent communication.

### Background

One of North Bristol NHS Trust's quality priorities for 2019/20 is to improve the care of people of all ages with a learning disability, autism or both who attend the trust for care and treatment.

A learning Disability and Autism Steering Group, was established April 2019 and responds to reports to the board via the patient and carer experience committee.

All NHS Trusts completed an NHS England and Improvement self-assessment and benchmarking exercise against the 3 priorities for NHS Trusts

- Respecting and protecting rights
- Inclusion and engagement
- Workforce

Our priorities were confirmed following a quality improvement workshop with staff that used our benchmarking feedback and the NHS England Priorities for NHS Trusts.

The views of carers from Bristol and South Gloucestershire will be integral to our improvement work using experience based design as well as feedback from people with learning disability autism or both.

Our plans will improve the quality of reasonable adjustments and fits well with our Academic Health Science Networks (AHSN) vision and plans to improve health for people with learning disability through the early recognition of soft signs of ill health, annual health checks and flu vaccination. Early recognition of deterioration using soft signs and NEWS2 links the collaborative work with our existing quality improvement work.

NHS North Bristol NHS Trust

## Starting our Improvement Journey

- The Trust's Learning Disability Liaison Team are well established, and work closely with Community Learning Disability Teams
- We have recruited 76 staff champions from across the organisation and the Liaison nurses are working closely with them to spread best practice and awareness.
- Plans for training are developing and will ensure greater capability and capacity at ward level.
- A quality improvement workshop with the network of champions September 2019 set our priorities and a timetable for improvement.

## Raising awareness

Promoting the LD Liaison team with staff.

Also this film made by, and for, women with learning disabilities, on breast screening support.

## Plans for the next 2 years

We will be using NHS England standards; respecting and protecting rights, inclusion and engagement and workforce as our primary drivers and listening to the views of carers and people with learning disability and autism.

This year we will:

- Deliver an improved training plan for learning Disability and Autism
- Improve the early recognition and treatment of deterioration, recognising soft signs of illness and the use of NEWS2.
- Promote the language of reasonable adjustments, and provide tools to support staff caring for patients with learning disability and autism.
- Improve written communication with patients by improving our library of accessible information and using video on our website.
- Register our changing places toilet and encourage its use.
- Develop forums for people with learning disability or autism to quality assess our services using experience based design for improvement.
- Review how we manage people with Profound and Multiple Learning Difficulties (PMLD) and people with learning disabilities and autism who also have long term conditions.

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| | | | | |
|---|---|---|---|---|
| **Report To:** | **Public Trust Board** | | **Agenda Item:** | **12** |
| **Date of Meeting:** | **30 January 2020** | | | |
| **Report Title:** | **Trust Strategy 2019-2024** | | | |
| **Report Author & Job Title** | **Tim Keen, AD Strategy** | | | |
| **Executive/Non-executive Sponsor (presenting)** | **Chris Burton, Medical Director** | | | |
| **Purpose:** | **Approval/Decision** | **Review** | **To Receive for Assurance** | **To Receive for Information** |
| | **X** | | | |
| **Recommendation:** | To approve the new Trust Strategy for the period 2019-2024 | | | |
| **Report History:** | Draft Strategy narrative reviewed and approved at October Board | | | |
| **Next Steps:** | Publication of strategy, staff engagement on what it means for them and strategy delivery reporting. | | | |

| **Executive Summary** | |
|---|---|
| The Trust have been reviewing the strategy approved in 2016 over the past year and has agreed that a refreshed document should be created.<br><br>This has been discussed at a number of Trust meetings and workshops. There has also been engagement with partner organisations and internally with staff groups.<br><br>The proposed narrative was discussed at October Board and the final version is now ready for final approval. | |
| **Strategic Theme/Corporate Objective Links** | |
| **Board Assurance Framework/Trust Risk Register Links** | |
| **Other Standard Reference** | |

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<table>
<tr><td>Financial implications</td><td>:<br><table>
<tr><th>Revenue</th><th>Total<br>£’000</th><th>Rec<br>£’000</th><th>Non Rec<br>£’000</th></tr>
<tr><td>Income</td><td></td><td></td><td></td></tr>
<tr><td>Expenditure</td><td></td><td></td><td></td></tr>
<tr><td>Savings/benefits</td><td></td><td></td><td></td></tr>
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<tr><td>Capital</td><td></td></tr>
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<tr><td>Other Resource Implications</td><td></td></tr>
<tr><td>Legal Implications including Equality, Diversity and Inclusion Assessment</td><td></td></tr>
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| | |
|---|---|
| **Appendices:** | Appendix A: NBT 5 year Strategy final document<br>Appendix B: NBT 5 year Strategy on a page |

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## 1. Purpose

1.1. To approve the new Trust Strategy for period 2019 to 2024.

## 2. Background

2.1. A refresh of the Trust strategy was commissioned in late 2018 building on the previous 2016-21 strategy. The brief for the strategy was for it to be ambitious, to provide clarity and to be deliverable. To support these aims, alongside the strategy the Trust has developed

- a financial sustainability plan that sets out the challenges we must address and
- a transformation programme describing our approach to deliver the strategy and address financial sustainability.

2.2. The strategy reflects our role as a leading partner within our health and care system and has been developed within the context our system long term plan.

## 3. Internal Audit report

3.1. The approach to developing the strategy has been reviewed by internal audit and assessed with Significant Assurance. The recommendations (3) have been accepted and being taken forward as required by the Audit committee.

## 4. Communications

4.1. The Trust's new five-year strategy has been written with our teams and divisions and reflects our commitment to working together to deliver exceptional care. There was considerable engagement with staff, patient reps and system partners carried out during the development of the strategy (particularly in the early autumn) which has helped shape the final version presented to Board.

4.2. Our focus now is on engaging staff on their role in delivery of the strategy. We plan to widely promote the strategy, to ensure that staff live, breathe and own it, that they can link to their own contribution to it, and that ultimately it guides their decision making.



4.3. Our approach to communications activity includes four key phases:

1. **Advance notification.**
    - Preview with staff in Friday Five on Friday 31st January.
    - Share final strategy with TMT members, requesting senior colleagues to plan how they will cascade and communicate with their own teams upon publication.
    - Notify NHS England and CCG of intention to launch.

2. **Formal launch**
    - Publish document and summary infographic on NBT website at 9.00am on Wednesday 5th February.
    - Send all staff email with summary infographic, linking to full strategy.
    - Issue news release to local media.
    - Promote on social media, with video of Chris Burton.
    - Send formal letter from Chief Exec and Chair to partner organisations, posted with a hard copy of the strategy.
    - Divisional triumvirates to cascade to their own teams, explaining what the strategy will mean for their work.
    - Promote in monthly NBT stakeholder bulletin on Friday 7th February.

3. **Ongoing to drive implementation**
    - Regular communications across February/March/April, focussing on each chapter, using case studies to illustrate how work is contributing to delivering the strategy.
    - Publish videos of other execs and clinical leaders explaining what the strategy means to them and their areas of work.
    - Face to face briefings for staff.
    - Recruit strategy champions to help us ensure that the strategy is impacting on decision making throughout our organisation.
    - Ensure that all of our plans and objectives for 2020/21 are aligned with our strategy.

4. **Long term**
    - Communications team to prioritise supporting projects that deliver the strategy, framing all internal and external corporate communications around the four areas of the strategy and regularly reinforcing the strategic messaging.

4.4. Essentially all of the work we do promote our five year plan will be designed not just to inform but to influence decision making across OneNBT.

# Our Strategy for 2019-2024

**By enabling our teams to be the best they can be we will provide exceptional health care, personally delivered.**

NHS
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## Our four areas of focus:

one NBT

### 1. Provider of high quality patient care

- Experts in complex urgent and emergency care
- Work in partnership to deliver great local health services
- A Centre of Excellence for specialist health care
- A powerhouse for pathology and imaging

### 2. Developing healthcare for the future

- Training, educating and developing our workforce
- Increase our capability to deliver research
- Support development and adoption of innovations
- Invest in digital technology

### 3. Employer of choice

- A great place to work that is diverse and inclusive
- Empowered clinically led teams
- Support our staff to continuously develop
- Support staff health and wellbeing

### 4. An anchor in our community

- Create a healthy and accessible environment
- Expand charitable support and network of volunteers
- Developing in a sustainable way

### Our values

- **Putting patients first**
- **Working well together**
- **Recognising the person**
- **Striving for excellence**

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**Exceptional healthcare, personally delivered**

# The North Bristol NHS Trust Strategy

NHS
North Bristol
NHS Trust

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## 2019 – 2024

one NBT

Exceptional healthcare, personally delivered

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# Introduction

**Dear colleague,**

**We launch this document on the back of our 2019 CQC inspection in which we achieved a GOOD rating overall and OUTSTANDING for caring. This achievement was down to you and a terrific example of what happens when we work together to provide the best care possible to our patients. I want us to continue this momentum as we launch this strategy and set out our bold ambitions for the next five years.**

I am delighted to share this strategy with you. It is your strategy, informed by what you have said you want to happen, how you want us to improve and the care you want to give to patients both now and in the years to come. It is also based on what you have said about how you want this organisation to be somewhere you enjoy working and an attractive employer for the future workforce. What is set out in this document reflects your ambitions and I have no doubt if we work together as OneNBT we will continue to provide exceptional healthcare, personally delivered.

We have a record of improvement we can all be proud of but for this to continue we have to be mindful of the challenges around us. Staying the same is not an option. The population we serve is growing, the health needs of the patients we care for are becoming more complex and the availability of new technology creates opportunities for us to think differently about the way we do things.

You have shown over the past five years that you are ready and willing to meet these challenges; working together, thinking innovatively and most importantly in partnership with our patients. We also know that we will not achieve what we have set out to do in this strategy if we work in isolation. Our patients do not only access their care at this hospital; they receive care in many different ways across the city and beyond. We have to be aware of that and work jointly with our health and care partners to develop joined-up, fully integrated services.

The national Long Term Plan was published in 2019 and our local Bristol, North Somerset and South Gloucestershire (BNSSG) plan has been shared with regulators. We have made sure that this strategy is aligned to those plans and we will ensure we are significant contributors to their success.

This strategy is important because it sets out how we will provide the very best care that we can for our patients, using the wonderful facilities we have available and working together in fantastic teams. Together we can achieve our ambitions that are so important to you and for all our patients.

**Andrea Young**
Chief Executive.

# Our vision, values and strategic intentions

## Our Strategy for 2019-2024

**By enabling our teams to be the best that they can be, we will provide exceptional healthcare, personally delivered**

**The best health and care is not the work of an individual, a single team or even one organisation. Partnership and collaboration is fundamental.**

"Exceptional healthcare" means our patients will recognise that we are exemplars of safe, harm-free care and that we give them the best possible health improvement. We will do this through outstanding Emergency Care, our centres of excellence for Specialist Services, our great Local Services and as a Powerhouse for Pathology and Imaging.

"Personally delivered" means patients are in charge of their own care and the decisions that need to be made for their health and wellbeing. A genuine partnership with patients and the public is at the heart of any changes we make and will ensure an outstanding patient and carer experience.

**This vision is underpinned by the organisation's values as described by our staff:**

Putting the patient first

Working well together

Recognising the person

Striving for excellence

To deliver this strategy we must understand the issues and challenges we are likely to face. We have identified eight areas which we know about our future.

1. The health needs of our local population will continue to change and grow. We will need to meet these demands and maintain capacity for specialist services. To do this we will need to embrace continuous improvement and innovation and to work with our partners to increase the amount of health and care provided outside the hospital.
2. We will continue to develop our organisation to be clinically led and support our staff to make decisions that support the delivery of world class care.
3. We will invest in the latest digital technology to create an organisation that adapts and adopts new ways of working that better meet the needs of its patients.
4. We will seek to make the best use of NHS resources for patient care and develop sustainable services for the long term.
5. We will continue to develop and grow specialist commissioned work but do not expect to expand the range of specialties we provide.
6. Our contribution to local and regional Pathology and Radiology will increase.
7. We will work in partnership with health and social care partners in Bristol, North Somerset and South Gloucestershire so that patients receive high quality, consistent care in the most appropriate location for their needs.
8. We will work to support our local communities beyond just the delivery of clinical care. We will do this by:
   - Increasing research activity
   - Training the future health workforce as a core part of our business
   - Invest in being an employer of choice, attracting the best staff in to the BNSSG health and care system
   - Playing an active part in helping people keep themselves healthy
   - Mitigating our impact on our local environment

## NHS long-term plan priorities for NBT

In 2019 the NHS in England announced its long term plan for those improvements that will make best use of the £20.5bn of additional funding by 2023/24, which was announced by the Government in 2018. With our local health and social care partners working within the Healthier Together partnership we will produce a local plan to deliver the national ambition. The thinking represented in this strategy will feed into the regional planning.

Our shared plan will set out what we will deliver as a group of organisations over the next five years. It will include how we involve patients and the population in our work, a description of local need, and how we will operate within the resource allocated to us.

We are working closely with University Hospitals Bristol NHS Foundation Trust and Weston Hospital NHS Trust to develop the specific elements of the plan for our hospitals and we will also work to integrate care with community partners and primary care.

At NBT we have a key role to play in many of the areas for improvement in the Healthier Together Plan. These include:

- Helping our partners to achieve the proposed increase in community health and care activity including the establishment of Primary Care Networks
- Redesign of emergency care with the introduction of urgent treatment centres and move to 'same day emergency care'
- Elimination of unnecessary outpatient appointments and finding technological solutions to ways of supporting patients with long term conditions in the community
- Leading work on the improvement priorities for 'the biggest killers and disablers of our population':
  - **Cancer** for which NBT is the biggest surgical provider in the South West
  - **Cardiovascular disease** for which NBT provides the hub for the vascular network
  - **Stroke** for which NBT is leading the development of the thrombectomy service
  - **Diabetes and respiratory illness** for which NBT has expertise to support local care and specialist care when required
  - **Maternity and neonatal care** where NBT has a large obstetric service in our Local Maternity System
- We are committed to research and innovation including increasing the number of patients participating in research
- We will contribute to the training plan required to deliver the planned growth of the medical, nursing and volunteer workforce
- Our own digital strategy supports the ambitions in the plan to create digitally enabled care
- Working with our civic partners to reduce carbon emissions as part of Bristol's One City Plan

## The Strategy - OneNBT

Through this strategy we will come together as OneNBT to provide the very best care that we can. There are four key elements to this ambition which are set out in four chapters over the next few pages. The chapters are underpinned by the following statements:

1. Our core purpose will always be to provide a standard of clinical care for the patients we serve that we would expect to receive ourselves. To sustain quality of care into the future we must also pay attention to our roles in developing the future healthcare workforce and contributing to future health research and innovation.
2. We are one of the largest employers in the South West of England and need to meet exemplary standards in the way we manage and work with our staff to make NBT a great place to work and an employer of choice. Equality and diversity is a priority for us not only to ensure we reflect the communities we serve but also to make sure we create a place where everyone can do their best work.
3. We are a large and established organisation acting as an anchor in our local community with associated responsibilities for sustainable development, local product sourcing, and population health and illness prevention.

## In summary the four chapters that make up the core focus of this strategy are:

### 1. Provider of high quality patient care

- Experts in complex urgent and emergency care
- Work in partnership to deliver great local health services
- A Centre of Excellence for specialist health care
- A powerhouse for pathology and imaging

### 2. Developing healthcare for the future

- Training, educating and developing our workforce
- Increase our capability to deliver research
- Support development and adoption of innovations
- Invest in digital technology

### 3. Employer of choice

- A great place to work that is diverse and inclusive
- Empowered clinically led teams
- Support our staff to continuously develop
- Support staff health and wellbeing

### 4. An anchor in our community

- Create a healthy and accessible environment
- Expand charitable support and network of volunteers
- Developing in a sustainable way

# Chapter 1. Delivering high quality, sustainable care for patients and carers

## NBT, what we do

We provide high quality clinical services for patients from local and regional populations.

- **Urgent care** – Emergency care is vital for both our local and specialist services. We will be exemplars of best practice in urgent and emergency care so that our patients have the best possible outcomes.
- **Local acute care** – we provide elective and urgent hospital services for a population of 500,000 people, primarily in South Gloucestershire and North Bristol. We will work in partnership with community and primary care to develop integrated care services that meet the rising needs of people in our aging population.
- **Specialist services** – we excel in complex surgical interventions providing great care for patients across the region and beyond. We also provide a suite of non-surgical specialist services that are a critical part of NHS care in the South West.
- **Diagnostic services** – NBT delivers both Pathology and Radiology at scale and to a high quality. We expect that the requirement for faster diagnosis for cancer patients and in urgent care will mean that activity in these services continues to rise. Our Genomics Laboratory Hub will be at the centre of developing the new Genomics Medicine Service across the South West of England.

## Experts in complex urgent and emergency care

**Our patients take comfort in knowing that first and foremost as a hospital we respond rapidly and effectively when there is urgent patient need. This is a fundamental right of patients. NBT's local and specialist service offer puts us at the centre of the urgent and emergency care requirement for our local and regional populations. We intend to be exemplars of best practice in delivery of urgent and emergency care.**

We will provide expert care and treatment 24 hours a day, 365 days a year for patients when they need us most, in emergencies.

We will work with partner organisations to ensure urgent care is provided in the most appropriate setting.

We will ensure rapid access to the right expertise in a specialist hospital or in the community.

We will be at the forefront of the innovations in care that are developing to manage increasing demand and the complexity of patients' conditions.

Our services will be rapid and responsive to patient need, returning people to home or community settings at the earliest opportunity.

We will continue to seek improvements in how we provide urgent and emergency care and have plans to:

- Increase provision of same day emergency care
- Have outpatient care immediately available when needed – consultant-led 'hot clinics' in every speciality with rapid access to appropriate care

## Working in partnership to deliver great local care

**Patients tell us they would rather receive care at home or nearer to home and spend less time in hospital. In partnership with others we will develop seamless care between organisations that reduce the need for hospital services. This will result in consistent care for patients, including safe and smooth transfers between hospital and community settings.**

Collaborating with partners we will realise our shared vision for patient-centred services that are truly integrated across the health and care system. With partners we will design pathways that:

- Minimise the need for hospital admission
- Ensure patients rapidly receive the right care in the best location for their needs
- Enable safe and smooth transfers of care between hospital and community settings
- Ensure consistent standards of care between provider services
- Deliver the very best care possible at each of the hospital sites in BNSSG

There are specific ambitions that will help us to improve both the quality and efficiency of our services. These include:

- Ways of working that minimise delays 7 days a week
- Patients never waiting unnecessarily in a hospital bed
- Long term care designed with patient need at the centre – supporting patients whilst avoiding unnecessary visits to hospital
- An effective Local Maternity System

Significant work is already underway with partners and will be further developed:

- An Integrated Care Bureau to support patients to get home or into a community service when they need it
- Work with General Practice to create better models of care for those patients who attend the Emergency Department with conditions more effectively managed by primary care
- Creating care pathways for people with long term conditions and frailty that support them in the community and avoid unnecessary hospital attendance
- Creating locality hubs so that people can access services closer to home

## A centre of excellence for specialist services

**We will be a leading provider of specialist services and have a reputation for improvements in patient care that are best in class. We want our city to be proud of its hospitals. We will work in partnership with University Hospitals Bristol NHS Foundation Trust to create a centre of specialist health care in the city of Bristol which has national and international recognition for clinical excellence.**

We are a major provider of specialist clinical care for the South West and beyond. Our specialist services include highly complex surgical interventions, cancer surgery, a range of specialist medical services and interventional radiology (neuro and general) as set out below.

**Specialist surgery**

**Complex surgery**
- Major Trauma
- Specialist orthopaedics
- Neurosurgery & neuroIR
- Plastics and Burns
- Vascular surgery
- Renal Transplantation
- Obesity surgery
- Benign Gynaecology
- Specialist maternal surgery

**Cancer surgery**
- Urology
- Breast
- Plastics/skin
- Neurosurgery
- Colorectal

Interventional Radiology

**Specialist medicine**

**Inflammation/Infection/Immunology**
- Respiratory medicine
- Renal medicine
- Rheumatology
- Specialised immunology and allergy
- Bone and joint infection
- HIV

**Neurosciences**

**Enablement services**
- Prosthetics
- Communication aids

**Womens Health**
- Neonatal Intensive Care

We pride ourselves on the skills and capabilities that enable us to be the standard-bearers of excellence for our specialist services. As well as being of the very highest clinical standard our specialist services must also be sustainable and delivered within the resources available to us and the wider healthcare system. This means that we will:

- Operate at sufficient scale to be efficient and clinically effective
- Standardise pathways in-line with clinical best practice
- Develop the clinical workforce we need now and in the future
- Secure the funding required in order to provide complex care sustainably

We expect that our specialist services will continue to grow due to the changing needs of our population. We will use this as an opportunity to deliver new and innovative ways of providing care that provide tangible and measurable benefits to our population. We will expand availability of thrombectomy as an urgent treatment for stroke. Through our Genomics Laboratory Hub and the associated Genomics Medicine Service we will ensure we position ourselves at the forefront of adoption of the coming genomics revolution and the associated benefits that it will bring.

## Clinical networks

To enable our vision of great patient care and outstanding outcomes, it is our intention to lead managed clinical networks of our services.

This will:

- Provide clinical leadership across our region to ensure a consistent standard of care
- Enable specialist work to be delivered in the right place at appropriate volumes, as expected for best practice
- Provide care in local hospitals where necessary skills are available and ensure there are opportunities for clinicians to enhance their skills across the network
- Enable management of the patient case mix across our provider network to ensure operational and financially sustainability whilst also providing the very best training and research opportunities
- Support the rapid development and adoption of innovations for the benefit of patients such as those expected from genomics and personalised medicine.

## A powerhouse for pathology and imaging

**We will lead networks of pathology and radiology services aimed at delivering early and rapid diagnoses. Our scale will enable superb cost-effective services. Our uniquely integrated pathology services, centred around a Genomics Laboratory Hub will ensure access of our populations to the most up-to-date technologies to support their care.**

Exceptional healthcare, personally delivered for the great majority of patients is dependent on fast, accurate diagnostics, particularly pathology and radiology. It is likely there will be continued innovation in diagnostic services in the next five years as technology develops, especially within areas such as genomics.

We are already an established leader in the provision of pathology services in our region and a leading provider of imaging. We provide them at scale which brings efficiencies as well as enabling responsive high quality delivery. We recognise that there will be increasing demand for diagnostic services not only as our local population grows but as we are able to treat illnesses earlier and more rapidly.

We will lead and work with partners in radiology provider networks as they develop to ensure the right services for the population over the next five years and beyond. This will mean:

- Imaging services that support urgent care for all partners are available 24/7
- There is ease of access for patients
- There is rapid diagnosis for suspected cancer
- Opportunities from new technologies are adopted rapidly
- Overall the imaging capacity in the health system meets the demand

## Genomics and personalised medicine

Our Genomics Laboratory Hub in collaboration with our partners is leading the development of the Genomics Medicine Services in the South West. This puts us at the very front of the transformation towards a more personalised way of delivering care based on genomic information about patients and disease.

As with other areas of our specialist portfolio our organisation will need to work closely with our commissioners and others across the South West to realise the vision of access to genomics testing and personalised medicine for the entire population.

We will work with our genomics experts to ensure that our own clinical services in NBT will be amongst the first to realise the benefit of these improvements for our patients.

## Personal delivery

We are committed to developing a genuine partnership with patients. By doing this, patients will be able to tell us exactly what they need and how they want to receive care. This means we will be best placed to provide the right care not only today, but as we develop our services, an offer that feels more personal.

We recognise that every patient is an individual with unique requirements based on their circumstances and wishes. Relationships with our patients will continue to change with the increased availability of information and the development of the use of social media and social networks. Patients tell us that if they are to be truly in charge of their care then they need a different relationship with clinicians so that they feel supported to make their own decisions about the healthcare they use.

We will make sure that patients, their representatives and carers are at the heart of every service improvement we make. We will also design care in collaboration with patients and the public that really addresses what matters to them and empowers them to be healthy and well.

## Leading and working with partners

Our aim is to lead a strong organisation as part of a vibrant local and regional healthcare system.

All four chapters of our strategy recognise that working with other healthcare providers and organisations is fundamental to realising our vision.

We expect to continue to build on the strong relationships we already have in place to create the Integrated Care System envisaged in the NHS Long Term Plan.

This will increasingly see us making plans together as a single health and care system rather than separately as a single organisation. To do that we will need to work in a different way – one where we and our provider partners are working more frequently as one joined-up seamless source of care – to meet the health and care needs of our populations.

In the next five years we will have a different partnership approach with:

- **Other providers** We work alongside amazing provider partners and we want to work more closely with them as we think about how we provide the best services we can. This includes:
  - The new local community care provider and primary care
  - BNSSG hospital providers as we develop a consistent hospital offer

  - Working with University Hospitals Bristol NHS Foundation Trust to create a specialist centre of excellence for the benefit of the whole South West
  - Creating networks of specialist care with neighbouring hospital Trusts
- **Our local authority partners** are the providers of services aimed at prevention, maintaining health and wellbeing and social care. We want to support this work to protect the future health of the local population and make sure that our staff work closely together to maximise care and independence in the community.
- **Our commissioners** We will work with our commissioners to understand and plan for the needs of our population and to advocate for the resources our health community needs.
- **Local community organisations and voluntary groups** also have a key role to play in helping our communities to stay healthy, well and independent. For example the Southmead Development Trust offers social prescribing which helps people to access a range of local, non-clinical services. We want to use this growing expertise as we develop our services to meet the needs of the population we serve.

We will continue the strong and effective work of our teams in quality improvement, research and innovation through the established partnership organisations:

- **The Clinical Research Network**
- **Bristol Health Partners**
- **The West of England Academic Health Science Network**

# Chapter 2. Developing healthcare for the future

## Education, training and development

As a responsible employer we care deeply for the people who work here and are committed to ensuring we have a highly skilled and motivated workforce. Not only is this the right thing to do, it is also fundamental to our success. We will continue to embrace our responsibility for developing the workforce of the future in collaboration with other local care providers, the Universities and Health Education England. We want this to be the start of an ongoing conversation with our workforce and we will:

- Continue our roles in undergraduate and post-graduate training of health care professionals, providing high quality clinical placements and excellent teaching facilities
- Work with others to establish new roles that increase the opportunities people have to join the health workforce and make maximum use of available skills
- Expand our excellent apprenticeship programmes
- Support and promote the continuous development of all of our staff so that each can maximise their potential

## Continuous improvement

We cannot predict all of the changes required of our services in the years ahead and so we must continue to invest in the capability of our people to enable them to address new challenges as they arise. We must create an organisation that is agile in responding to new challenges. We are proud of our culture which encourages our workforce to continually improve and expect to continuously innovate what we do in the years ahead.

Effective working in complex teams is a core reason for our recent successes at NBT. We will continue to develop team working capabilities using our award winning Perform methodology. We intend that this will be embedded in every part of our organisation.

We will develop high levels of capability by using data to identify challenges that require action and to support effective change.

We will bring together the change management expertise in the Trust to maximise the transformation resource available to our services. The capability in the Programme Management Office, the Quality Improvement team and in the Perform Academy will be continuously reviewed to ensure that we have the correct mix of skills for delivering the improvements we need.

## Research

We are a well-established research centre with a multidisciplinary infrastructure that supports a broad range of clinical research. Delivering excellent clinical research is important for us as it supports improving patient outcomes as well as attracting and retaining talented staff. It is therefore our intention to further develop our strengths in research and maximise opportunities for our patients and staff to be involved.

We will:

- Increase our capability to deliver research that is important to, and prioritised by, patients
- Continue to be a key contributing member of Bristol Health Partners and the West of England Clinical Research Network to enhance our combined research strengths
- Ensure access to cutting-edge treatments with appropriate safeguards that improve patient outcomes
- Improve patient safety and care by rapidly adopting evidence based research outcomes

## Innovation and technology

In the future the adoption of technology and digital solutions will be fundamental to our transformation.

We have recognised the opportunities from advances in technology in our Digital Strategy through which we will deliver:

- Digital systems that support safe and effective care
- Patient care information available wherever the patient is located in the health system. This will improve quality, avoid wasted duplication and ensure access to information is not a cause of delays
- Improved availability of data to help understand and develop our services and support our continuous improvement programmes
- Easily accessible information that will help our teams plan their work, purchase the right equipment and act within available resources
- Information in the hands of patients and carers to enable them to take control of their health and care
- Ability to rapidly adopt the opportunities of new technologies as they arise

We will also develop our capacity to support the generation of innovations, and accelerate their adoption into our services. In particular, we will:

- Partner with the Academic Health Science Network, universities and industry to collaborate on the development of technologies that address our patient's needs
- Build on technologies such as clinical robotics and 3D printing to improve effectiveness of our services
- Make sure we are ready to take advantage of opportunities that present themselves from artificial intelligence and machine learning technologies
- Stay at the forefront of the personalised healthcare revolution driven by the development of genomics

# Chapter 3. An employer of choice

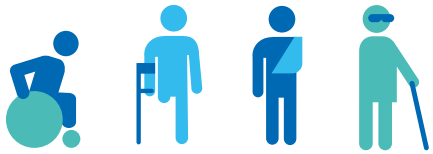
There is no part of society that the NHS does not reach and we should never underestimate the responsibility we have to the people we serve and care for. At the same time we are nothing without the people who work for us. Without the vast array of skills and capabilities of our staff we would not be able to provide the very personal care we do or achieve the bold ambitions we have set out in this strategy. We can only be successful by continuing to employ talented people with a commitment to providing excellent care. We need to recognise that working in a busy hospital can be tough and the wellbeing of the people who work here can be challenged. If we want our staff to feel healthy, happy and well then we need to be totally committed to creating an environment for work that allows our people to thrive and deliver their very best for our patients.

## A great place to work

As a large and established employer we seek to provide a great place to work. To achieve that it is important we recognise that people are leading increasingly busy lifestyles with many conflicting demands. People want to work more flexibly and the idea of a set working base with set working patterns is increasingly outdated. We will continue to work with our staff to ensure an appropriate balance between flexibility in employment options and the need to provide 24/7 services.

We strive to support our staff to make working at NBT fit well with their lives, be that by:

- Providing onsite childcare services
- A comprehensive travel to work offer
- Onsite facilities for staff including catering and fitness classes
- Hospital Arts and Sustainability programmes



## Empowered teams

Through meaningful engagement with our staff we will enable people to contribute their best ideas. We want our teams to make the decisions that improve their services. We will continue our Service Line Management programme to realise and ensure our teams can sustain their visions for their services.

## Diversity and inclusion

All individuals bring different perspectives making the value of a diverse workforce immense. Our ambition is to become a truly inclusive OneNBT, where people feel a sense of belonging and identity. To achieve this we have adopted an approach called Valuing You through which we will create equality of opportunity for all and reduce pay gaps and access to senior roles regardless of gender, physical ability, age, sexuality and ethnicity.

## Development

We will provide a broad training and development offer for all our staff so they are supported in their continuous development. All staff will have the skills they need to be successful in their roles and opportunities to stretch their capabilities so that they can achieve the best that they can.

## Health and wellbeing

By supporting our staff to be fit and healthy themselves, we can provider better care for our patients. We recognise the pressure inherent in providing health care and we will continue to improve the support we provide for our staff's health and wellbeing, building on the programmes we have already established.

# Chapter 4. An anchor in our community

## An organisation local people and patients are proud of

We are proud to be at the heart of communities in the north of Bristol, South Gloucestershire and North Somerset. We highly value our place in these communities and the support we receive.

It is important to us that our services meet our local population's needs. We continue to listen to our patients and community representatives to learn how our services can be improved. We also engage with Local Authority health scrutiny committees, Health and Wellbeing Boards, Health Watch and local community and voluntary groups and organisations.

Health is more than just a hospital. Our local population's health and wellbeing is impacted by issues such as housing, education, employment, access to local services and the environment. With this in mind we will seek partnerships with local businesses, public sector partners and charitable organisations where we can support each other's visions and aims. Where possible we will work with local suppliers, supporting the local economy as well as reducing environmental impacts of our supply chain.

## Making a difference to our community

We actively promote the use of our estate and facilities for wider community use and will continue to seek further opportunities to share our assets for the benefit of all the community. This will build on investments already made in creating new park space across our Southmead site and our arts programme which has brought sculpture, paintings and music in many forms for the benefit of patients, staff and the general public. Our facilities are used by a wide range of groups including craft classes, patient education, a weekly farmers' market, a transport hub and allotments for growing fruit, herbs and vegetables.

## Volunteers

Our volunteer workforce is a jewel in the crown of our services. We are very fortunate to have hundreds of volunteers from our community who give up their personal time to support the hospital and enrich our services. We aspire to expand the support we receive from our volunteers and will work with them to find ever more ways in which they can contribute to improving patient care.

## Southmead Hospital Charity, League of Friends and other charitable partners

Through the support of our own hospital charity and the many charities which support the work we do, we are able to improve patient care through new facilities and innovative equipment. This makes a huge difference to the care we can offer. We are grateful and proud of the support given to us through our charity partners and will continue to work with them to expand their contribution.

## Sustainable healthcare

Increasingly we live in an age where we are rightly challenged on our contribution to protecting and enhancing the natural environment. This is an area we take extremely seriously and have been an exemplar in for many years. However, we can and will do much more.

We fully recognise the detrimental impacts our services can have on the natural environment and this cannot continue. Staff and patient journeys - as just one example - are a significant contributor to carbon emissions. We will seek to urgently reduce these impacts and engage with our staff, patients, visitors and the local community to encourage them to do the same, for the benefit of public health for now and generations to come.

We are a leader in the field of sustainable healthcare, developing sustainable models of care across our services. The Trust has set targets to reduce our carbon emissions and will continue to agree an annual sustainable development plan to deliver those targets.

We will work closely with our partners across BNSSG to ensure our estates, our services, our staff, patients, suppliers and our local community are prepared for the anticipated impacts of a changing climate.

## Implementation and delivery

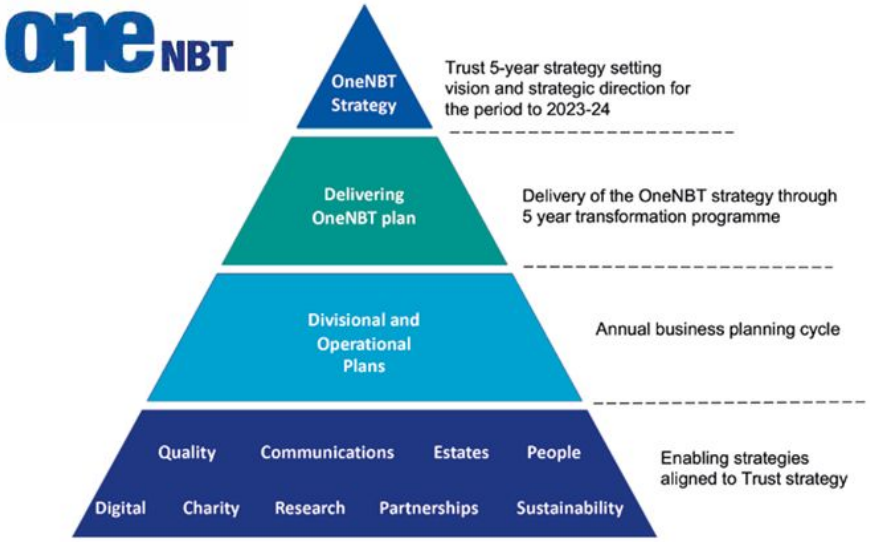
Our OneNBT strategy provides a clear and ambitious vision for the next five years, shaping our future and responding to the challenges ahead. We are confident that by working alongside our partners we can make it become our reality.

Alongside this strategy, we have developed 5-year projections of expected demand for services and assessed the capacity required from the Trust so that we can meet this demand effectively.

In order that we can deliver our vision we need substantial change in how we provide our services. We do not underestimate the scale of the challenge and have developed a transformation programme to support delivery.

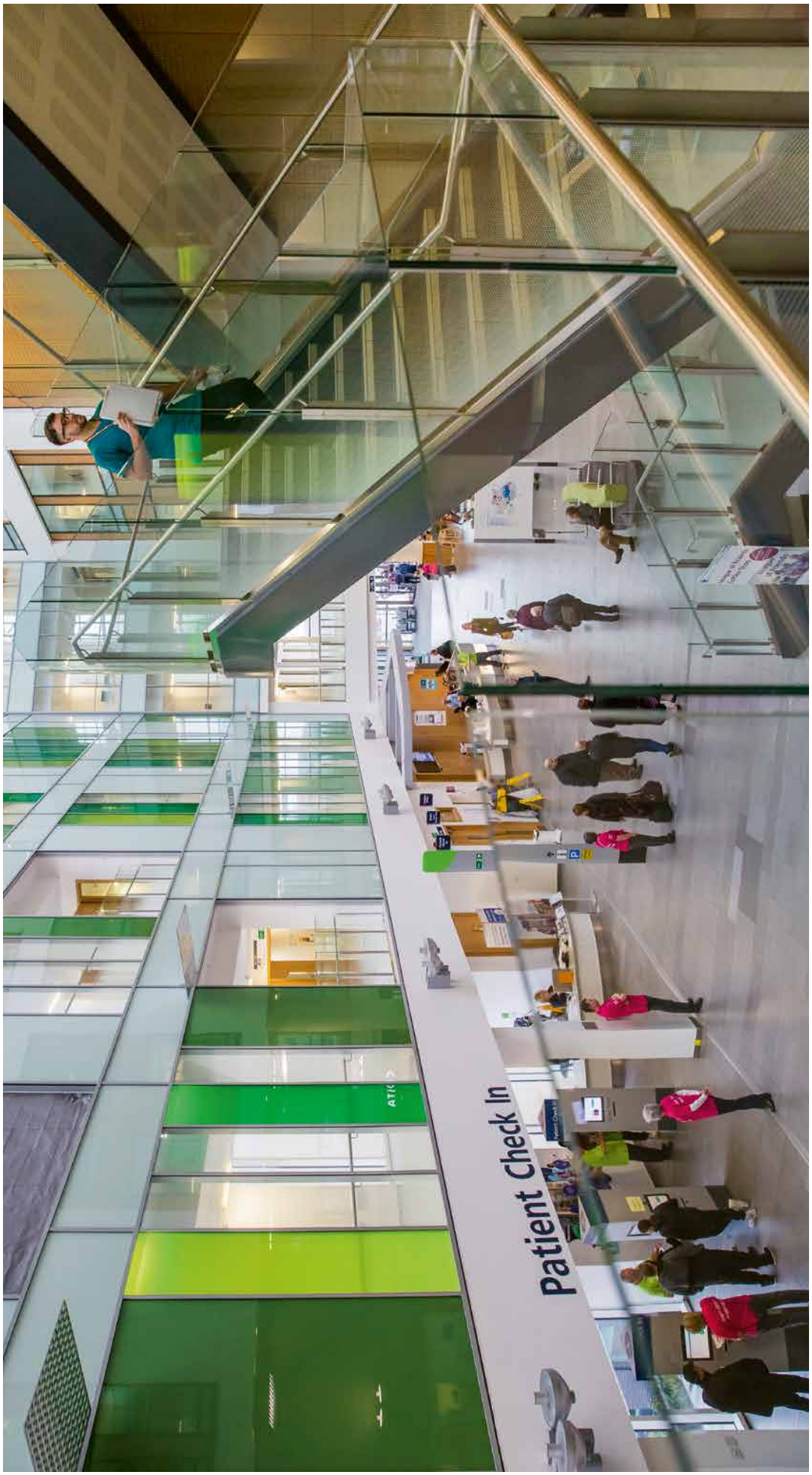
Annual objectives will be set each year through our annual business cycle which will drive the practical actions that deliver our strategic aim;

**Exceptional healthcare, personally delivered.**



**Our Strategy for 2019-2024**

**By enabling our teams to be the best that they can be, we will provide exceptional healthcare, personally delivered**


Patient Check In

If you have any questions or comments about this or any other guides please contact a member of the communications team by emailing

**NBTCommunications@nbt.nhs.uk**

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|---|---|---|---|---|
| **Report To:** | Trust Board | | **Agenda Item:** | 13 |
| **Date of Meeting:** | 30 January 2020 | | | |
| **Report Title:** | Integrated Performance Report | | | |
| **Report Author & Job Title** | Lisa Whitlow, Associate Director of Performance | | | |
| **Executive/Non-executive Sponsor (presenting)** | Executive Team | | | |
| **Purpose:** | **Approval/Decision** | **Review** | **To Receive for Assurance** | **To Receive for Information** |
| | | | X | |
| **Recommendation:** | The Trust Board is asked to note the contents of the Integrated Performance Report via email for December. | | | |
| **Report History:** | The report is a standing item to the Trust Board Meeting. | | | |
| **Next Steps:** | This report is received at the Joint Consultancy and Negotiation Committee, Operational Management Board, Trust Management Team meeting, shared with Commissioners and the Quality section will be shared with the Quality and Risk Management Committee. | | | |

| **Executive Summary** |
|---|
| Details of the Trust's performance against the domains of Access, Safety, Patient Experience, Workforce and Finance are provided on page three of the Integrated Performance Report. |

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*This document could be made public under the Freedom of Information Act 2000.*
*Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.*

<table>
<tr><td>Strategic Theme/Corporate Objective Links</td><td>This report covers all Strategic Themes with the exception of Maximise the use of technology – right information for the right decisions.</td></tr>
<tr><td>Board Assurance Framework/Trust Risk Register Links</td><td>The report links to the BAF risks relating to internal flow, staff retention, staff engagement, productivity and clinical complexity.</td></tr>
<tr><td>Other Standard Reference</td><td>CQC Standards.</td></tr>
<tr><td>Financial implications</td><td>Whilst there is a section referring to the Trust’s financial position, there are no financial implications within this paper.
<table>
<tr><th>Revenue</th><th>Total £’000</th><th>Rec £’000</th><th>Non Rec £’000</th></tr>
<tr><td>Income</td><td></td><td></td><td></td></tr>
<tr><td>Expenditure</td><td></td><td></td><td></td></tr>
<tr><td>Savings/benefits</td><td></td><td></td><td></td></tr>
</table>
<table>
<tr><td>Capital</td><td></td></tr>
</table></td></tr>
<tr><td>Other Resource Implications</td><td>Not applicable.</td></tr>
<tr><td>Legal Implications including Equality, Diversity and Inclusion Assessment</td><td>Not applicable.</td></tr>
</table>

| **Appendices:** | Not applicable. |
|---|---|

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NHS North Bristol NHS Trust

## North Bristol NHS Trust

# INTEGRATED PERFORMANCE REPORT

## January 2020 (presenting December 2019 data)

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# North Bristol Trust Integrated Performance Report Scorecard

North Bristol NHS Trust

| Domain | Description | National Standard | Current Month Trajectory (RAG) | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Trend | Benchmarking (in arrears except A&E & Cancer as per reporting month) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | National Performance | Rank | Quartile |
| Responsive | A&E 4 Hour - Type 1 Performance | 95.00% | 86.15% | 84.87% | 77.89% | 70.47% | 74.10% | 69.73% | 76.16% | 72.53% | 72.49% | 87.89% | 85.14% | 80.04% | 80.18% | 74.64% | | 70.54% | 36/118 | |
| | A&E 12 Hour Trolley Breaches | 0 | 0 | 0 | 0 | 21 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 4 | 9 | 2 | | 0-348 | 3/32 | |
| | Ambulance Handover < 15 mins (%) | 100% | 91.64% | 91.15% | 90.02% | 92.36% | 92.66% | 89.26% | 93.93% | 93.75% | 94.02% | 97.18% | 97.29% | 94.09% | 94.34% | 92.65% | | | | |
| | Ambulance Handover < 30 mins (%) | 100% | 99.54% | 99.50% | 98.62% | 99.10% | 99.27% | 98.27% | 99.39% | 98.91% | 98.93% | 99.78% | 99.81% | 99.19% | 99.14% | 99.22% | | | | |
| | Ambulance Handover > 60 mins | 0 | 0 | 0 | 1 | 0 | 2 | 12 | 0 | 4 | 0 | 0 | 0 | 0 | 1 | 0 | | | | |
| | Delayed Transfers of Care | 3.50% | 3.50% | 4.86% | 4.36% | 3.99% | 5.82% | 4.92% | 7.02% | 6.06% | 5.40% | 7.75% | 8.90% | 7.28% | 7.19% | 6.89% | | | | |
| | Stranded Patients (>21 days) - month end | | | 111 | 146 | 138 | 133 | 160 | 133 | 131 | 135 | 276 | 156 | 138 | 128 | 129 | | | | |
| | Bed Occupancy Rate | | 95.00% | 91.00% | 97.09% | 97.94% | 96.53% | 96.97% | 95.94% | 95.07% | 95.46% | 94.80% | 95.18% | 96.49% | 96.22% | 96.77% | | | | |
| | Cancelled Operations (Same day - non-clinical) | 0.80% | | 0.86% | 1.29% | 1.45% | 0.89% | 1.35% | 1.33% | 0.78% | 0.71% | 0.94% | 0.94% | 1.30% | 1.10% | 1.25% | | 1.53% | 47/151 | |
| | Cancelled Operations (28 Day Rebooking) | 0 | 3 | 2 | 2 | 3 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 0 | 1 | 0 | | 0-80 | 4/39 | |
| | Diagnostic 6 Week Wait Performance | 1.00% | 5.55% | 4.11% | 3.89% | 2.32% | 3.10% | 4.27% | 5.48% | 6.84% | 8.16% | 9.39% | 8.69% | 9.09% | 8.87% | 12.56% | | 2.94% | 125/141 | |
| | Diagnostic 13+ Week Breaches | 0 | 0 | 35 | 20 | 8 | 10 | 15 | 74 | 84 | 130 | 205 | 225 | 239 | 63 | 147 | | | | |
| | RTT Incomplete 18 Week Performance | 92.00% | 87.73% | 87.41% | 87.61% | 86.95% | 86.71% | 85.18% | 85.14% | 85.03% | 85.21% | 83.39% | 83.20% | 83.28% | 82.58% | 82.43% | | 84.37% | 121/175 | |
| | RTT 52+ Week Breaches | 0 | 13 | 51 | 38 | 44 | 18 | 19 | 16 | 17 | 14 | 14 | 16 | 13 | 14 | 14 | | 0-175 | 15/35 | |
| | Total Waiting List | | 28640 | 26431 | 26459 | 27304 | 27910 | 27995 | 29179 | 28590 | 28740 | 28587 | 29313 | 29118 | 28351 | 28078 | | | | |
| | Cancer 2 Week Wait | 93.00% | 80.52% | 80.82% | 75.74% | 92.44% | 90.27% | 84.70% | 83.44% | 78.44% | 71.79% | 65.54% | 69.92% | 87.23% | 91.33% | - | | 91.33% | 107/140 | |
| | Cancer 2 Week Wait - Breast Symptoms | 93.00% | 93.99% | 26.00% | 48.16% | 82.20% | 82.69% | 89.83% | 88.83% | 76.97% | 96.75% | 94.64% | 96.08% | 98.61% | 87.50% | - | | 87.50% | 61/108 | |
| | Cancer 31 Day First Treatment | 96.00% | 96.47% | 93.90% | 92.28% | 95.49% | 93.28% | 93.08% | 88.24% | 88.03% | 90.35% | 89.47% | 90.20% | 85.76% | 95.93% | - | | 95.93% | 96/117 | |
| | Cancer 31 Day Subsequent - Drug | 98.00% | 100.00% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 99.37% | - | | 99.37% | 1/29 | |
| | Cancer 31 Day Subsequent - Surgery | 94.00% | 94.06% | 87.88% | 75.63% | 80.87% | 79.17% | 80.77% | 82.52% | 77.88% | 83.33% | 82.56% | 75.23% | 69.09% | 91.66% | - | | 91.66% | 59/67 | |
| | Cancer 62 Day Standard | 85.00% | 73.10% | 87.04% | 82.17% | 81.67% | 85.98% | 84.40% | 78.95% | 76.99% | 74.10% | 88.84% | 72.58% | 66.98% | 77.37% | - | | 77.37% | 99/139 | |
| | Cancer 62 Day Screening | 90.00% | 89.71% | 89.13% | 89.04% | 91.07% | 91.84% | 93.33% | 91.84% | 84.31% | 85.00% | 92.59% | 90.00% | 77.50% | 83.76% | - | | 83.76% | 39/69 | |
| | Mixed Sex Accomodation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | Electronic Discharge Summaries within 24 Hours | 100% | | 82.08% | 82.40% | 82.65% | 83.55% | 80.77% | 83.69% | 83.57% | 84.39% | 82.99% | 84.40% | 84.34% | 83.37% | 83.57% | | | | |
| Quality Patient Safety & Effectiveness | Never Event Occurance by month | 0 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | | | |
| | WHO (Emergency and Elective) | | 95% | 97.40% | 97.30% | 97.50% | 97.40% | 97.70% | 97.70% | 97.30% | 97.50% | 97.70% | 97.50% | 98.60% | 98.80% | 99.90% | | | | |
| | Pressure Injuries Grade 2 | | | 15 | 21 | 29 | 21 | 43 | 27 | 31 | 24 | 34 | 46 | 43 | 43 | 32 | | | | |
| | Pressure Injuries Grade 3 | | | 0 | 0 | 0 | 3 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | | | | |
| | Pressure Injuries Grade 4 | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | | |
| | Falls per 1,000 bed days | | | 30 | 31 | 28 | 31 | 30 | 31 | 30 | 31 | 31 | 30 | 31 | 30 | 31 | | | | |
| | #NoF - Admissions to Acute Ortho Ward <4 Hours | | | 80.00% | 62.22% | 53.19% | 58.49% | 59.57% | 60.71% | 67.39% | 63.41% | 69.44% | 75.44% | 76.36% | 72.34% | 68.00% | | | | |
| | #NoF - Surgery <36 Hours if Medically Fit | | | 68.60% | 66.70% | 93.60% | 94.30% | 80.90% | 76.80% | 87.00% | 90.20% | 83.30% | 75.40% | 87.30% | 91.50% | 92.00% | | | | |
| | #NoF - Assessed by Orthogeriatrian <72 Hours | | | 94.30% | 93.30% | 100.00% | 98.10% | 97.90% | 96.40% | 100.00% | 95.10% | 100.00% | 96.50% | 98.20% | 100.00% | 96.00% | | | | |
| | Stroke - Patients Admitted | | | 84 | 71 | 60 | 80 | 79 | 67 | 88 | 77 | 89 | 76 | 89 | 83 | 82 | | | | |
| | Stroke - Scanned <1 Hour of Clock Start | | | 80.88% | 66.15% | 71.15% | 73.61% | 67.61% | 70.00% | 70.00% | 75.34% | 81.48% | 68.66% | 65.06% | 68.42% | 71.43% | | | | |
| | Stroke - Thrombolysed <1 Hour | | | 57.14% | 71.43% | 81.82% | 40.00% | 33.33% | 71.43% | 62.50% | 60.00% | 77.78% | 75.00% | 50.00% | 37.50% | 55.56% | | | | |
| | Stroke - Directly Admitted to Stroke Unit <4 Hours | | | 66.67% | 68.75% | 72.92% | 67.14% | 55.71% | 58.18% | 49.35% | 64.29% | 72.86% | 50.00% | 50.65% | 62.16% | 58.00% | | | | |
| | MRSA | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | | | | |
| | E. Coli | | | 2 | 6 | 6 | 3 | 3 | 2 | 5 | 2 | 6 | 4 | 7 | 7 | 7 | | | | |
| | C. Difficile | | | 2 | 1 | 2 | 4 | 3 | 5 | 6 | 8 | 3 | 6 | 5 | 2 | 3 | | | | |
| | MSSA | | | 3 | 5 | 3 | 2 | 3 | 1 | 1 | 5 | 3 | 5 | 2 | 3 | 1 | | | | |
| | VTE | 95% | 95% | 96.59% | 96.34% | 96.97% | 97.02% | 96.84% | 96.72% | 96.67% | 96.65% | 96.15% | 95.99% | 96.43% | 96.24% | | | | | |

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North Bristol NHS Trust

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | National Performance | Rank | Quartile |
| Quality Caring & Experience | FFT A&E (Recommend) | | | 90.83% | 89.55% | 88.77% | 88.03% | 85.32% | 88.26% | 88.01% | 84.03% | 91.00% | 91.22% | 92.97% | 91.52% | 91.48% | | 84.02% | 25/132 | |
| | FFT A&E (Response Rate) | | 15.00% | 20.00% | 20.93% | 21.49% | 20.03% | 16.51% | 19.39% | 20.56% | 19.57% | 19.05% | 18.74% | 20.00% | 22.49% | 21.07% | | 20.93% | 15/134 | |
| | FFT Inpatients (Recommend) | | | 93.89% | 93.62% | 92.19% | 93.24% | 93.30% | 92.64% | 92.82% | 93.95% | 93.23% | 93.72% | 93.52% | 93.68% | 93.59% | | 95.80% | 113/159 | |
| | FFT Inpatients (Response Rate) | | 30.00% | 16.78% | 18.59% | 19.16% | 19.04% | 11.47% | 17.58% | 17.40% | 18.50% | 16.54% | 17.88% | 16.83% | 18.38% | 17.70% | | 24.76% | 131/168 | |
| | FFT Outpatients (Recommend) | | | 95.56% | 95.80% | 95.30% | 95.94% | 95.03% | 95.44% | 95.63% | 95.16% | 94.96% | 95.36% | 95.31% | 95.59% | 95.76% | | 93.66% | 82/192 | |
| | FFT Outpatients (Response Rate) | | 6.00% | 14.55% | 18.71% | 14.66% | 18.05% | 12.35% | 18.54% | 17.73% | 17.69% | 15.10% | 17.16% | 18.95% | 14.04% | 11.17% | | 7.68% | | |
| | FFT Maternity (Recommend) | | | 95.79% | 94.95% | 97.59% | 94.69% | 97.87% | 97.94% | 96.74% | 96.67% | 93.90% | 95.60% | 93.26% | 94.68% | 90.80% | | 96.39% | 43/71 | |
| | FFT Maternity (Response Rate) | | 15.00% | 19.27% | 21.43% | 18.32% | 25.80% | 22.38% | 20.17% | 21.05% | 18.11% | 17.19% | 20.92% | 18.39% | 18.80% | 21.75% | | 20.93% | 60/121 | |
| | PALS - Count of concerns | | | 44 | 65 | 35 | 26 | 76 | 82 | 93 | 126 | 118 | 81 | 119 | 104 | 90 | | | | |
| | Complaints - % Overall Response Compliance | | 90% | 54.00% | 49.00% | 70.00% | 76.00% | 63.00% | 33.00% | 71.00% | 89.00% | 91.00% | 92.00% | 87.00% | 90.00% | 81.00% | | | | |
| | Complaints - Overdue | | | 16 | 29 | 41 | 10 | 34 | 25 | 20 | 9 | 1 | 4 | 1 | 2 | 3 | | | | |
| | Complaints - Written complaints | | | 48 | 50 | 48 | 51 | 62 | 56 | 52 | 55 | 51 | 53 | 47 | 41 | 36 | | | | |
| Well Led | Agency Expenditure ('000s) | | | | | | | 1003 | 1136 | 1305 | 1179 | 1329 | 968 | 836 | 990 | 868 | | | | |
| | Month End Vacancy Factor | | | | | | | 10.06% | 10.12% | 10.79% | 11.55% | 11.58% | 9.39% | 8.75% | 8.77% | 9.21% | | | | |
| | Turnover (Rolling 12 Months) | | | | | | | 15.30% | 15.24% | 15.47% | 15.10% | 14.82% | 14.75% | 14.46% | 14.44% | 14.47% | | | | |
| | Sickness Absence (Rolling 12 month -In arrears) | | | | | | | 4.26% | 4.27% | 4.30% | 4.31% | 4.35% | 4.36% | 4.38% | 4.43% | | | | | |
| | Trust Mandatory Training Compliance | | | | | | | 88.34% | 89.77% | 90.00% | 88.30% | 90.01% | 88.95% | 88.89% | 88.80% | 88.97% | | | | |
| Finance | Deficit (£m) | | | -16603 | -18492 | -19937 | -21352 | -659 | -1458 | -3384 | -3259 | -4181 | -4452 | -4363 | -4161 | -3695 | | | | |
| | NHSI Trust Rating | | | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 3 | | | | |

# EXECUTIVE SUMMARY
# December 2019

## Urgent Care

For the fifth consecutive month the Trust has exceeded the England position for ED 4 hour wait performance (Type 1). Ranking in the second quartile for December, the Trust also continues to be ranked first among the 11 Adult Major Trauma Centres for 4 hour wait performance. However, December was a more challenging month operationally both within the Trust and across the system, with reduced ED hour wait performance overall and two reported 12 hour trolley breaches.

## Elective Care and Diagnostics

The numbers of patients on an RTT waiting list size is on plan for the second time since April. There were 14 patients waiting greater than 52 weeks for their treatment in December against a trajectory of 13. The majority of patients breaching are awaiting an Orthopaedic operation. Overall diagnostics performance was 12.56% in month, which is a further decline in performance due to ongoing capacity constraints and growth in demand. A bid for centrally held Elective Care funds has been made for additional CT and Endoscopy capacity. This should result in improved performance by year-end, but not full delivery of the recovery trajectory. There were no urgent operations cancelled for a subsequent time and no breaches of the 28 day re-booking target.

## Cancer wait time standards

The Trust achieved the 62 day waiting time trajectory in November, with Performance of 72.91%. Backlog clearance plans are in place with additional capacity sought for clearance through January and February 2020. Sustained delivery of the national wait time standard is on track to achieve the 85% target from the end of Quarter 1 of 2020/21. The recovery trajectory for the Two Week Wait standard was achieved in November, largely due to Skin performance improvement. An overall return to TWW standard is not expected until Quarter 2 of 2020/21, as we develop longer-term plans to close the demand and capacity gap.

## Quality

There were three overdue complaints at the end of December. In order to ensure compliance, weekly divisional meetings take place with a revised escalation process. The performance improvement for responding to complaints has continued into December. In December WHO safer surgery compliance again reached its highest level for the past 12 months at 99.90%.

## Workforce

Overall there has been a positive shift in workforce related indicators in December with a decrease in Agency expenditure and the Trust continues to achieve the 14.5% Turnover target. Vacancy factor increased in December to 9.2% and the Trust saw a small net loss of staff, particularly in registered nursing and midwifery however there is a strong pipeline for the remainder of the year which is anticipated to improve the vacancy position by March 2020.

## Finance

The Trust has a planned deficit of £4.9m for the year in line with the agreed control total with NHS Improvement (NHSI). At the end of December, the Trust reported a deficit of £3.7m which is £0.1m favourable to the planned deficit including Provider Sustainability Fund and Financial Recovery Fund. The Trust has a 2019/20 savings target of £25m of which £11.8m was achieved at the end of December. The Trust financial risk rating on the NHSI scale is 3 out of 4.

# RESPONSIVENESS
## SRO: Chief Operating Officer
## Overview

**Urgent Care**

The Trust failed the four hour performance trajectory of 86.15% in December with performance of 74.64% and reported two 12 hour trolley breaches in month, during a period of extreme system-wide pressure. Despite this, the Trust continues to perform well when compared with Type 1 performance nationally, reporting near the top of the second quartile and ranking 1st out of 11 Adult Major Trauma Centres and ranking 3rd out of 32 reported positions for 12-hour trolley breaches.

Bed occupancy averaged at 96.77%, however higher levels of variation in bed occupancy across the month and a lack of traction in delivering the system stranded action plan has led to significant pressure post Christmas. High levels of DToC patients (6.89% vs. 3.5% target) continue to be experienced and would have released 25 beds to the Trust had the national target been achieved. Social care delays are driving the largest proportion of stranded bed days.

**Planned Care**

**Referral to Treatment (RTT) -** The Trust has not achieved the RTT trajectory in month with performance of 82.43% against trajectory of 87.73%. The total RTT wait list size in month has achieved trajectory for the second time since April, reporting 28078 against a trajectory of 28640. The number of patients exceeding 52 week waits in December was 14 against a trajectory of 13; the majority of breaches (13) being in Trauma and Orthopaedics. It is predicted that the cancellations due to bed pressures experienced to date in January will impact on the number of patients waiting greater than 52 weeks over the next few months, as patients are rescheduled to accommodate the longest waiting patients, extending the wait time for other patients. Elective activity has been below plan in December (the elective plan is already at a reduced level in December to allow for winter pressures and the Christmas period). This is predominately as a result of cancellations prior to the day of operation (as opposed to same-day cancellations) and theatre staffing vacancies.

**Cancelled Operations -** In month, there were no urgent operations cancelled for a subsequent time and no breaches of the 28 day re-booking target.

**Diagnostic Waiting Times -** The Trust did not achieve the recovery trajectory for diagnostic performance in December 2019 with actual performance at 12.56% versus a trajectory of 5.55%. Ongoing underperformance in CT and Endoscopy with the addition of MRI and Non-obstetric Ultrasound in month has caused this deterioration. The MRI position is expected to improve in January, with Non-obstetric Ultrasound taking longer to recover due to a short-term capacity shortfall. A bid for Elective Care funds has been submitted to provide additional Endoscopy and CT activity prior to year-end. Even with additional funding the Trust is predicting under delivery of c.0.5% against the recovery trajectory.

**Cancer**

The Trust has achieved one of the seven Cancer Wait Times standards in November. There has however been an improvement in performance against every standard in month with the exception of TWW breast symptoms. Urology backlog clearance remains on track to clear the backlog by the end of Quarter 1 2020/21. Urology remains the only specialty with 104 day breaches. Since the introduction of the harm review process, no instances of physical harm have been identified.

**Areas of Concern**

The system continues to monitor the effectiveness of all actions being undertaken, with daily and weekly reviews. The main risks identified to the delivery of the Urgent Care Improvement Plan (UCIP) are as follows:

- UCIP Risk: Lack of community capacity and/or pathway delays fail to meet bed savings plans as per the bed model.
- UCIP Risk: Length of Stay reductions and bed occupancy targets in the bed model are not met leading to performance issues.

# QUALITY PATIENT SAFETY AND EFFECTIVENESS
# SRO: Medical Director and Director of Nursing & Quality
# Overview

## Improvements

**Maternity Services –** Induction of labour suite opened on the 06 January.

**WHO Checklist –** Compliance reached its highest level for the past 12 months for both Elective and Non-Elective.

## Areas of Concern

**MRSA –** One reported case of MRSA bacteraemia in December, occurring within ICU and the investigation has commenced. Year to date there has been three reported cases for the organisation.

# WELL LED
# SRO: Director of People and Transformation and Medical Director
# Overview

**Corporate Objective 4: Build effective teams empowered to lead**

**Continue to reduce reliance on agency and temporary staffing**

December agency spend decreased by £122k compared to November, however overall the Trust is overspent on pay year to date. Nursing and midwifery saw a £100k reduction in agency expenditure in December. Part of this reduction was due to a restriction on annual leave for two weeks in December leading to a reduction in demand for temporary staffing for this period.

**Vacancies**

The Trust vacancy factor increased in December to 9.2%, an increase of 37 WTE vacancies. This was predominantly driven by an increase in substantive funded posts (20 WTE) and a net loss of staff in December (7.2 WTE). Registered nursing and midwifery saw the greatest net loss of 21 WTE as Band 5 starters in December were low which is an anticipated seasonal trend. However the Trust has a strong pipeline of domestic and international starters for the last quarter of the year and the Trust anticipates a band 5 nurse vacancy position of 170 WTE in March 2020 from a starting vacancy position of 290 WTE in April 2019.

**Turnover**

The Trust turnover remains stable at 14.5%. 2020/21 will see continued focus to drive a further step change in improvement to turnover. Key delivery will be focussed through the NHSi Retention Improvement plan, BNSSG flexible working project and implementing the 2020 – 2025 People Strategy and Workforce Transformation Programme.

**Improving the sustainability and wellbeing of our workforce**

The rolling 12 month sickness remains static. The slight deterioration in the Trust sickness absence position has been predominantly driven by an increase in long term sickness. People and Digital Committee have asked for a deep dive to understand this in more detail. Work during 20/21 will focus on better understanding the underlying reason for these absences; and broadening the wellbeing programme to focus on improving general health and wellbeing: eg. through healthy eating, exercise and encouraging positive lifestyle choices.

# FINANCE
# SRO: Director of Finance
# Overview

At the end of December, the Trust reported a deficit of £3.7m which is £0.1m favourable to the planned deficit including Provider Sustainability Fund and Financial Recovery Fund.

A forecast has been prepared which shows the Trust meeting its control total. There are a number of risks to delivery of the year end control total, the greatest of which are the ability of the Trust to recover Elective activity in the remaining months of the year and the full delivery of savings schemes. The Trust has identified a number of mitigating actions to counter these risks in order for the Trusts control total to be met.

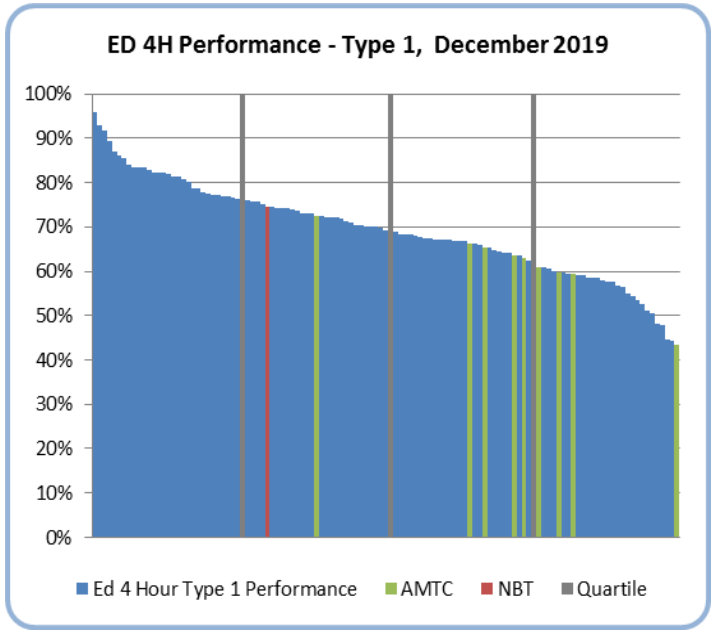
The Trust has repaid a net £2.0m year to date to the end of November which is inline with plan and brings the total Department of Health borrowing to £176.3m, which is lower than planned due to the higher cash balance held as a result of slippage of capital expenditure and higher receipts from commissioners.

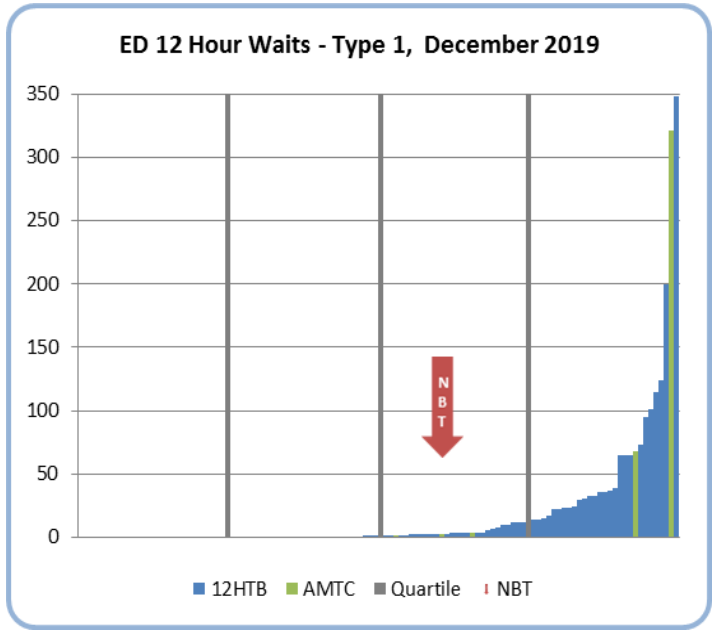
The Trust has a savings target of £25m for the year, of which £11.8m was achieved at the end of December against a plan of £17.1m.

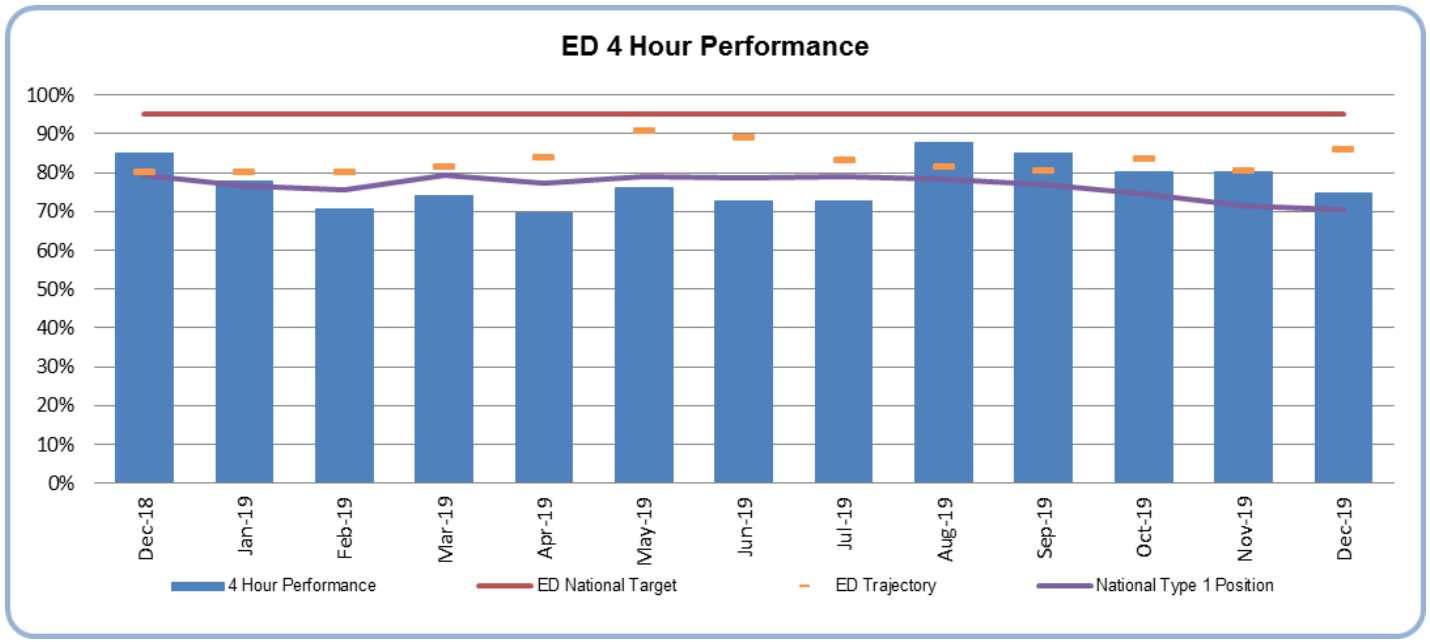
The Trust is rated 3 against the Finance Risk Rating tool by NHS Improvement (NHSI) which is driven by the high levels of historical debt and is inline with plan.

# RESPONSIVENESS

## Board Sponsor: Chief Operating Officer
## Evelyn Barker



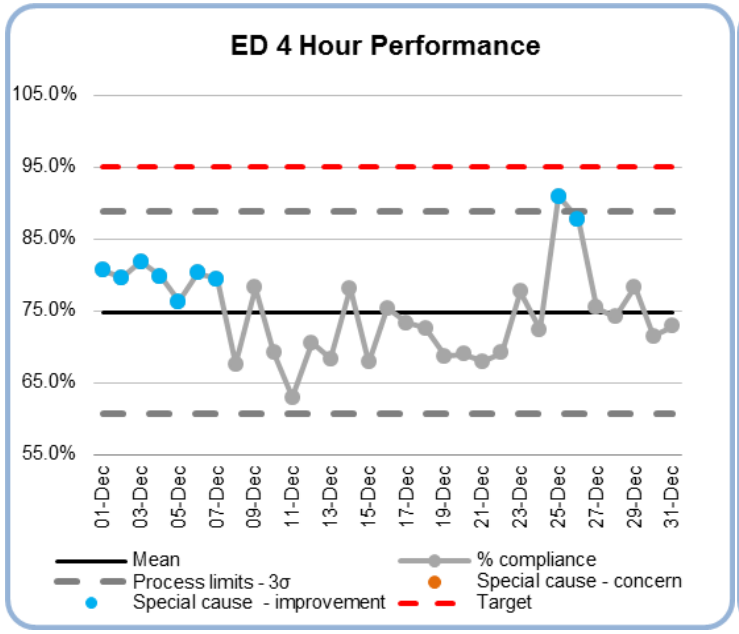



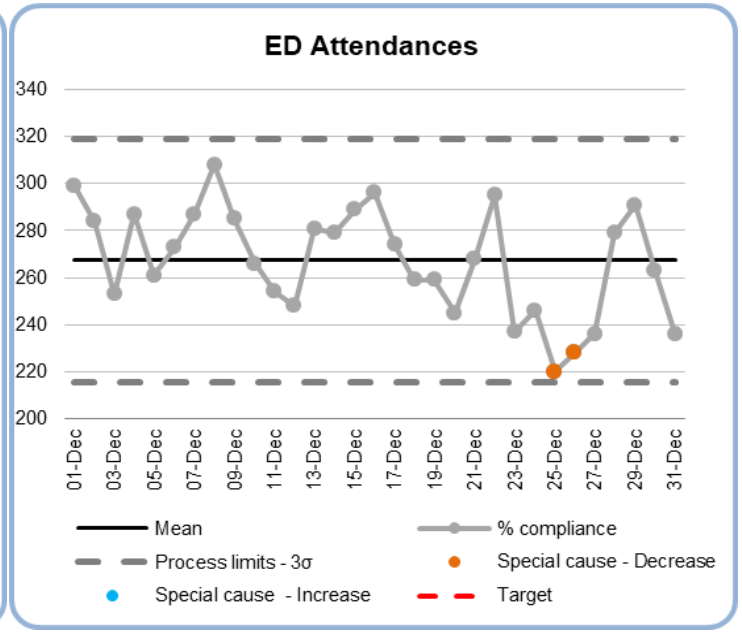

**Urgent Care**

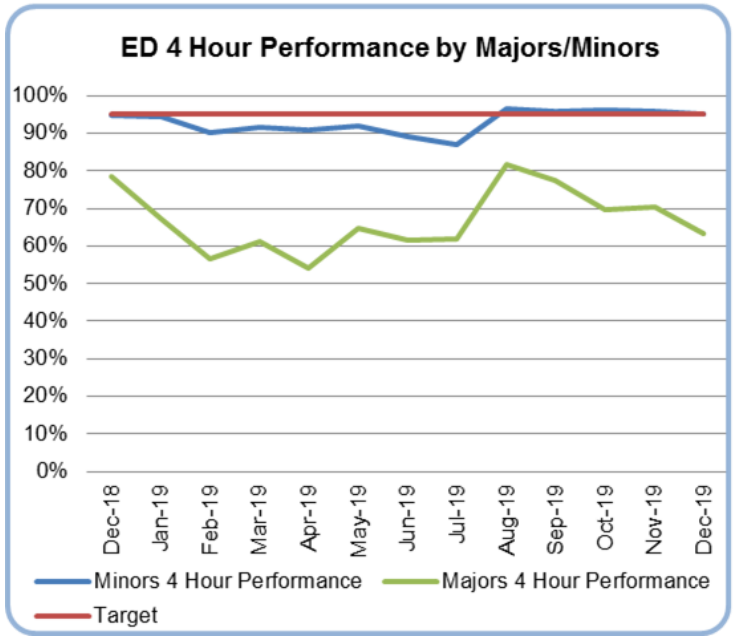
The Trust failed the four hour performance trajectory of 86.15% with performance of 74.64% and reported two 12 hour trolley breaches in month, during a period of extreme system-wide pressure.

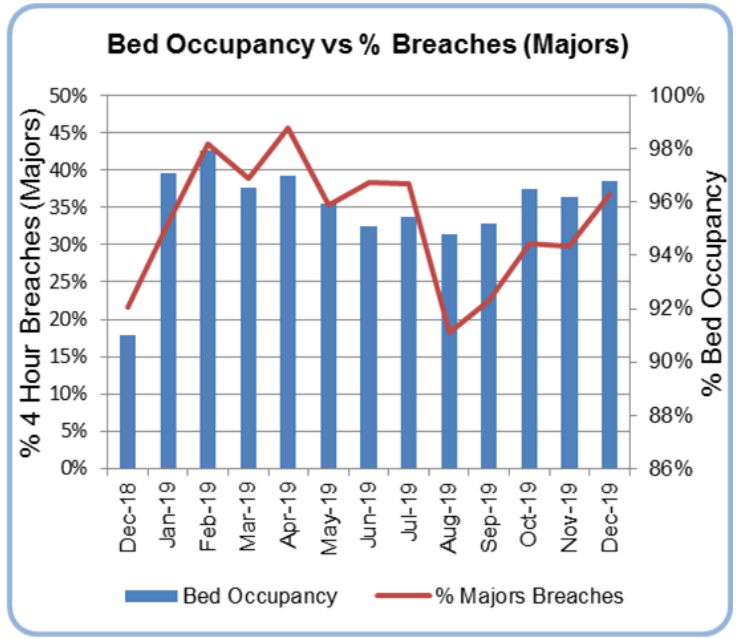
At 8285, there were 5.51% more attendances than SLA.
Non-elective admissions were down against plan for long-stay admissions (-7.44%), but were up against plan for short-stay admissions (17.78%), which follows the trend of increased short-stay versus long-stay activity in 2019/20 year to date. This profile of admissions continues to adversely impact income, but reflects the national direction of travel to introduce more same-day emergency care.

ED performance for the NBT Footprint stands at 81.48% and the total STP performance was 80.64% for December.



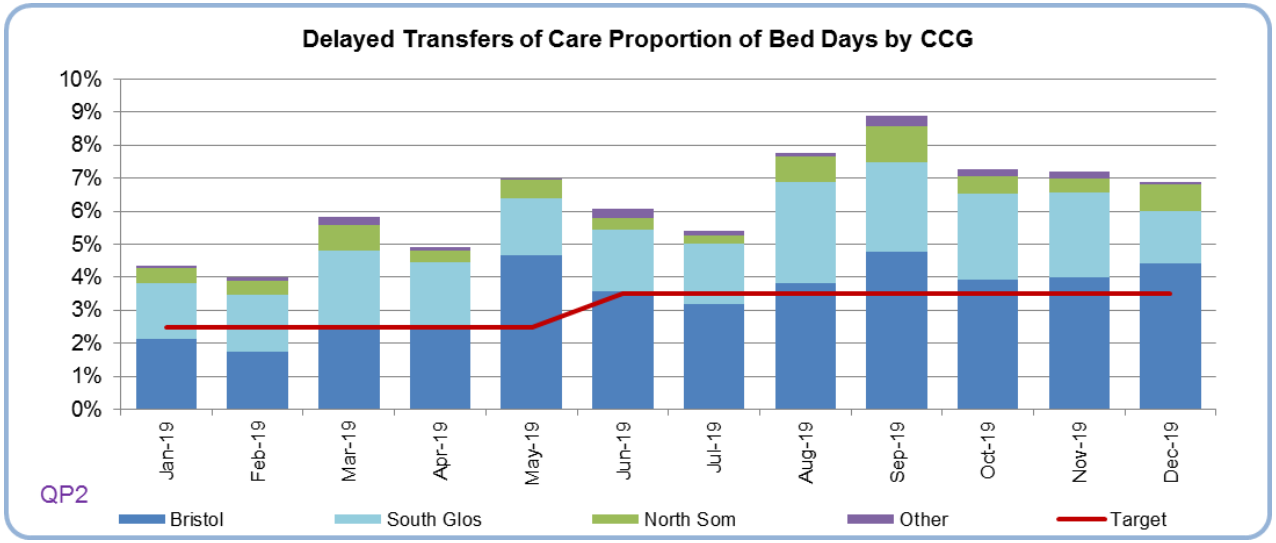

## 4 Hour Performance

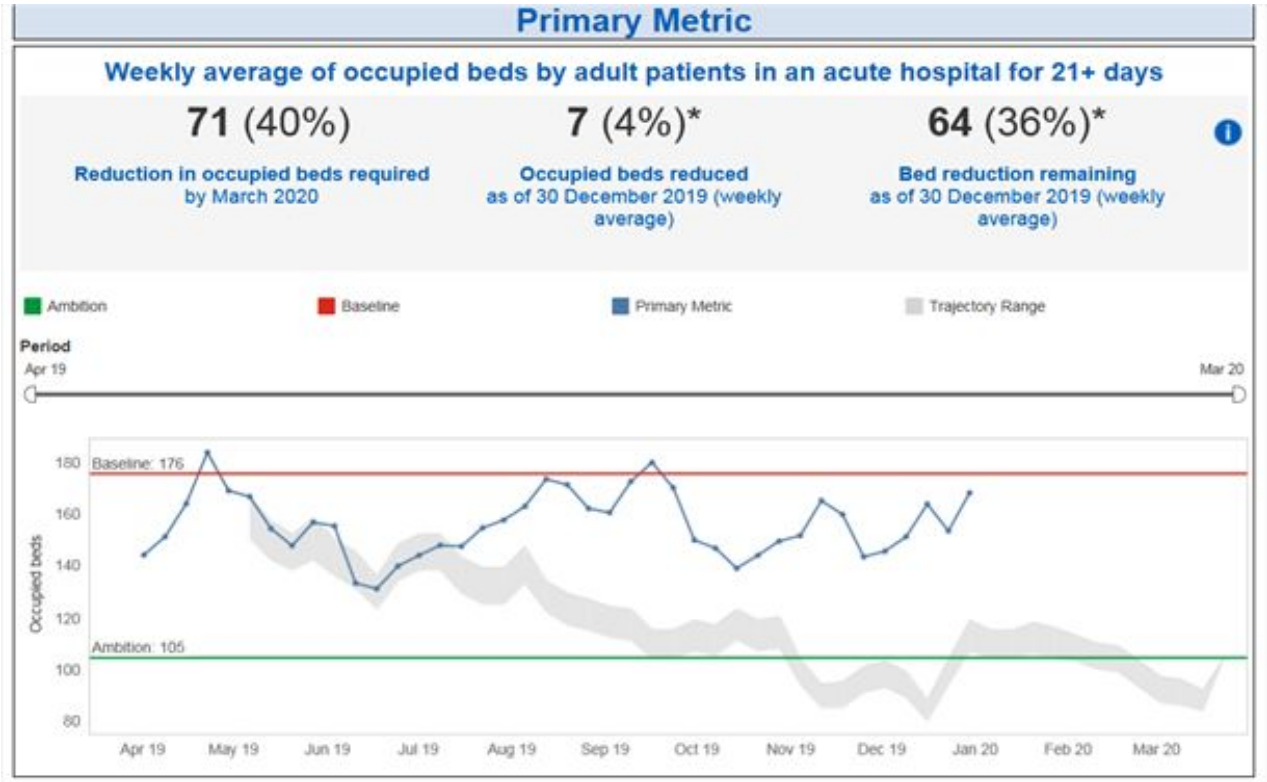
Average ambulance arrivals, at 100 per day, were the highest experienced across the last 22 months.

Of the breaches within ED in December, 56.88% were a result of waits for a bed whilst 28.08% were a result of ED delays.

Bed occupancy experienced greater variation in December, varying between 89.61% and 100.81% in month. Average LOS has been consistent with planned levels used to populate the Trust bed model. However, surge in attendances and admissions and continued delayed transfers of care out of the hospital (as described in the DToC and Stranded Patient section of this report), which impacts on timely bed availability and 4hr performance.

Internal actions to drive the 4 hour recovery are overseen by the Urgent Care Improvement Steering Group. Key work streams include: increasing the proportion of same day emergency care across all divisions; criteria led discharge supported by 'Perform'; implementation of primary care streaming in ED and length of stay reduction plans.




## DToCs and Stranded Patients

The DToC rate for the month of December was 6.89% of occupied bed days. If the System were at national target levels of 3.5%, this would have released 25 beds to the Trust.

The Trust's stranded patients (those with a LOS over 21 days) has continued to increase through Quarter 3 and the number of complex referrals for support from all providers was at its highest level all year.

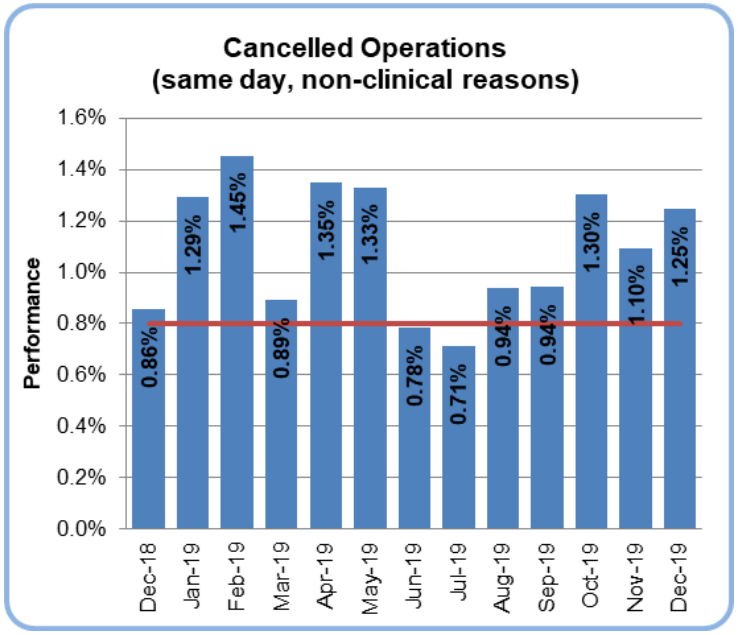
The top drivers of delayed discharges were:

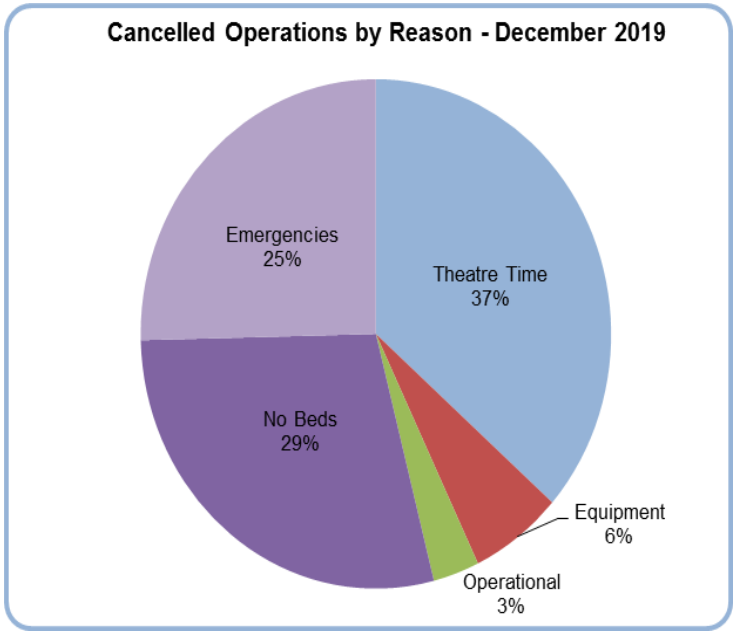
- Waits for Pathway 1 and 2 with a total of 677 DToC bed days;
- Waits for placement across all categories were reported with total bed days of 432 DToC bed days; and
- Waits for Social Work allocation, which were particularly noted in the Bristol team, with 375 DToC bed days linked to this single code.

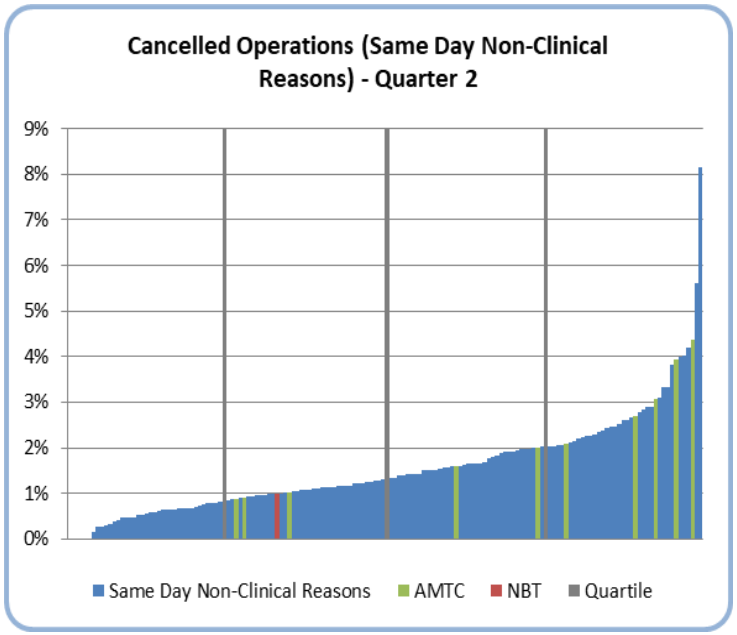
Additional non-recurrent winter funding from NHSE/I will impact in Quarter 4 to combat the main drivers of delayed bed days including:

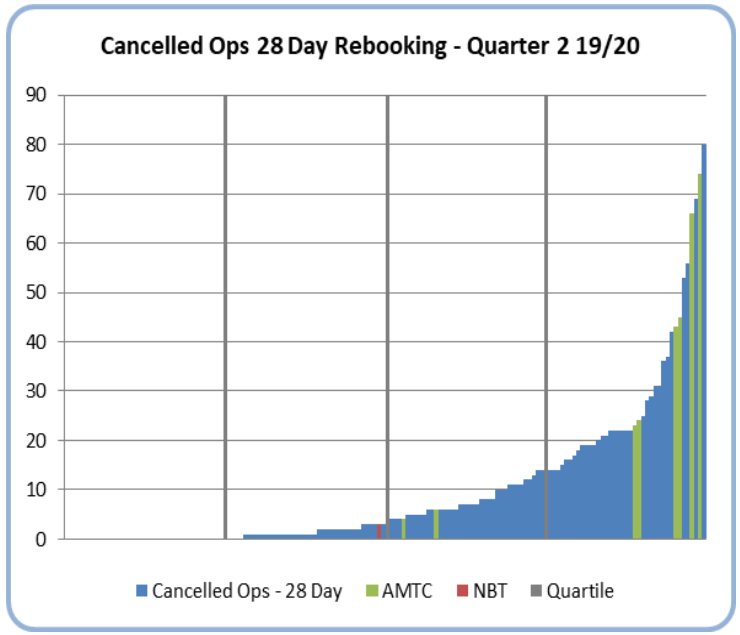
- Further reablement capacity to increase P1 slots across Bristol and South Gloucestershire;
- Further P3 bed capacity;
- Recruitment campaigns focused on the Domiciliary Care Market, to increase care provision; and
- Financial incentives for weekend care home discharges.

The additional funding is insufficient to recover the stranded trajectory or return the DTOC level to the 3.5% standard.



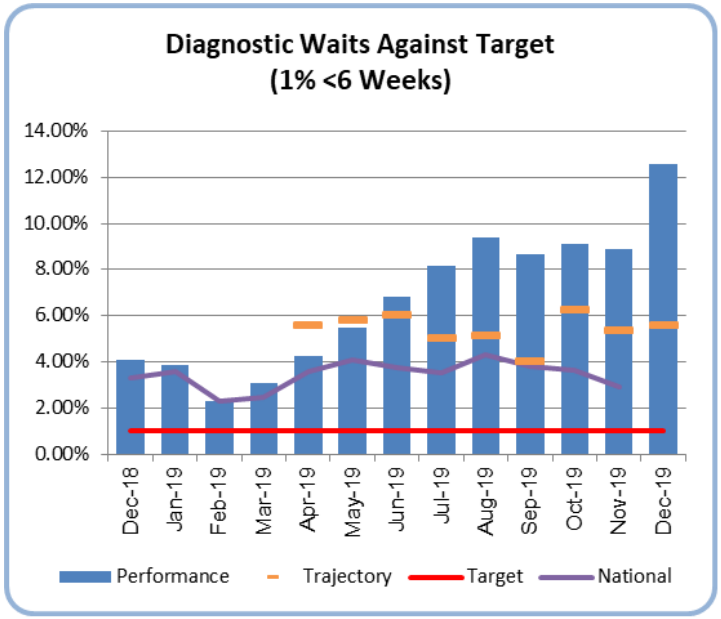



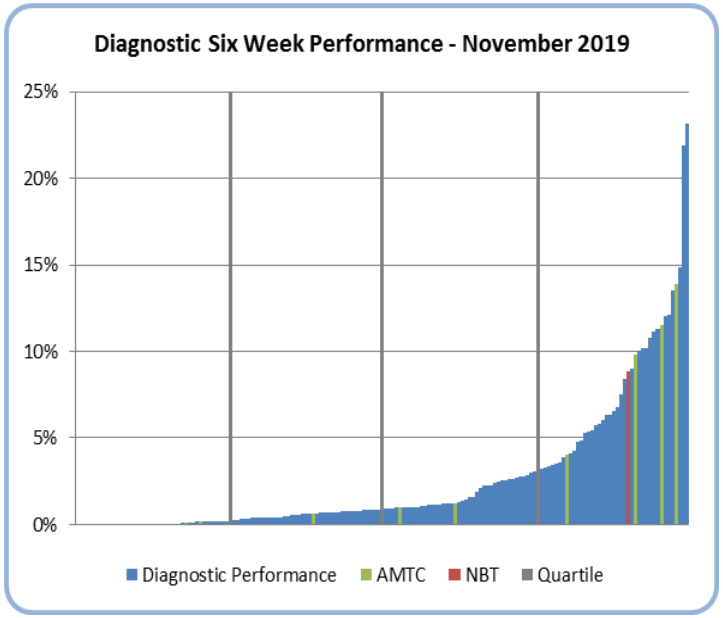

## Cancellations

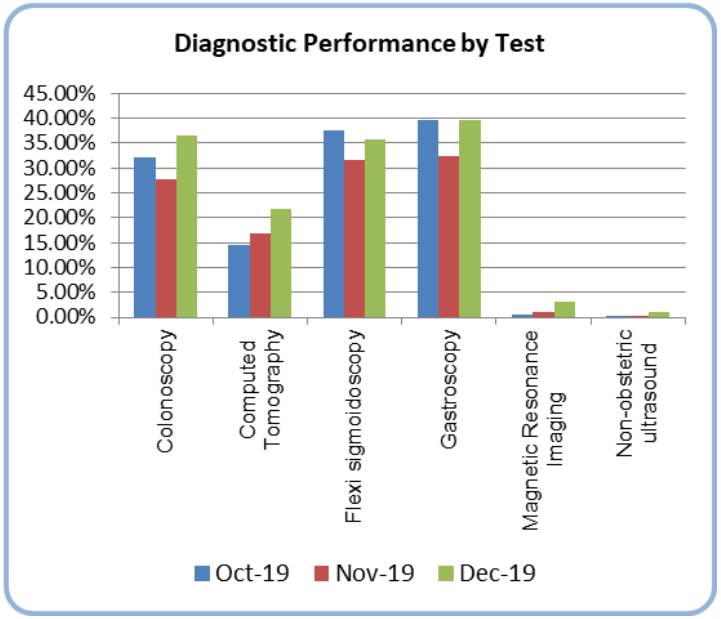
The proportion of cancellations due to lack of beds in December is not significantly different compared with the average over the last 13 months. This is reflective of the plans to reduce elective activity across the winter months; reducing the requirement for beds. Cancellations due to Emergencies were above average in December at 25% versus 18%.

For the seventh consecutive month there were no urgent operations cancelled for a second time.

There were no operations that could not be rebooked within 28 days of cancellation in December 2019. This position is expected to deteriorate in January 2020 due to increased operational bed pressures.




| Test Type | Total Wait List | Patients waiting >6-weeks | %Performance Nov-19 | %Performance Dec-19 |
|---|---|---|---|---|
| Computed Tomography | 2958 | 644 | 16.75% | 21.77% |
| Gastroscopy | 701 | 278 | 32.35% | 39.66% |
| Colonoscopy | 656 | 240 | 27.76% | 36.59% |
| Flexi sigmoidoscopy | 354 | 127 | 31.72% | 35.88% |
| MRI | 1951 | 61 | 0.97% | 3.13% |
| Non-Obstetric Ultrasound | 3415 | 35 | 0.26% | 1.02% |

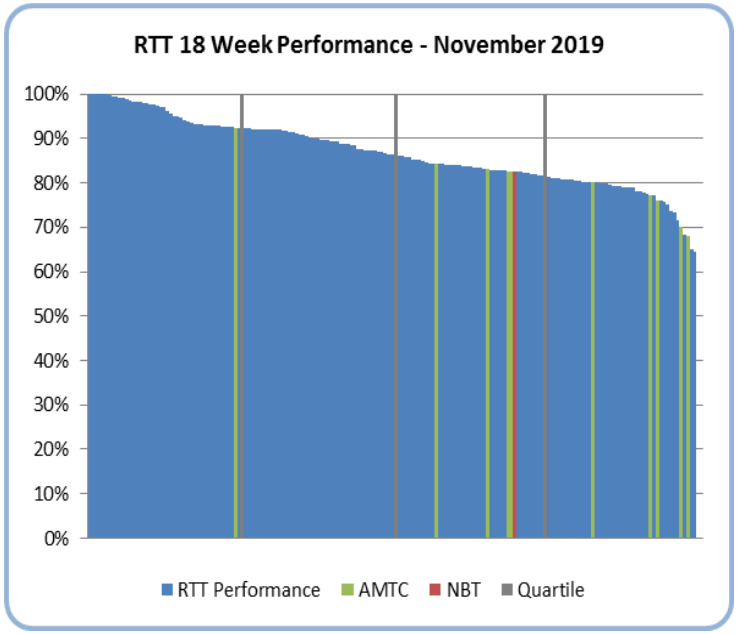
## Diagnostic Waiting Times

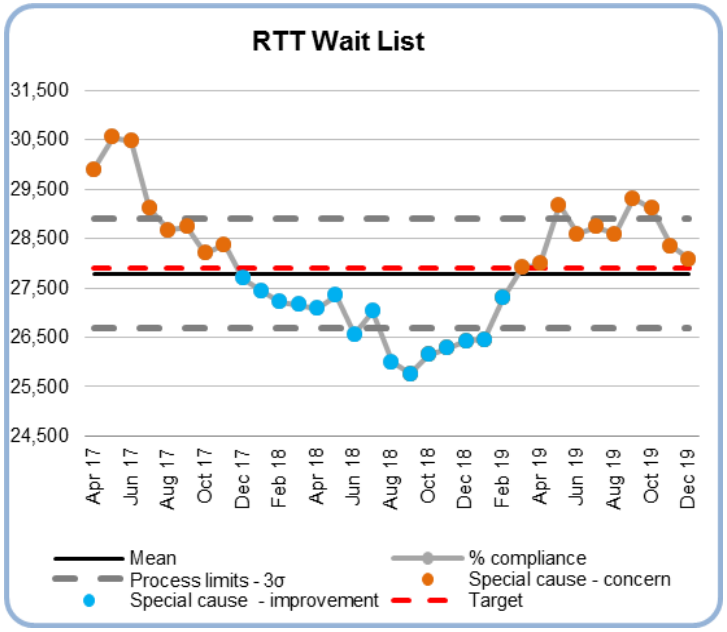
The Trust did not achieve the recovery trajectory for diagnostic performance in December 2019 with actual performance at 12.56% versus a trajectory of 5.55%.

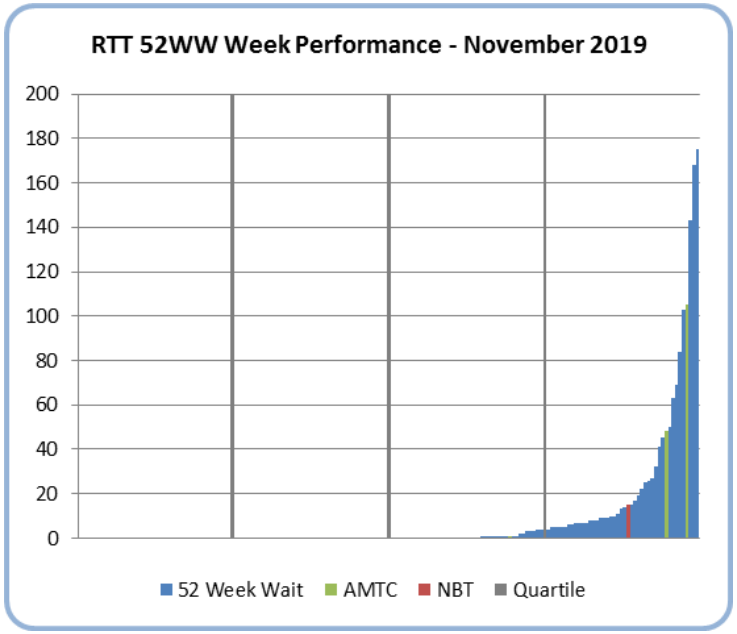
The same four test types have reported in month underperformance (Colonoscopy; CT; Flexi-Sigmoidoscopy and Gastroscopy) with the addition in December 2019 of MRI and Non-obstetric Ultrasound. There were 1386 patients in total waiting beyond 6 weeks for their test of which 147 were waiting greater than 13 weeks. A harm review is undertaken for patients waiting greater than 13 weeks for their test to ensure there has been no harm as a result of the extended wait.

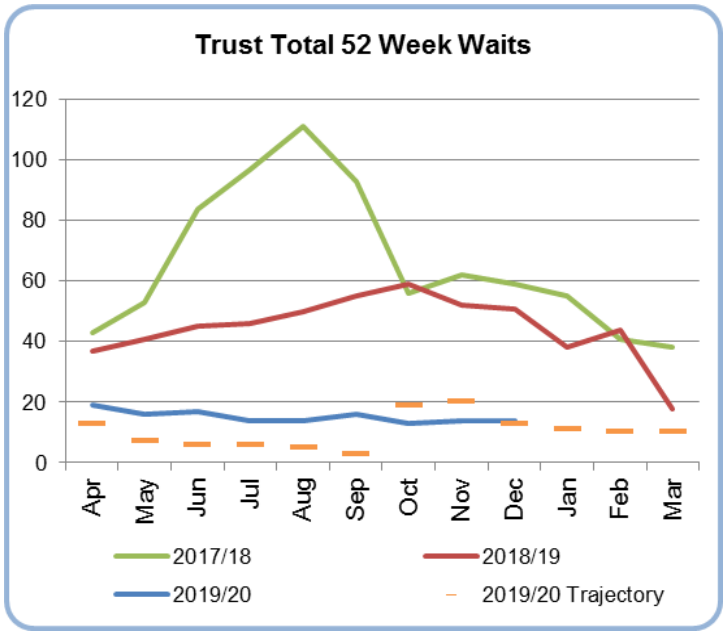
Non-obstetric Ultrasound performance remains at risk in January 2020 due to a short-term capacity shortfall in Thyroid scanning, but MRI is expected to return to standard.

A bid for Elective Care funds to support delivery of the national diagnostics target has been made for additional CT and Endoscopy capacity. Due to the further deterioration in CT performance, as a result of further capacity constraints (including delayed outsourcing ) and growth in demand, even with additional funds the trust is not predicting to deliver its recovery trajectory at year-end by c. 0.5%.



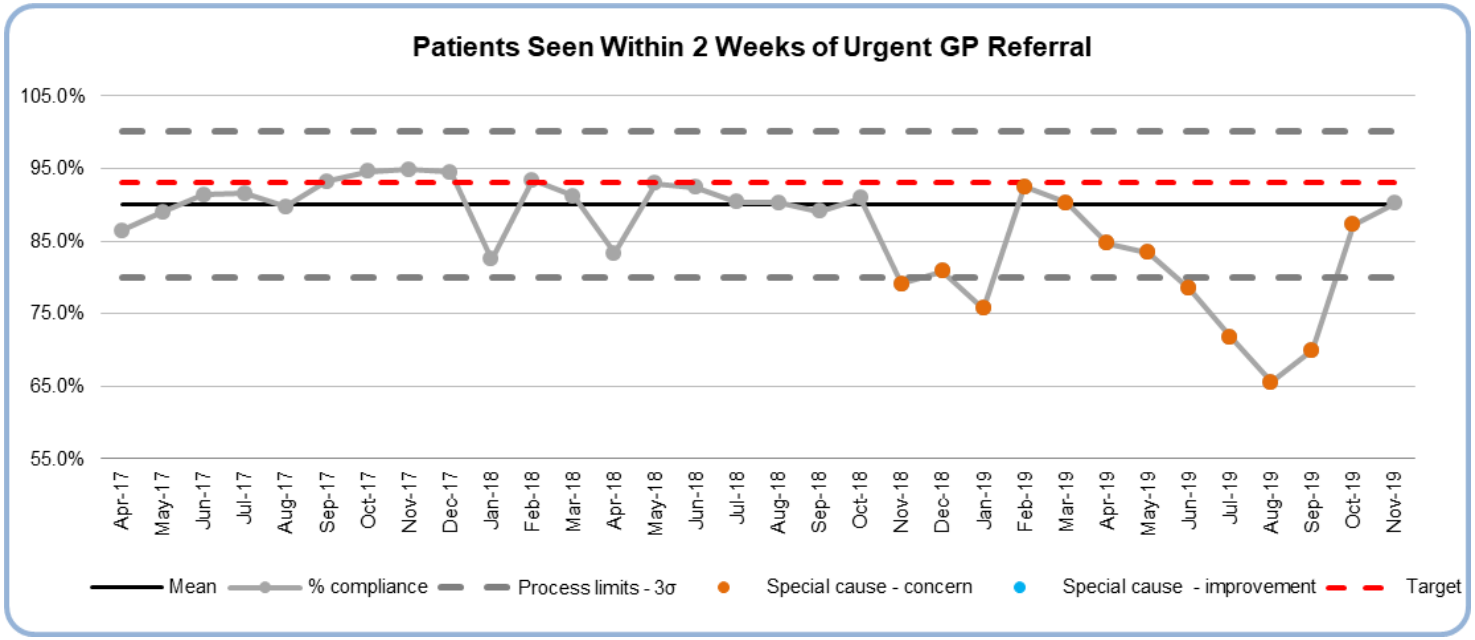



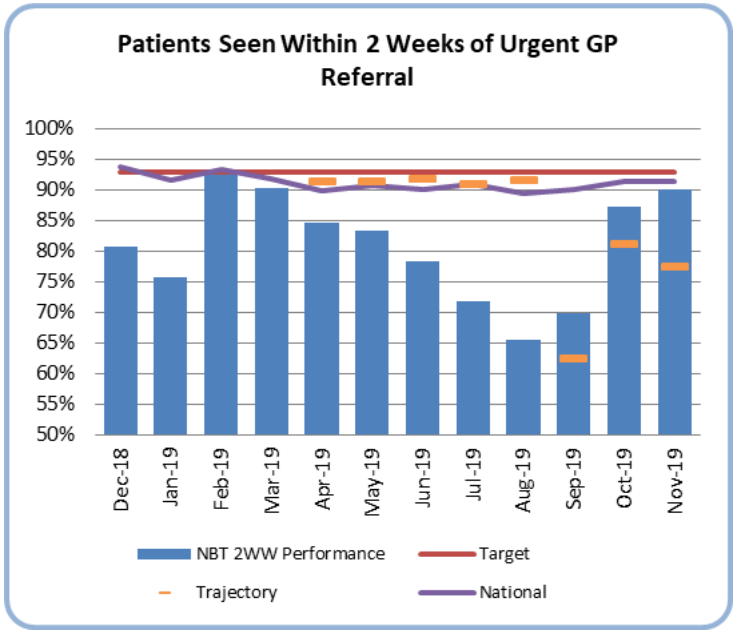



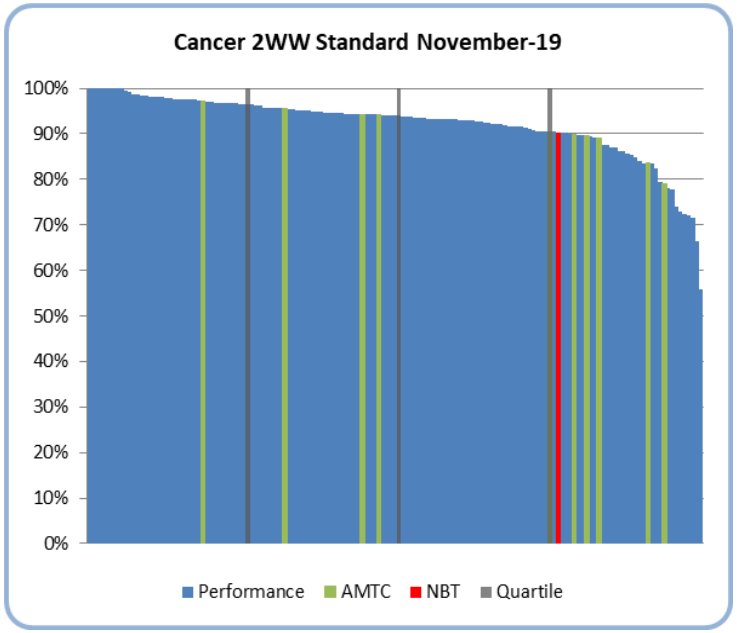

**Referral to Treatment (RTT)**
The Trust has not achieved the RTT trajectory in month with performance of 82.43% against trajectory of 87.73%.

The RTT wait list size reduced further in December, reporting 28078, achieving trajectory of 28640. The Trust, however, has an increasing number of patients experiencing issues (ASIs) when trying to book their appointment eRS. This is following a period of improvement when ASIs were reduced to 716 at the end of September. There are 1240 patients waiting on an ASI list as at 30 December 2019. Should all these patients be booked then the Trust wait list would increase by c.4% and performance would also increase by c.8%, as the majority of these patients have been waiting less than 18 weeks for their treatment. There are also a number of patients awaiting an appointment via a Referral Assessment Service (RAS). Neurology has the highest number of ASIs, which will be reduced by year-end following appointment of a Locum Consultant.

The Trust has reported 14 patients waiting more than 52 weeks from referral to treatment in December against a trajectory of 13. There were 13 patients under Trauma and Orthopaedics and one in Urology. Remedial actions to reduce the number of breaches continue to be delivered.



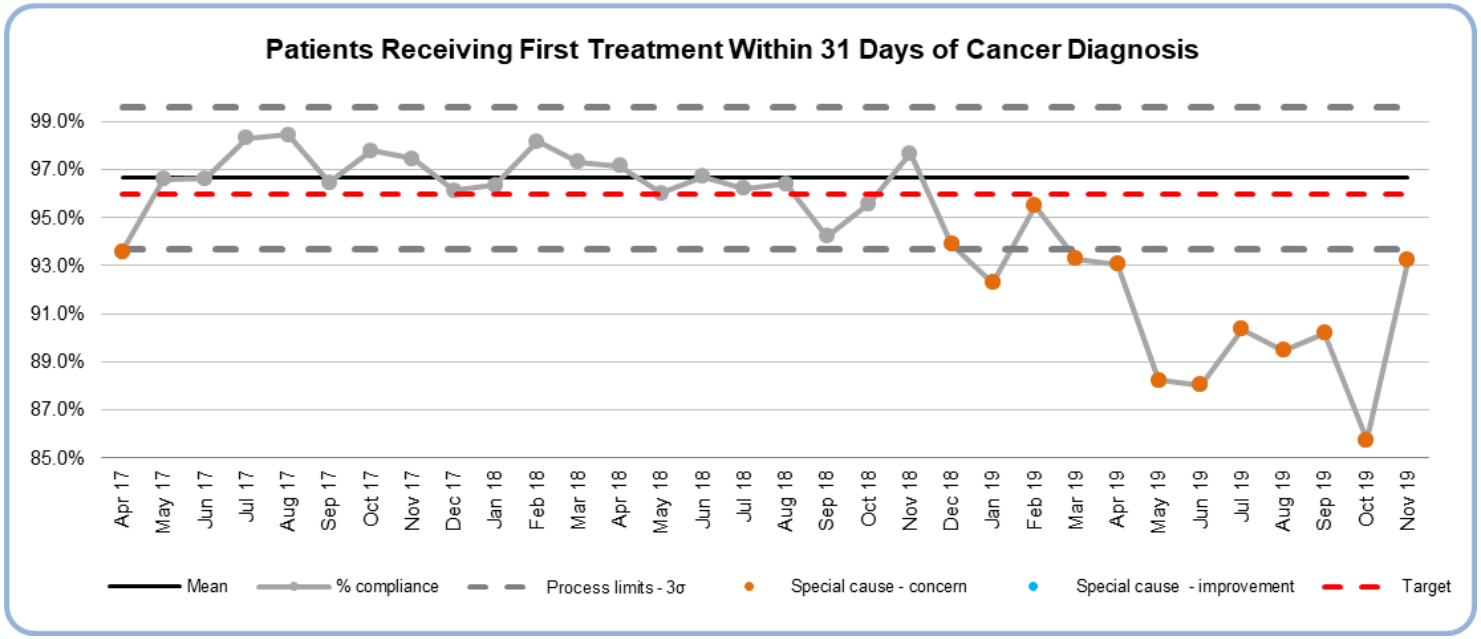

## Cancer

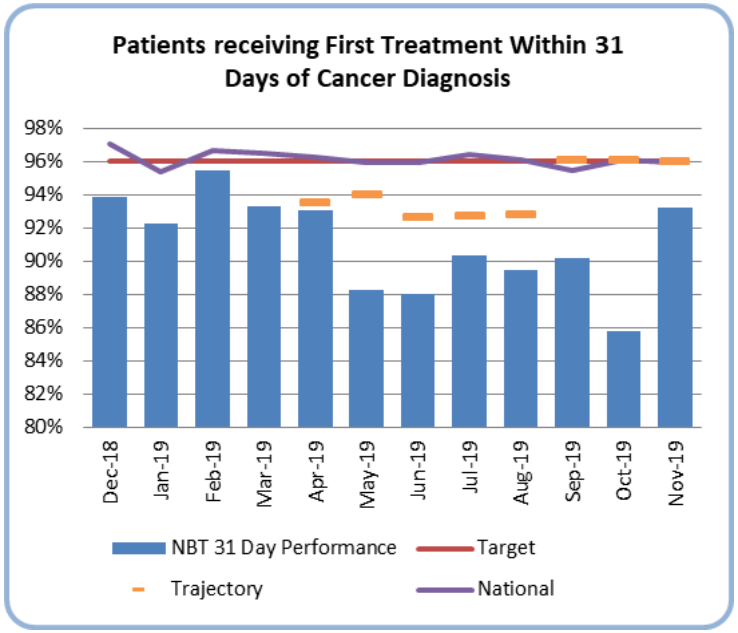
The nationally reported cancer position for November 2019 shows the Trust achieved one of the seven cancer waiting times standards, with improvement across all standards apart from TWW breast symptoms.

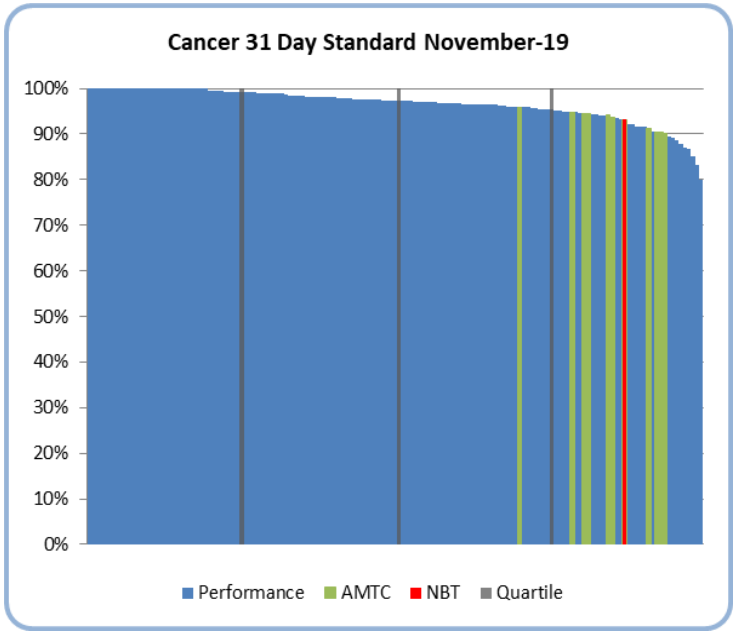
The Trust achieved the recovery trajectory for the TWW standard in November, largely attributable to an improvement in Skin TWW performance.

Lower and Upper GI TWW continues to show poor performance due to Endoscopy capacity and this is likely to continue until end of Quarter 1 of 2020/21. The commencement of the sub-contract with Prime Endoscopy has been delayed until February. Once delivery has commenced this activity will support further improvement against the TWW standard.

There was a National Awareness Campaign for Breast Cancer in October causing an increase in referrals to the Breast symptomatic service in November. The Trust was unable to secure sufficient capacity to cope with the influx of referrals as a result of the campaign. The increased demand will continue to adversely impact performance into January.



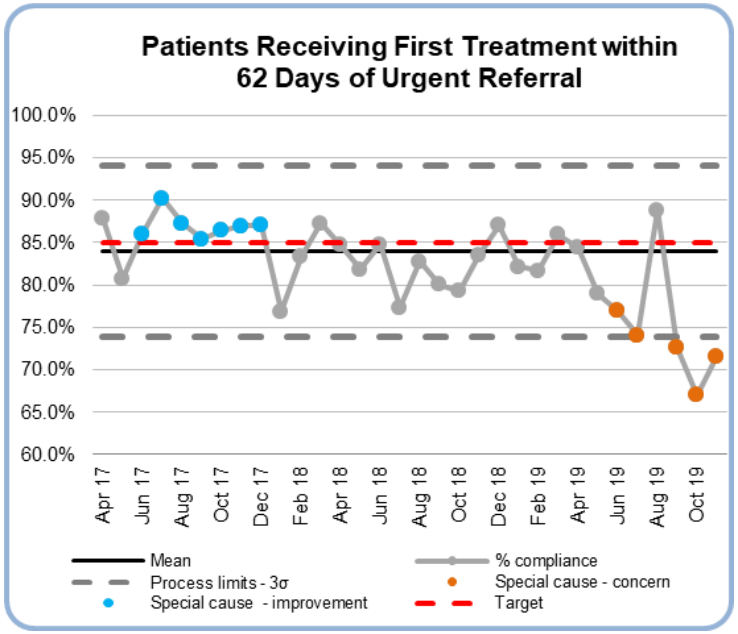



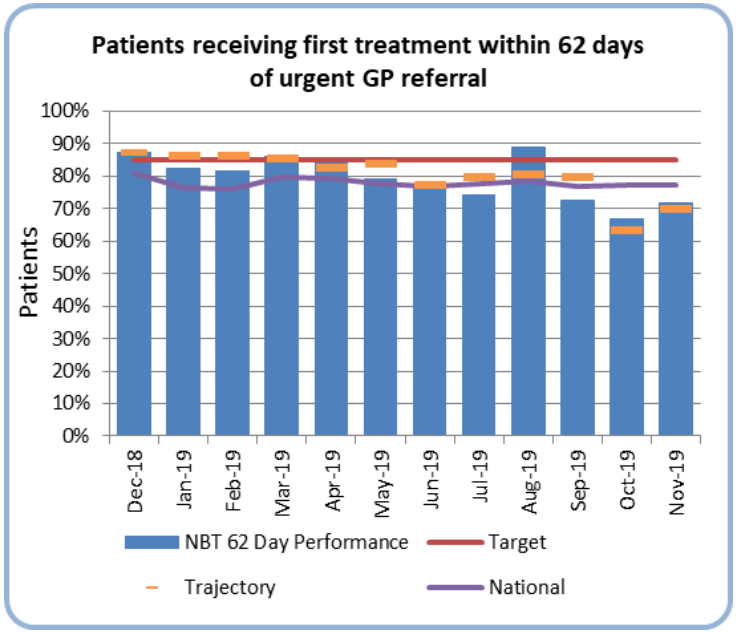



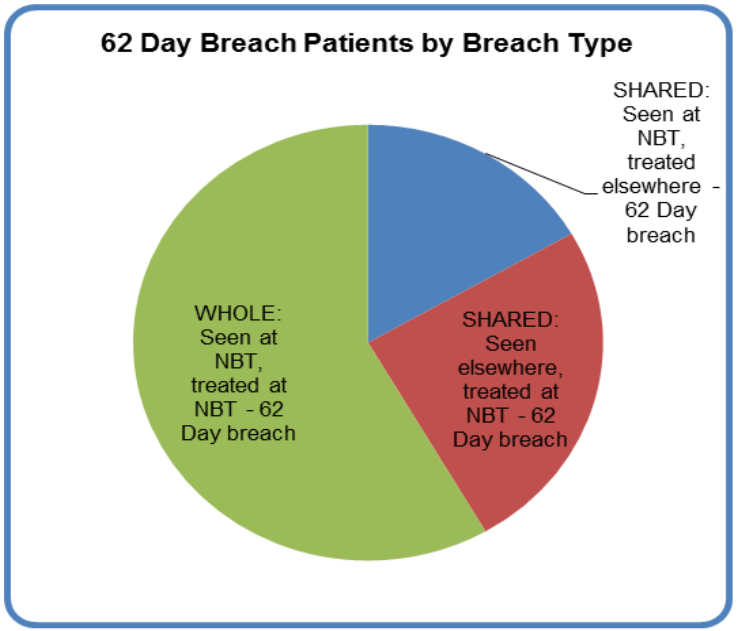

The Trust did not meet the 31 day first treatment trajectory in November. The majority of breaches were in Urology and related to lack of robotic capacity.

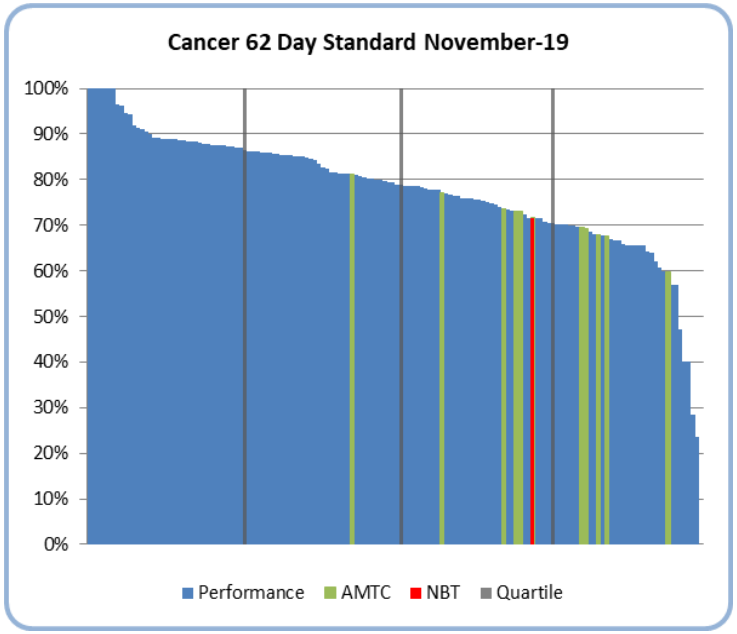
The Trust failed the 31 day subsequent treatment trajectory in November for patients requiring surgery. Breaches were the result of ongoing lack of surgical capacity within Skin and Urology.

There were 15 over 104 day breaches in November (all within Urology); 13 required a harm review within the Trust, one was treated elsewhere and will be subject to their internal process of harm review. One breach was active monitoring. Since the harm review process for patients waiting over 104 days was introduced in 2019, no instances of physical harm have been found.




The Trust achieved the 62 Day trajectory in November. Urology's backlog clearance plans are ongoing, although they have experienced difficulties with patient choosing to wait longer for treatment going into December. Additional capacity has been identified in January and February to support ongoing clearance plans.

In November, 42 patients breached the 62 day standard, 43% were due to late inter-provider transfers. Hospital and system delays continue to be the main cause of breaches in 62 day compliance.

As part of performance improvements the Trust has been monitoring its internal performance against the 62 day standard. The Trust treated 72.91% of all patients who were initially referred to and treated at NBT within the national standard.

NB: The breach types and breach **reasons** come from the internal reporting system and therefore, may not exactly match the overall numbers reported nationally.

NHS North Bristol NHS Trust

# Safety and Effectiveness

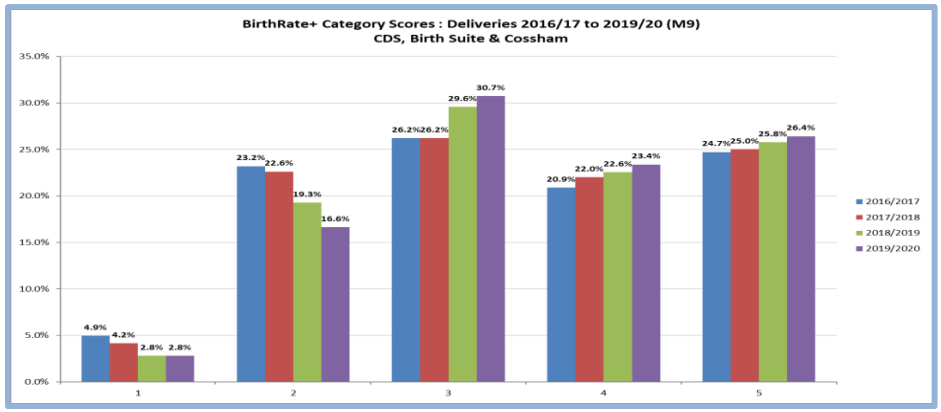
## Board Sponsors: Medical Director and Director of Nursing and Quality
## Chris Burton and Helen Blanchard

| Birth | | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Births | | 478 | 458 | 448 | 439 | 490 | 454 | 524 | 481 | 455 | 497 | 505 | 414 |
| Midwife to Birth Ratio | | 01:30 | 01:30 | 01:28 | 01:27 | 01:30 | 01:28 | 01:32 | 01:29 | 01:28 | 01:28 | 01:29 | 01:24 |
| Normal Birth Rate | | 56.0% | 51.1% | 55.7% | 53.7% | 56.3% | 56.1% | 53.8% | 53.0% | 53.9% | 53.2% | 52.4% | 53.2% |
| Caesarean Birth Rate | | 32.1% | 37.9% | 32.0% | 35.0% | 30.8% | 30.4% | 31.6% | 34.0% | 32.3% | 32.8% | 35.3% | 33.9% |
| Emergency Caesarean Birth Rate | | 18.0% | 23.0% | 17.7% | 22.4% | 19.3% | 21.2% | 16.0% | 19.9% | 18.0% | 16.2% | 16.1% | 20.2% |
| Induction of Labour Rate | | 34.0% | 37.7% | 38.3% | 41.5% | 36.1% | 43.0% | 36.5% | 38.2% | 36.5% | 38.5% | 35.3% | 40.2% |
| Total Births in Midwife Led Environment | | 14.9% | 12.0% | 14.5% | 15.4% | 17.9% | 14.1% | 13.4% | 13.6% | 13.1% | 8.9% | 14.5% | 15.9% |
| Birth Location | Cossham BC | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.2% | 0.0% | 0.0% | 1.2% | 2.2% |
| | Mendip BC | 12.6% | 10.7% | 13.4% | 12.8% | 16.6% | 12.8% | 12.4% | 12.6% | 11.8% | 7.9% | 12.5% | 12.7% |
| | Home | 2.3% | 1.3% | 1.1% | 2.5% | 1.2% | 1.3% | 1.0% | 0.8% | 1.3% | 1.0% | 0.8% | 1.0% |
| | CDS | 83.7% | 86.7% | 83.3% | 84.2% | 80.3% | 83.6% | 84.1% | 85.1% | 86.0% | 89.3% | 84.1% | 82.2% |
| One to One Care In Labour | | 97.4% | 97.7% | 96.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 97.7% |
| Stillbirth | Actual | 2 | 3 | 5 | 2 | 1 | 2 | 1 | 2 | 3 | 4 | 1 | 3 |
| | Rate | 0.41% | 0.60% | 1.10% | 0.45% | 0.20% | 0.44% | 0.19% | 0.41% | 0.66% | 0.80% | 0.20% | 0.72% |

The generic case mix shows the acuity of women before labour – The table below shows that women with the highest complexity of pregnancy and labour, categories iii, iv and v. make up for 89.4% of women being in these categories by the time they are in labour,

| **CASEMIX** | Cat I | Cat II | Cat III | Cat IV | Cat V |
|---|---|---|---|---|---|
| Delivery Suite % Case mix | 1.4 | 9.2 | 23.3 | 27.6 | 38.5 |
| *Generic % Case mix (before labour)* | *5.9* | *14.8* | *20.6* | *24.5* | *34.2* |

This is further shown in the increasing acuity by year.




## Recruitment

- The Birth rate plus report has been received and analysed by senior midwifery team. The information is being used to inform staffing requirements for 20/21.
- Recruitment of a Senior midwife is in progress to support implementation of Saving Babies Lives version 2 to meet the improvements in CTG interpretation and training across the service.

## Midwifery update

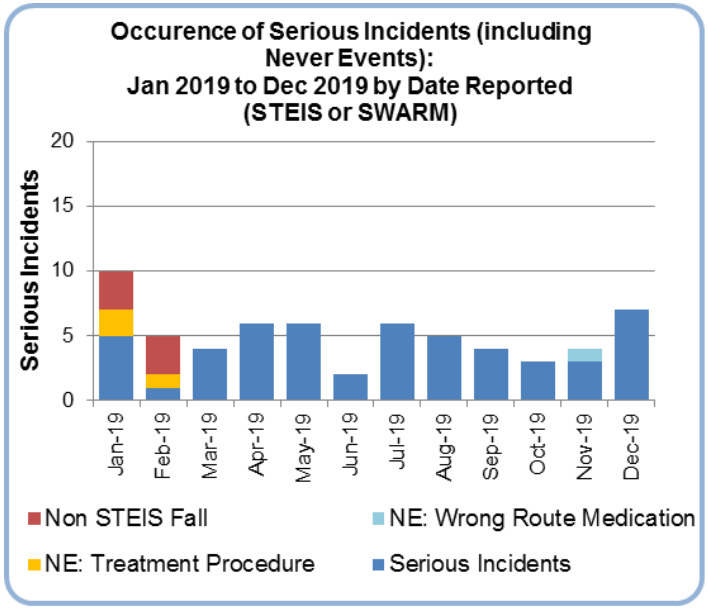
- The Continuity of Carer model is being developed as part of Better Births (National Maternity Transformation, supported by midwives at Cossham Birth Centre and in the home birth team. A Midwife is now always located at Cossham Birth Centre as part of the plans to improve bookings and births.
- An audit is in progress of Babies Born before Arrival during the year and postnatal readmissions to assess the potential benefit of community midwives being on call.
- Induction of labour suite opened on the 6th January 2020. An audit of outcomes and women's experiences is in progress.

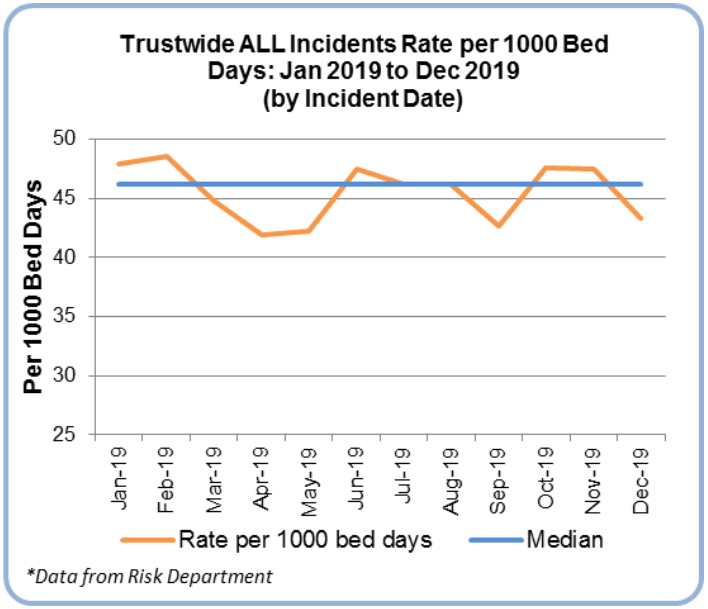
## Areas of concern

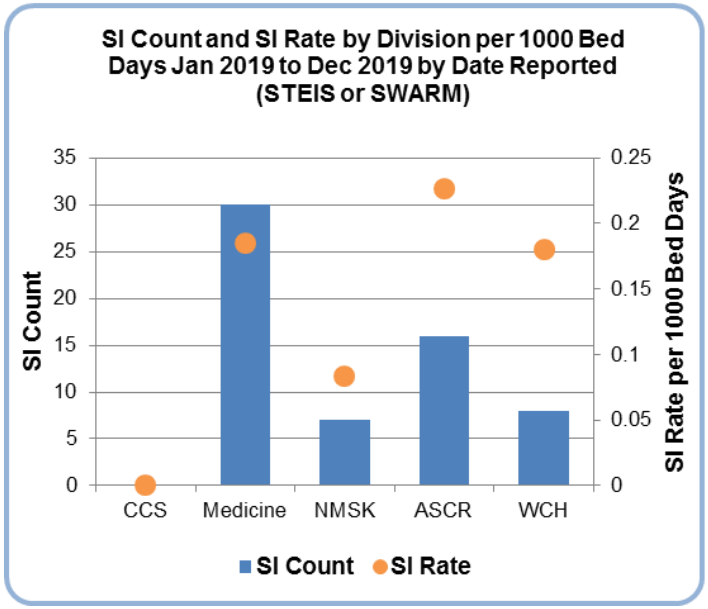
- Overall Caesarean Section rates continue to increase as a consequence of the of the guidelines for induction of labour.

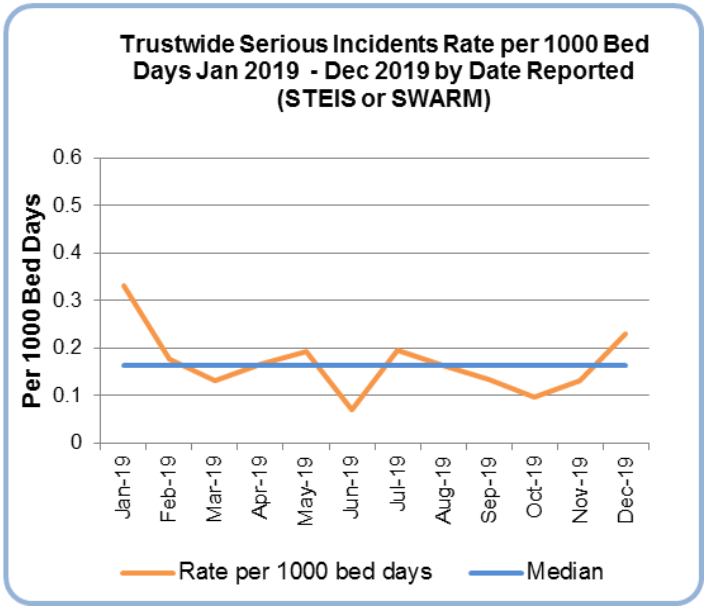
# Quality & Patient Safety Additional Safety Measures

**Board Sponsor: Director of Nursing**




**Serious Incidents (SI)**
Seven serious incidents were reported in December 2019:

- 4 x Patient Falls
- 2 x Tissue Viability
- 1 x Maternity & Obstetrics

**Never Events**
There were no new Never Events reported in December 2019.

The SIRI investigation regarding the Never Event in November is ongoing and due for completion in February 2020.

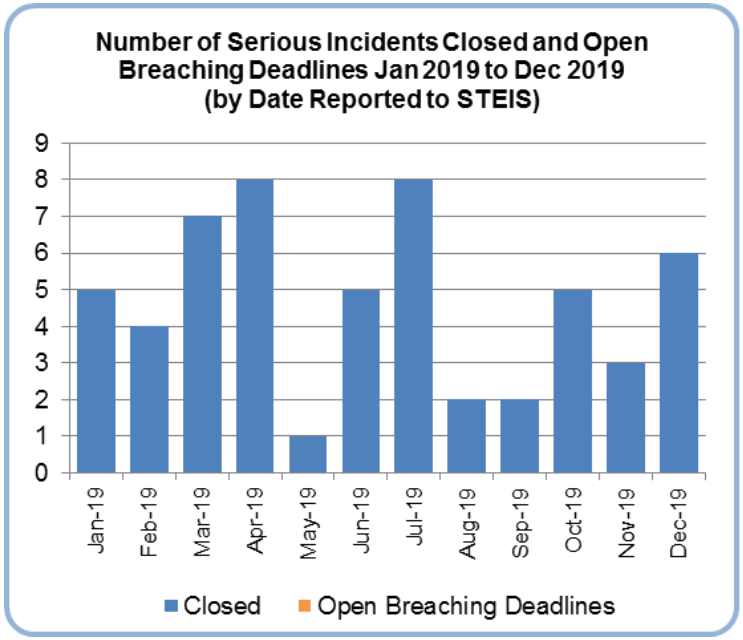
**SI & Incident Reporting Rates**
Incident reporting has decreased in December to 43.32 per 1000 bed days. While NBT's rate of reporting patient safety incidents remains within national parameters, it is noted that we are in the lower quartile of similar NHS Trusts.

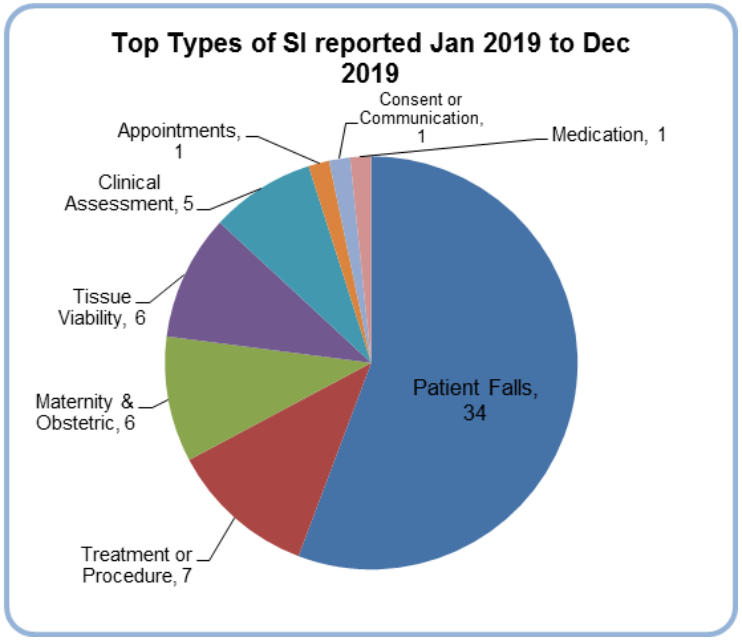
The Patient Safety Incident Improvement Project is focusing on improving our rates of reporting to facilitate learning.

**Divisions:**
SI Rate by 1000 Bed Days
ASCR – 0.23
Med – 0.19
WCH – 0.18
NMSK – 0.08
CCS – 0

# Quality & Patient Safety
# Additional Safety Measures

**Board Sponsor: Director of Nursing**




| CAS Alerts – December 2019 | | | | |
|---|---|---|---|---|
| **Alert Type** | **Patient Safety** | **Facilities** | **Medical Devices** | **Supply Distribution Alerts** |
| New Alerts | 1 | 0 | 3 | 2 |
| Closed Alerts | 0 | 0 | 3 | 2 |
| Open alerts (within target date) | 1 | 1 | 1 | 0 |
| Breaches of Alert target | 0 | 0 | 0 | 0 |
| Breaches of alerts previously issued | 0 | 1 | 0 | 0 |

**Data Reporting basis**
The data is based on the date a serious incident is reported to STEIS. Serious incidents are open to being downgraded if the resulting investigation concludes the incident did not directly harm the patient. This may mean changes are seen when compared to data contained within prior Months' reports

**Central Alerting System (CAS)**
Six new alerts reported, with none breaching their alert target dates. However there is one previously issued Facilities/Estates alert that is in breach of it's target: *EFA/2019/004: Zebra printer Power Supply Units (PSUs): fire risk – product recall expanded.* IM&T are carrying out the necessary replacement exercise, across all areas affected.

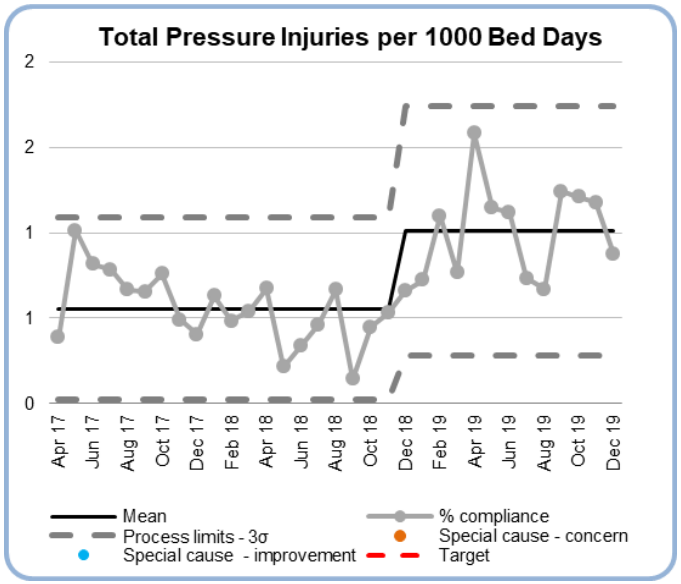
**Incident Reporting Deadlines for Serious Incident Investigation submission**

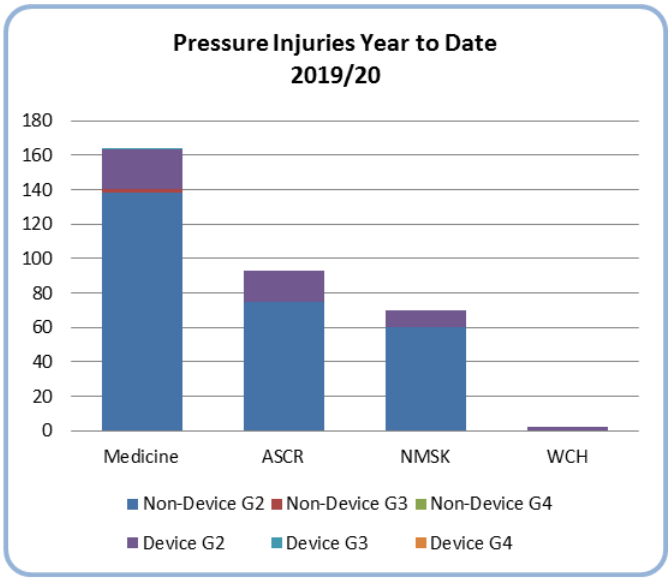
No serious incidents breached their December 2019 reporting deadline to commissioners. There have been no breaches since July 2018.

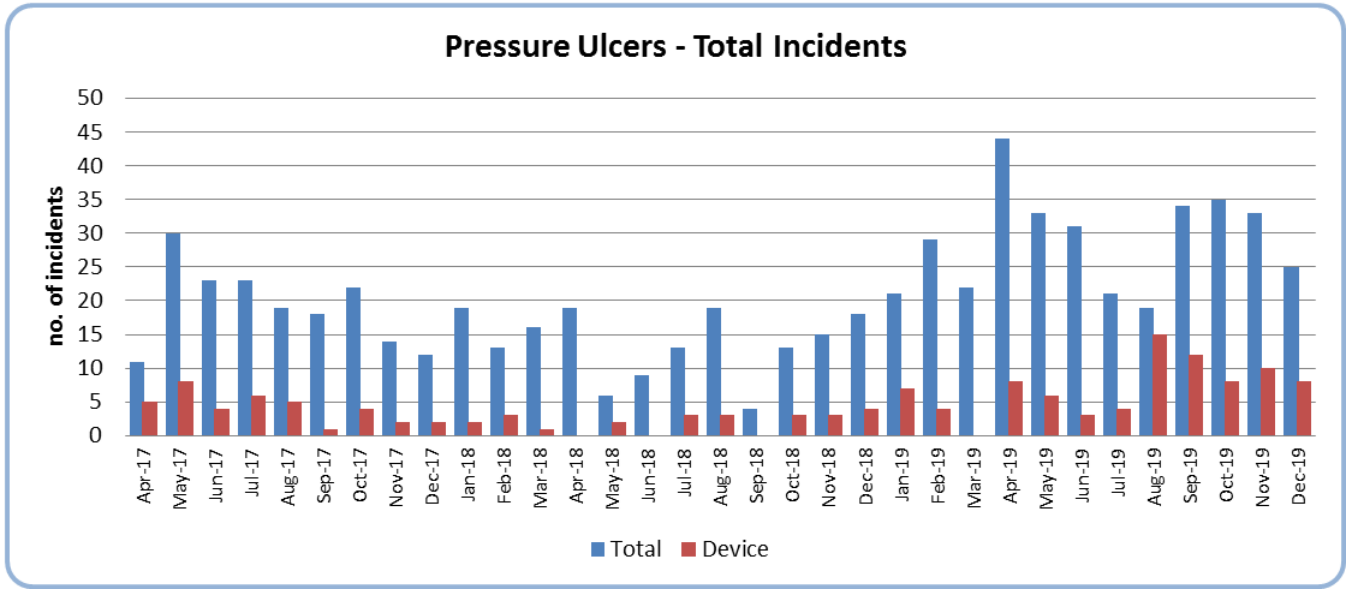
**Top SI Types in Rolling 12 Months**

Patient falls remain the most prevalent of reported SIs. These are monitored through the Trust Falls Group.

This is followed by
- Treatment or Procedure
- Maternity & Obstetrics.
- Tissue Viability




## Pressure Injuries (PIs)

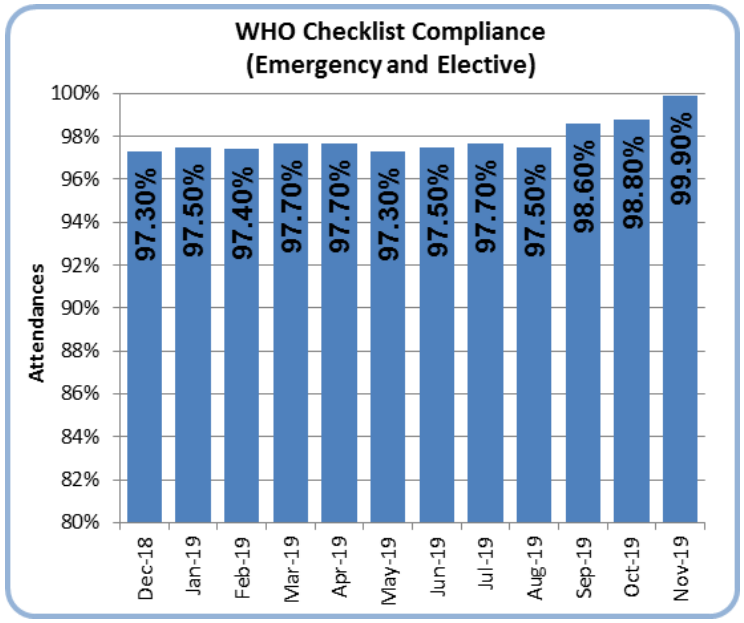
The Trust ambition for 2019/20 is a

- 30% reduction of Grade 2 pressure injuries.
- 30% reduction of device related pressure injuries
- Zero for both Grade 3 and Grade 4 pressure injuries.

During December there was one reported Grade 3 pressure injury which occurred within Medicine to a patient's heel as a result of a deep tissue injury. The cause of the injury was found to be the failure to check heels due to bandages to the legs not being removed. There was sustained prolonged direct pressure to vulnerable skin.

This month has seen a reduction in Grade 2 pressure injuries with 32 reported on 30 patients, eight (24%) which were related to devices.

Nursing intensive support teams have begun for three clinical areas within Medicine and ASCR. The objective is to work collaboratively with the clinical teams using quality improvement methodology to mitigate the risk of pressure injuries within these areas with the emphasis on learning and actions to improve.

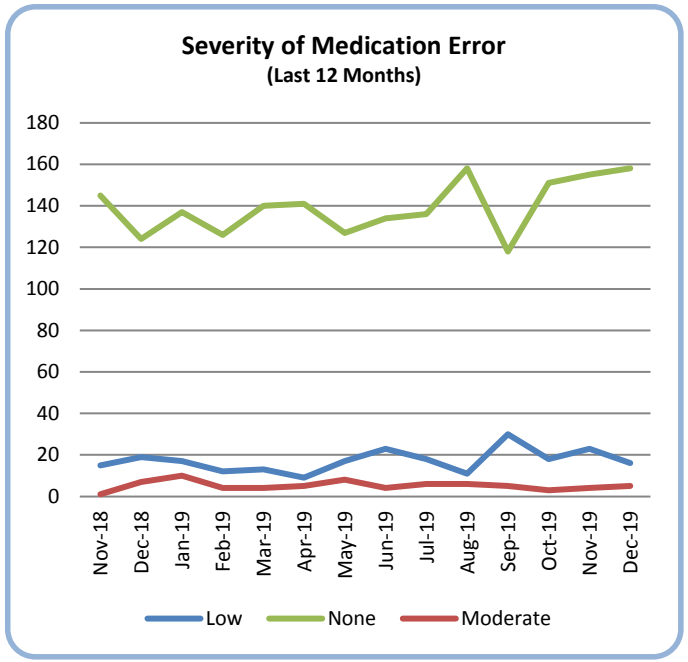


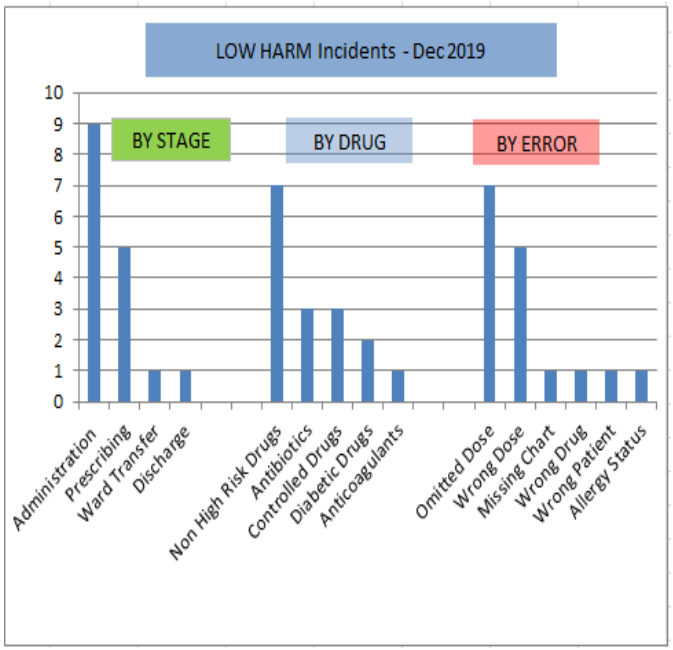

## WHO Checklist Compliance

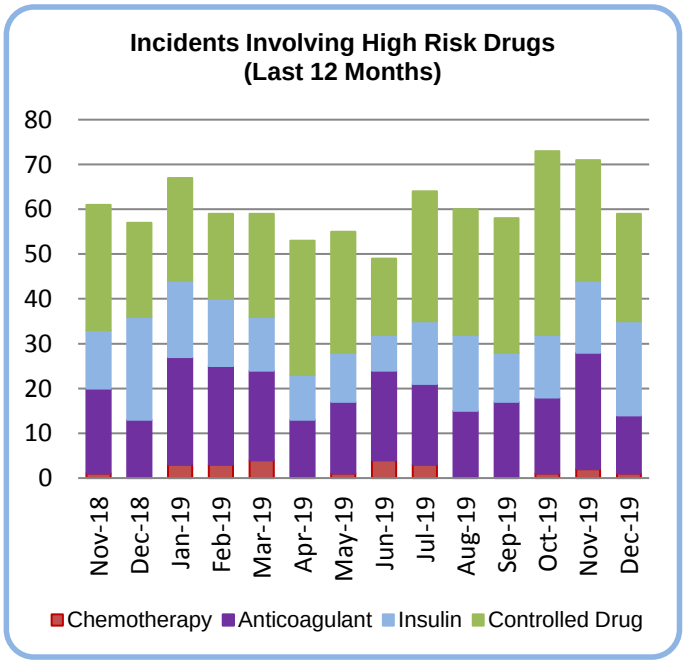
The Board expects that a WHO surgical safety checklist will be completed and documented prior to each operation in theatres. The Medical Director has discussed the reporting of checklist compliance with the surgical team led by Dr Lucy Kirkham (Consultant Anaesthetist). The team has demonstrated their process that assures that 100% of checklists are completed for both elective and emergency patients undergoing operations in the NBT operating theatres (in Brunel and Women's Health).

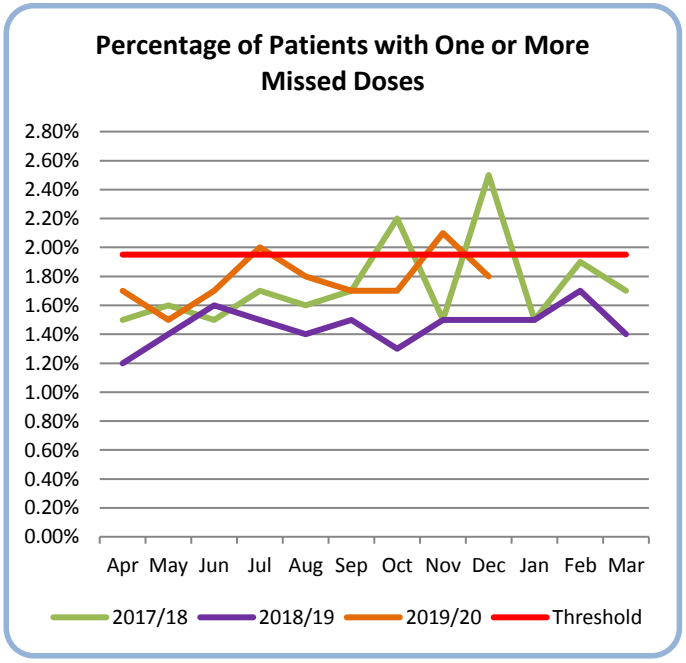
The IPR report of less than 100% is due to data capture prior to the validation process and recording of some procedures in the denominator where we would not expect the WHO checklist to be completed as they have other nationally recognised safety processes in place (NATSIPS).

The team are working to improve reporting in the IPR to represent a more validated position and this in part is why the data has showed improved compliance in recent months.




## Medicines Management

### Severity of Medication Error

During December 2019, the number of "No Harm" medication errors represented 88% of all medication errors.

Over the last 12 months the number of "No Harm" incidents reported monthly has increased by 27%, demonstrating the strong safety culture within the Trust.

### Low Harm Incidents

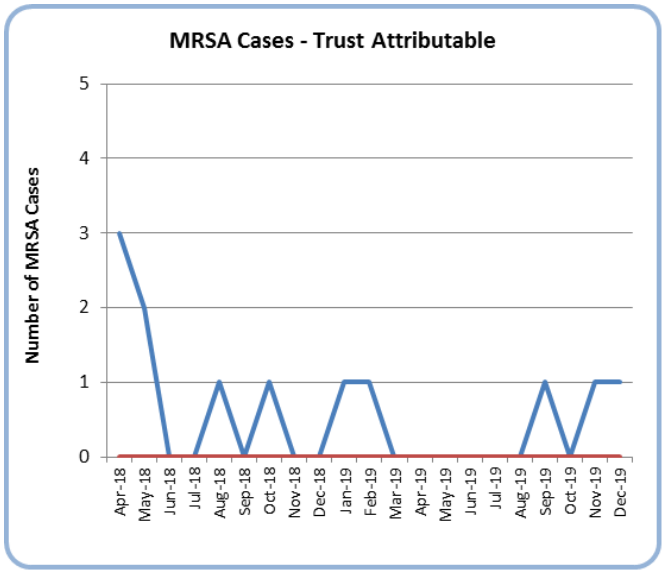
The number of low harm incidents accounted for 9% of all incidents during December 2019. The additional graph highlights that 56% of low harm incidents occurred during the administration stage, with 56% involving a high risk medication and 44% were as a result of an omitted dose.

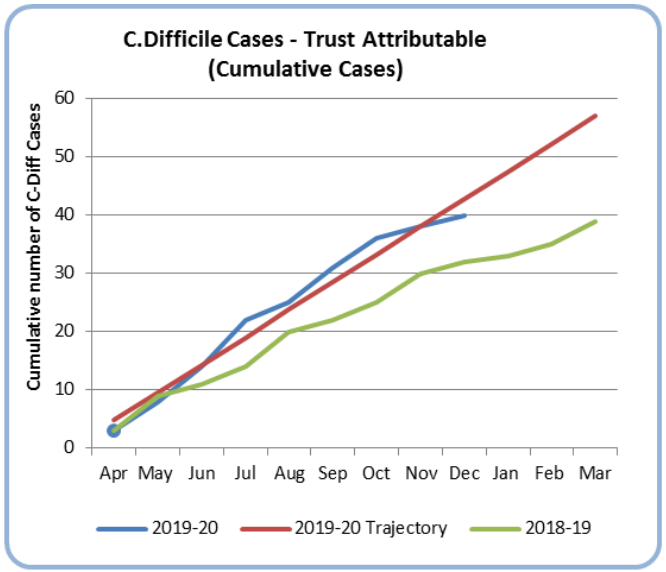
### High Risk Drugs

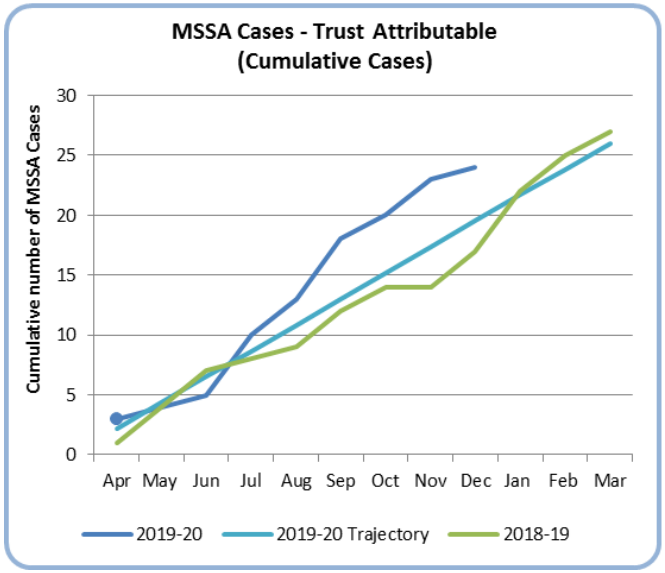
High Risk Drugs formed 31% of all medication incidents reported during December 2019. All incidents relating to high risk drugs are monitored by the Medicines Governance team.

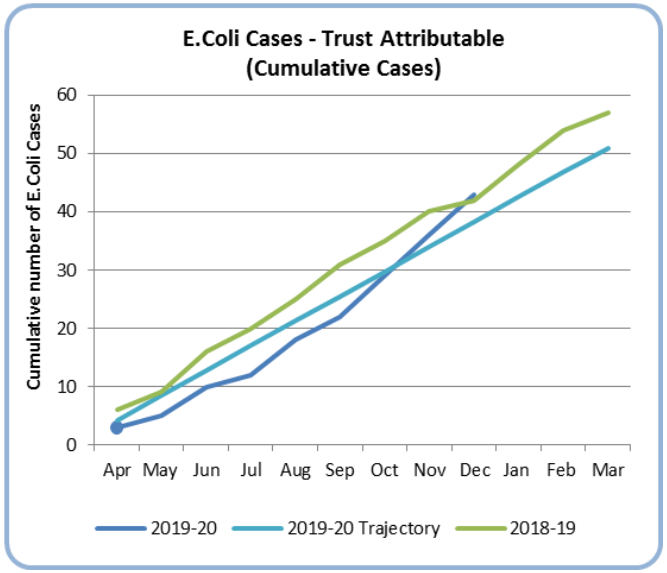
### Missed Doses

The percentage of patients with missed doses during December 2019 was 1.8%. The clinical pharmacy team closely monitors the KPI's associated with all missed doses. Any ward(s) that breaches the missed dose target of <1.95% on two consecutive months undertake an intensive 2-week "missed dose audit".




**MRSA**
One reported case of MRSA bacteraemia in December occurring within ICU, the investigation has commenced. Year to date there has been three reported cases for the organisation.

**C. Difficile**
In December there were three cases reported against the trajectory. Two were hospital onset hospital acquired and one community onset hospital acquired.

**MSSA**
There was one reported case of MSSA bacteraemia in December within ICU. As an organisation we remain above trajectory, although the rate is comparable to regional and national benchmarks.

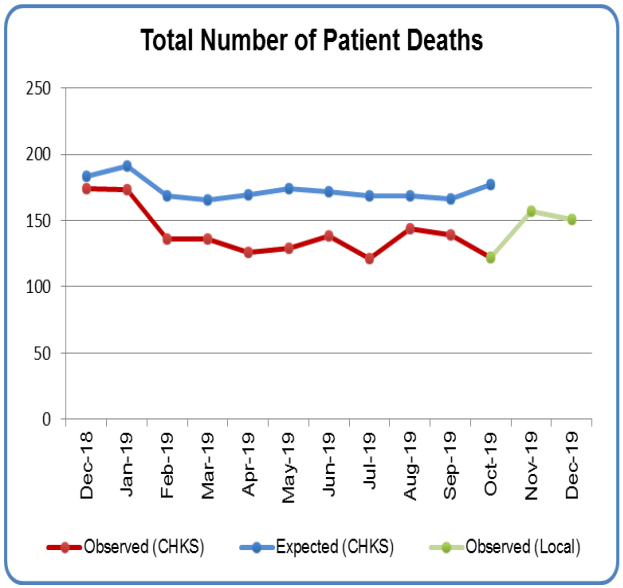
**E. Coli.**
The Trust target for 2019/20 is a 10% reduction on the previous year. The focus for improvement is on the management of urinary catheters.

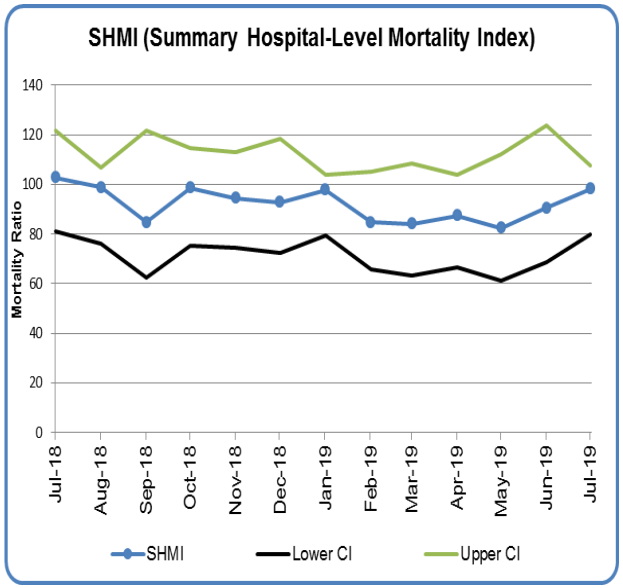
**Influenza**
As an Organisation we are monitoring cases of influenza. The current levels of influenza and influenza like illness are comparable to other regional Trusts.

In December there was one ward affected by confirmed influenza resulting in partial restrictions. This clinical area is now fully operational.

**Norovirus**
In December there have been two ward areas affected by confirmed norovirus, resulting in the partial restrictions to both wards. Both clinical areas are now fully operational.

## Mortality Outcome Data




## Mortality Review Completion

| Nov 18 to Oct 19 | Completed | Required | % Complete |
|---|---|---|---|
| Screened and Excluded | 993 | | |
| High Priority Cases | 187 | | |
| Other Reviewed Cases | 303 | | |
| **Total Reviewed Cases** | **1483** | **1784** | **83.1%** |

| Overall Score | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Care Received | 0.0% | 3.1% | 19.1% | 56.7% | 21.1% |

The overall score percentages are derived from the score post review and does not include screened and excluded.

| Date of Death | Nov 18 to Oct 19 |
|---|---|
| In Progress | 2 |
| Reviewed Not SIRI | 12 |
| Reported as SIRI | 0 |
| **Total Score 1 or 2** | **14** |

### Overall Mortality

Mortality data has remained within the expected range.

### Mortality Review Completion

The current data captures completed reviews from 01 Nov 2018 to 31 Oct 2019. In this time period (this is now reported as a 12 month rolling time frame), 83% of all deaths had a completed review. Of all "High Priority" cases, 86% completed Mortality Case Reviews (MCR), including fifteen of the sixteen deceased patients with Learning Disability and five of the six patients with Serious Mental Illness.

### Mortality Review Outcomes

The number of cases reviewed by MCR with an Overall Care score of adequate, good or excellent is 96.9% (score 3-5). There have been fourteen mortality reviews with a score of 1 or 2 indicating potentially very poor, or poor care which have been reviewed through Divisional governance processes.

All of these cases were reviewed through the Clinical Risk Operational Group.

### Learning from Deaths Internal Audit:

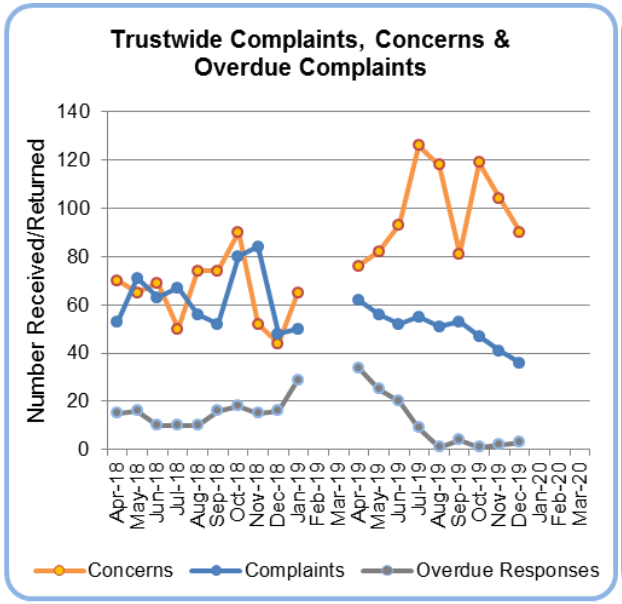
In September 2019, NBT's Internal Auditors, KPMG, concluded a review of the approach to the national requirements relating to reviewing patient deaths in hospital.

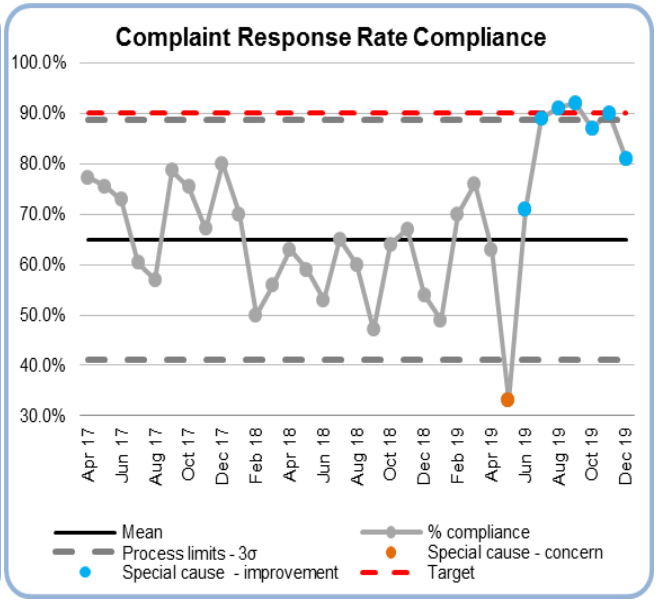
This was a positive report, the outcome of which was "Significant Assurance, with minor improvement opportunities".

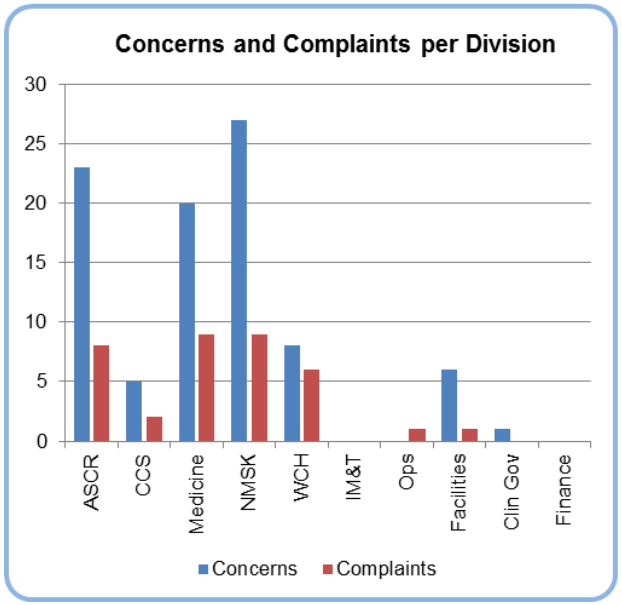
NHS North Bristol NHS Trust

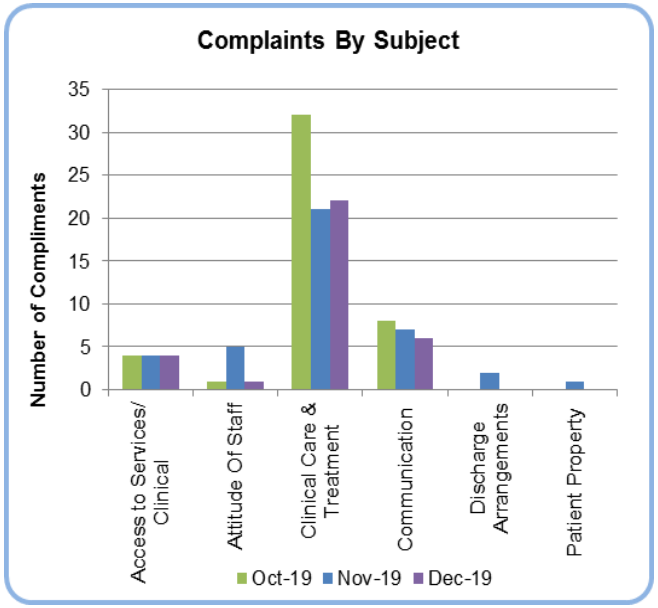
# Quality Experience

## Board Sponsor: Director of Nursing and Quality Helen Blanchard




N.B. Feb-19 and Mar-19 data has been removed for complaints, concerns and overdue complaints owing to data quality issues.

## Complaints and Concerns

In December 2019 the Trust received 36 formal complaints and 90 PALS concerns.
The 36 formal complaints can be broken down by division:

| | | | |
|---|---|---|---|
| ASCR | 8 | CCS | 2 |
| Medicine | 9 | NMSK | 9 |
| WACH | 6 | Facilities | 2 |

The number of formal complaints received continues to fall. This reduction, and the reduction in Patient Advice and Liaison Service (PALS) concerns in month is not unusual for this time of year.

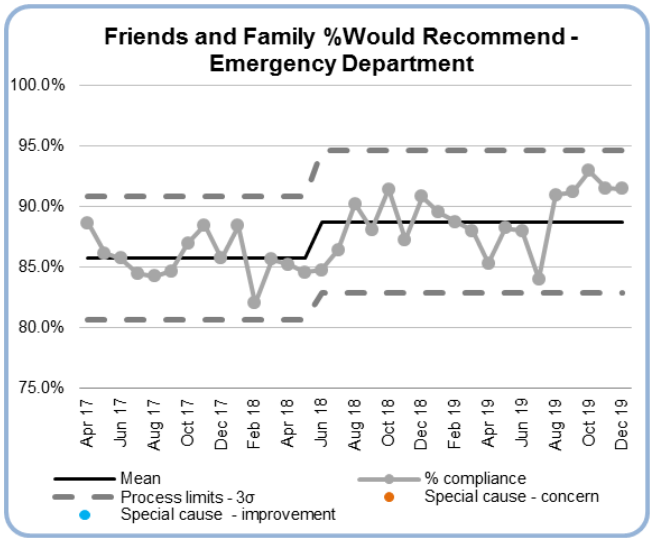
## Compliance Response Rate Compliance

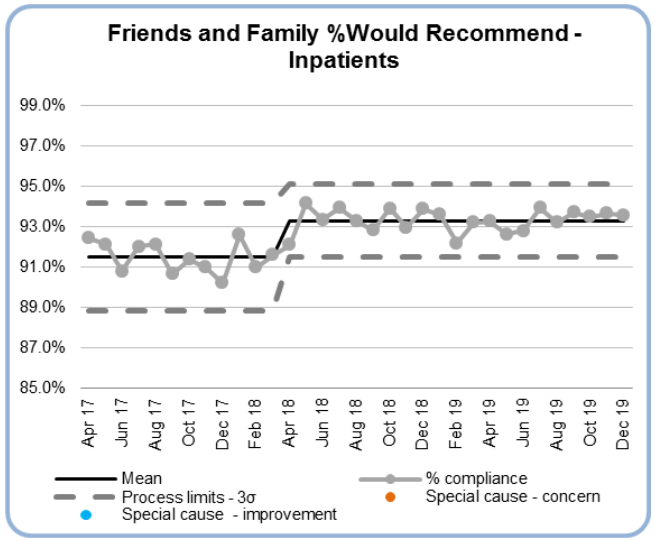
The chart demonstrates statistically significant performance improvement (the result of a process change and not natural variation).

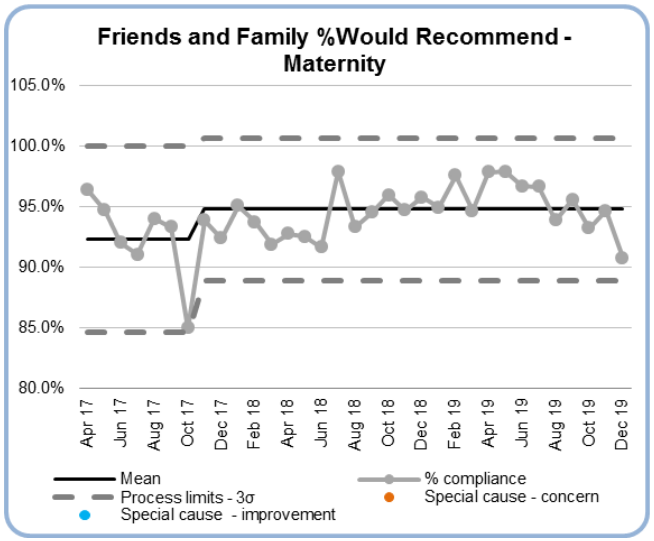
In December 81% of complaints were closed within the initial agreed time frame. That is 29 of the 36 complaints due to be closed in the month were responded to on time.

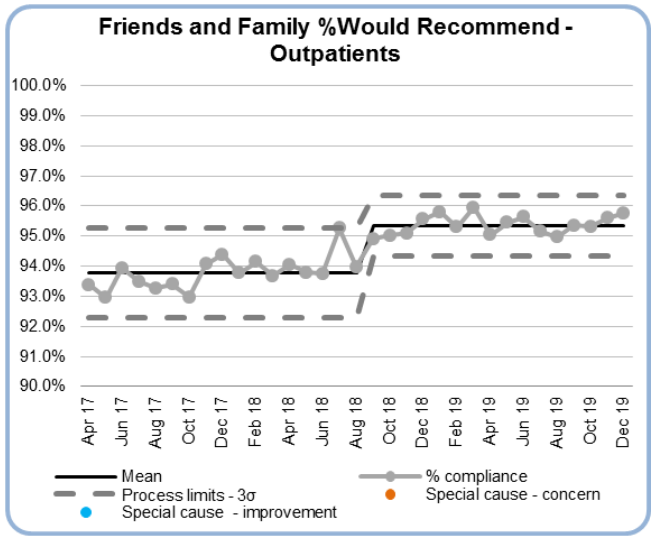
## Overdue complaints

Weekly tracker reports and meetings take place with divisions. These reports identify those over due against the dates they are due back to the central team for the completion of the final response. ASCR Division continue to experience a number of complaints overdue in this respect. Key issues and challenges have been identified and continue to be worked through by the Head of Nursing.




| FFT Recommend Rate | Target | NBT Actual |
|---|---|---|
| ED | 90% | 91.48% |
| Inpatients | 95% | 93.59% |
| Outpatients | 95% | 95.76% |
| Maternity (Birth) | 95% | 90.80% |

Of note:

**Emergency Department (ED)**

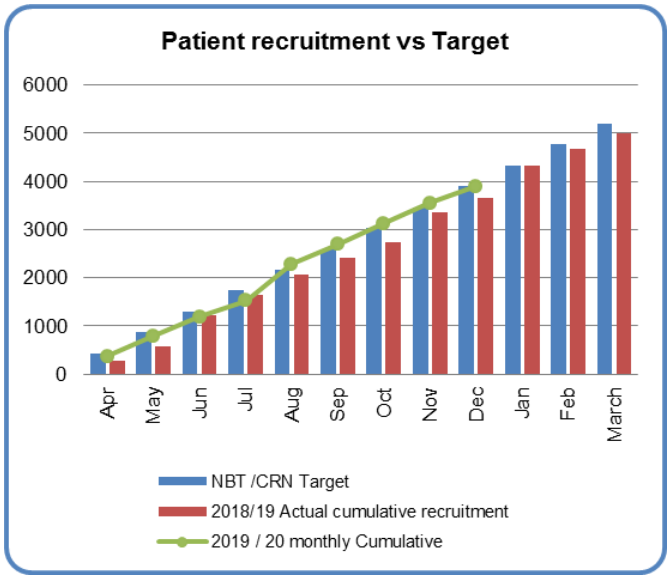
The percentage of patients recommending the service remains high. There were 1233 respondents to the FFT feedback opportunity; 553 leaving narrative explaining their score. Reviewing the themes and sentiment the influencing factors for positive scores are *caring & professional staff* who are *reassuring* and *hard working.*

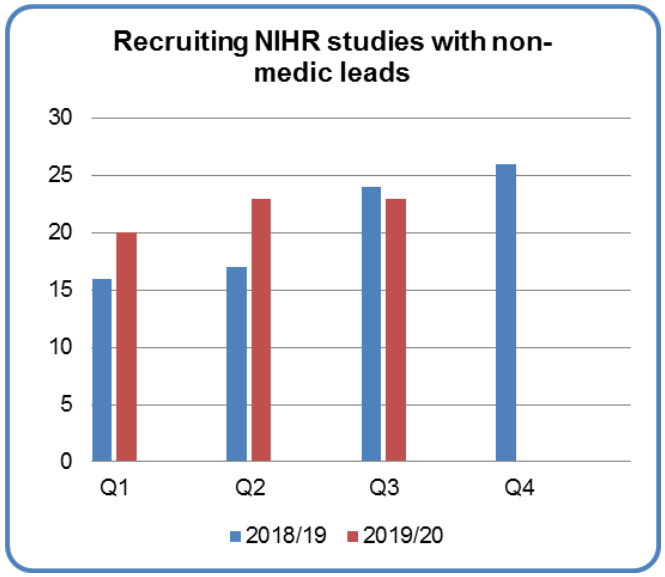
**Maternity (Birth)**

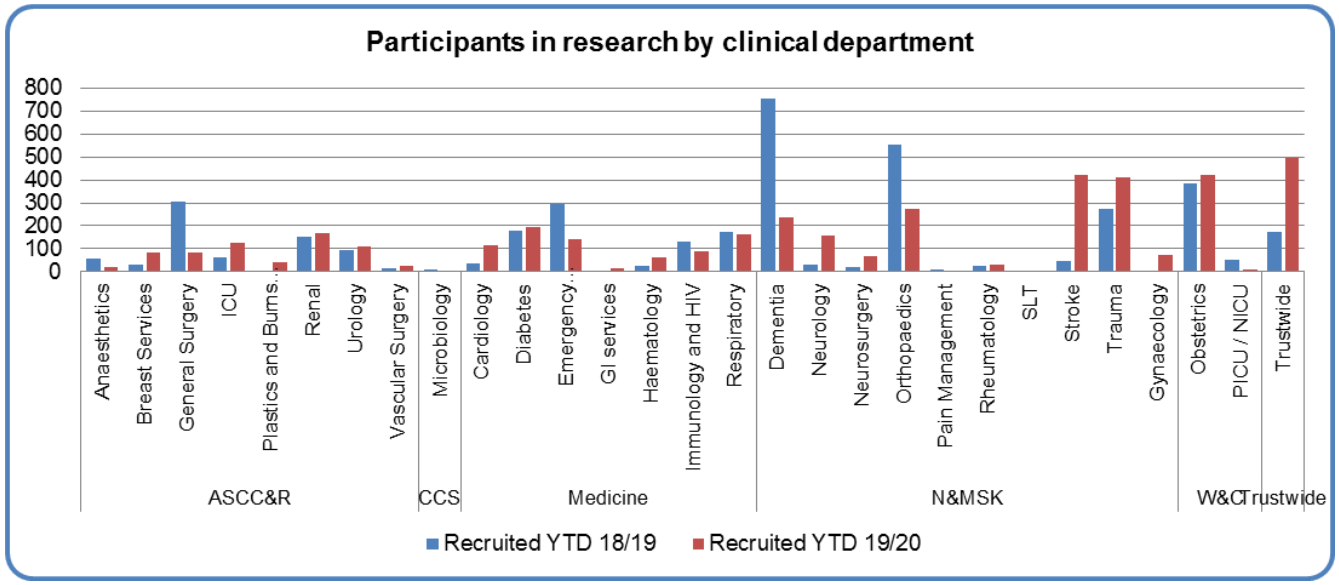
The data would appear to be showing a steady decrease in the percentage of patients who would recommend the service. A review of the qualitative data was undertaken to understand the possible cause of this. There were 390 FFT surveys sent with 87 respondents. Of these, 48 left comments. This review identified that the majority of the feedback was very positive with very few comments being negative. Monitoring will continue

# Research and Innovation

## Board Sponsor: Medical Director




Recruitment performance has improved and we have now achieved 100% recruitment against the target. Research and Innovation (R&I) are confident of maintaining this performance through the remainder of the year.

R&I is continuing to support and encourage non-medic PI's from all professions.

Due to a generous charitable donation to the NBT Research Fund, R&I opened a Trust-wide open call for applications to fund research projects up to £20k each. We were delighted to have received 28 applications, of which 13 applications have been shortlisted. The Awarding Panel will meet on 03 February.

NBT currently holds 39 research grants (NIHR, charity and other) to a total value of £21m, with five NBT-led grants in set-up (£270k).

R&I have appointed two new posts to drive significant programmes of research development across the Medicine Division, Stroke, and Respiratory Unit.

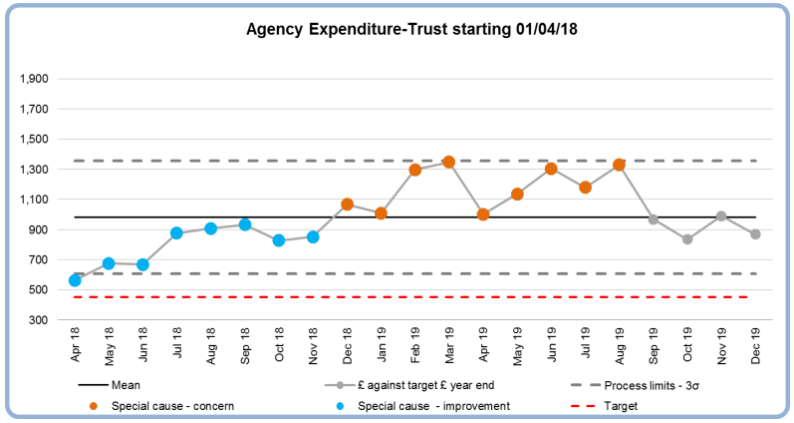
The Bladder and Bowel Confidence (BABCON) Health Integration Team was approved by Bristol Health Partners in October providing an identity for continence care across the city. NBT are the proud sponsor of this fantastic collaboration of patients, the public, UWE, UoB, Bristol City Council, AWP, BNSSG CCG and UHBristol to focus on improving continence care, education, research and inclusion citywide.

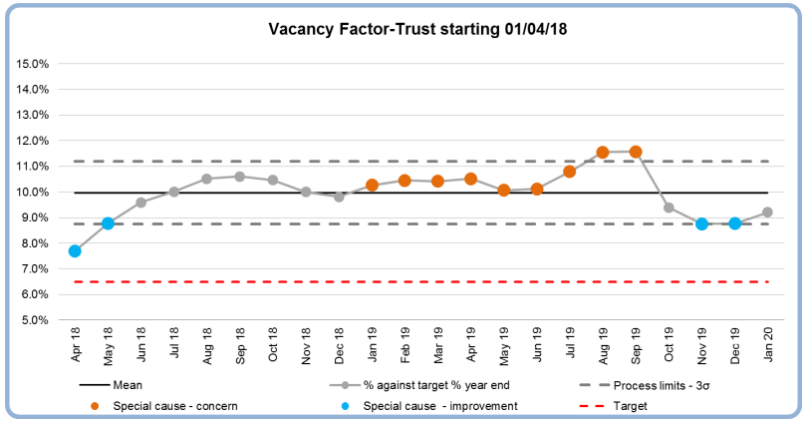
NHS North Bristol NHS Trust

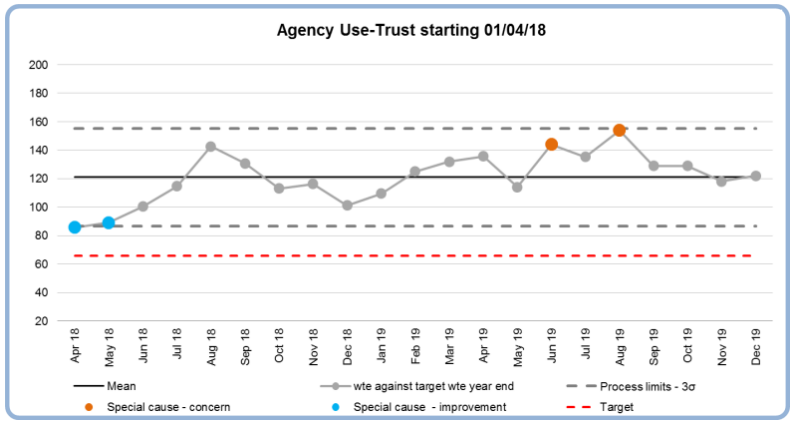
# Well Led

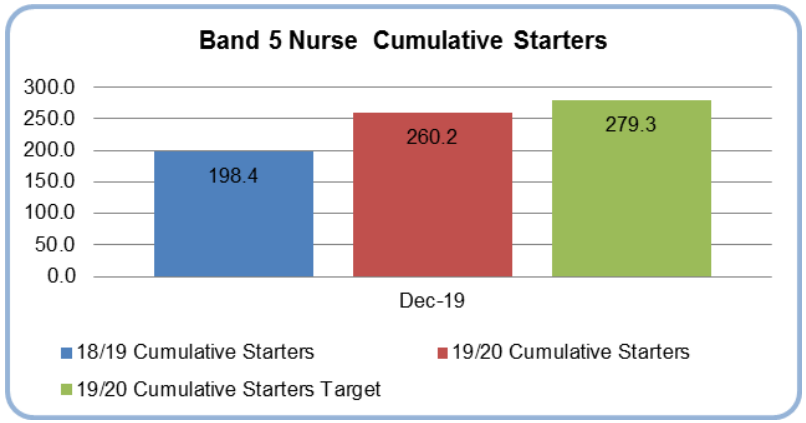
## Board Sponsors: Medical Director, Director of People and Transformation
## Chris Burton and Jacqui Marshall

# Workforce




**Pay**

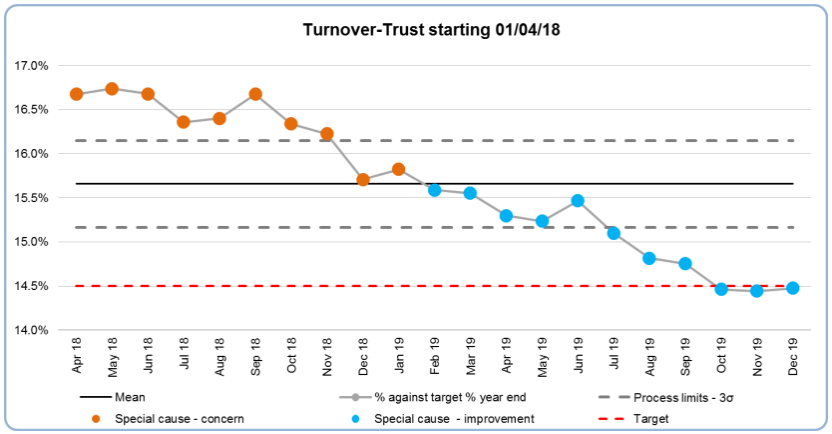
Pay has exceeded budget for 2019/20 year to date, predominantly in medical staffing and registered nursing. Agency usage and expenditure in December followed seasonal expectations. Bank fill rates have yet to reach expected improvement resulting from the rate change in November and analysis/action plans are under way to ensure the relevant improvement is reached.

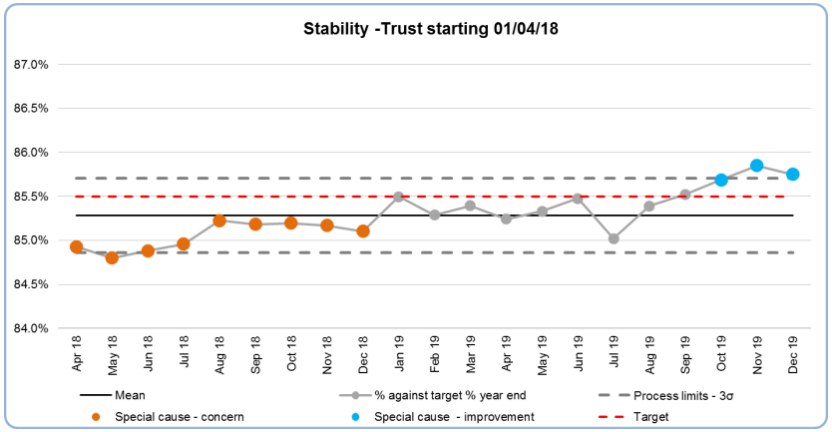
For consultants and registered nursing total worked has not exceeded establishment, it is the use of high cost temporary staffing that has driven expenditure. Consultant recruitment plans continue to address high cost agency use continuing to be implemented in 2020/21, and the recruitment approach for registered nursing in 2020/21 aims to deploy new starters into hotspot areas to further impact on high cost temporary staffing use. For junior doctors, the deployment of eRostering is in progress and will be key to supporting the effective deployment of this staff group and identifying opportunities to reduce temporary staffing use.

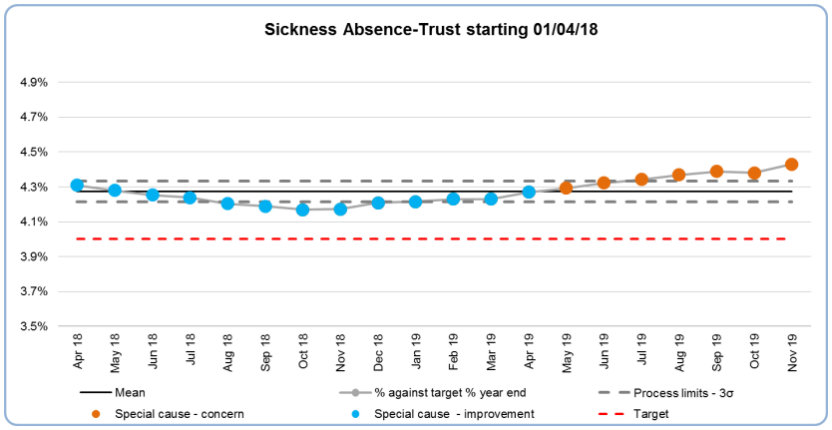
**Nursing and Midwifery Resourcing**

Nursing starters in December were slightly lower due to the time of year and the year to date position is still below our internal target however is 74 WTE above our 2018/19 year to date position. Current planning for 2020/21 is in progress to finalise the anticipated impact of nurse recruitment operationally and in terms of the Trust vacancy position and overall opportunity for reducing high cost nursing agency use in hotspot areas.

# Engagement and Wellbeing




**Turnover and Stability**

Overall Trust turnover and stability continue to improve and this remains a key area of focus to continue to improve on our position.

**Project:**

- NHSI/NBT retention action plan now developed and approved by the Executive Team, around the key themes of Starting Well, Staying Well and Stopping Well;

**Operational Actions:**

- Work-life balance/Flexible Working 'e-brochure' is complete and ready to go live on HR Portal;
- Continued support of EU staff to help them gain 'Settled Status', promoted through a variety of methods;
- Communications plan in place for February to re-promote the Itchy Feet phone line and linked resources on the HR Portal.

**Sickness**

Whilst we have seen the seasonal increase in short term sickness we would expect as yet this has not been adverse compared to previous years and does not contribute to the deterioration in the Trust position. Predominantly this has been driven by long term sickness and in particular for the reasons 'other' and 'unknown.

**Operational**

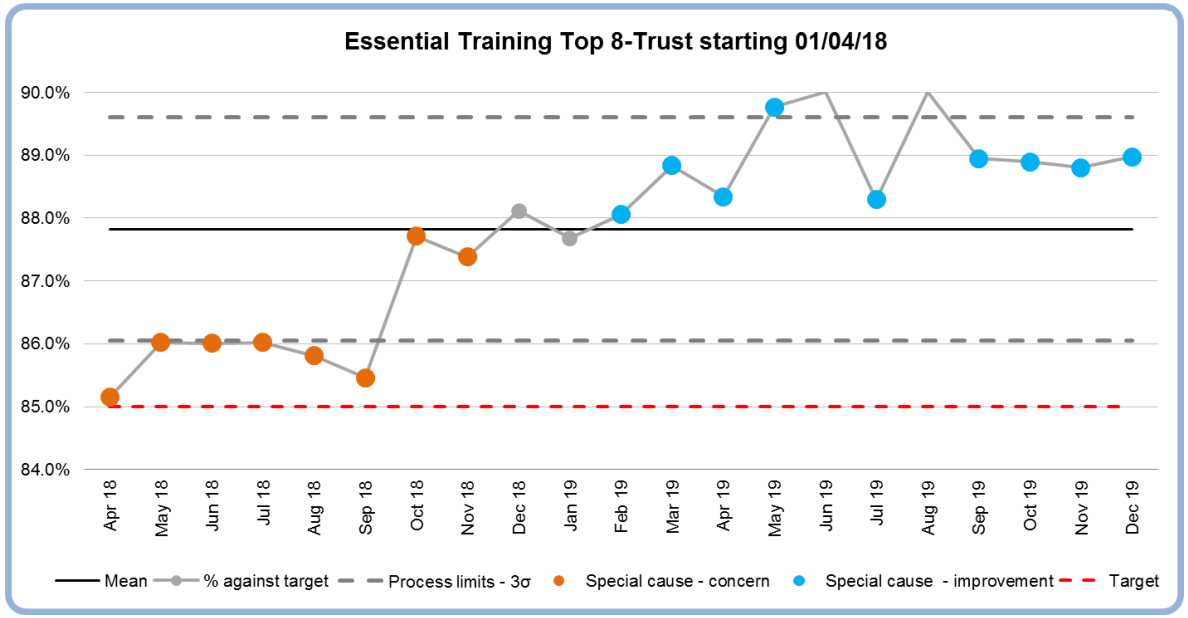
- Recruited four junior doctor wellbeing fellows with dedicated time to focus on improving junior doctor wellbeing, including raising awareness amongst junior doctors of existing corporate wellbeing initiatives

- Following the short-term sickness audit, analysis underway on 'what happened next' for Stage 3 sickness staff who were **not** dismissed i.e. has their sickness improved, remained high or have they left – to close the loop on understanding the effectiveness of our decision-making at Stage 3;

- Employee Relations Case Tracker being widely used now for recording/managing sickness cases, with some areas using this for sickness case dashboard discussions;

- Long-term Sickness/Maternity Leave Return to work support pack for staff now complete and ready for roll-out;

- Work commissioned around targeted sickness absence support for Theatres.

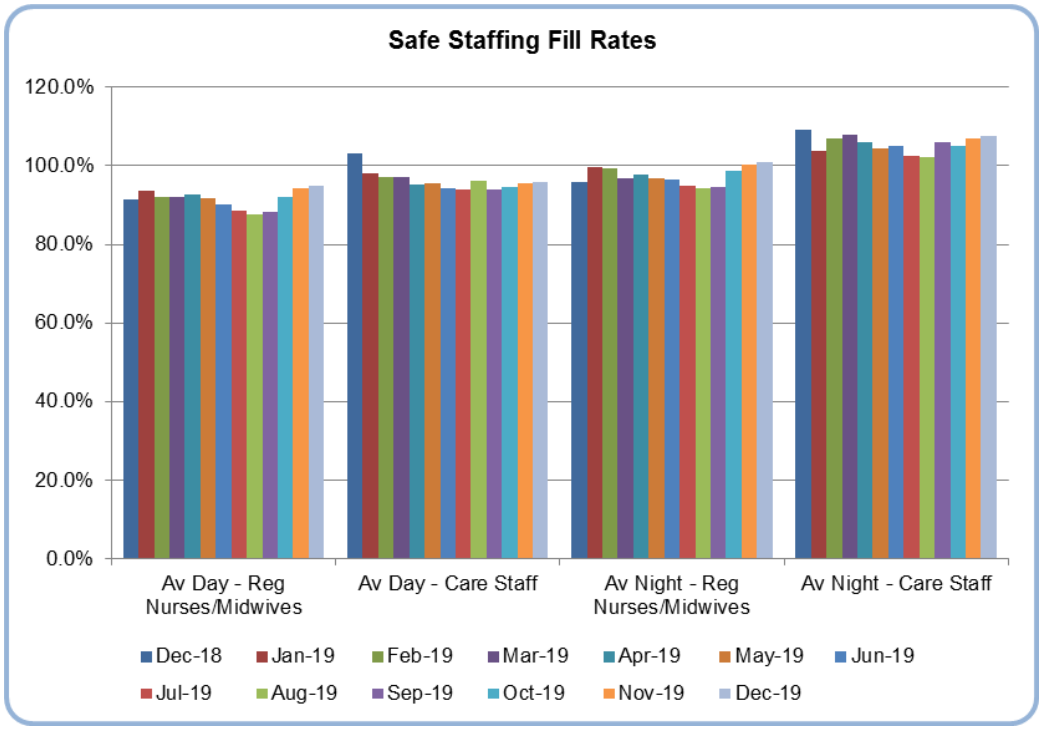



| Training Topic | Variance | Nov-19 | Dec-19 |
|---|---|---|---|
| Child Protection | 0.3% | 89.0% | 89.4% |
| Equality & Diversity | 0.4% | 91.1% | 91.5% |
| Fire Safety | -0.3% | 87.9% | 87.7% |
| Health &Safety | 0.9% | 92.4% | 93.3% |
| Infection Control | 0.3% | 90.6% | 90.9% |
| Information Governance | -0.9% | 86.2% | 85.3% |
| Manual Handling | 0.5% | 83.8% | 84.3% |
| Waste | 0.0% | 89.0% | 89.0% |
| **Total** | **0.2%** | **88.80%** | **88.97%** |

**Leadership & Management Development**
**OneNBT Leadership Programme**

We currently have 290 staff enrolled on the OneNBT Leadership programme with 37 still to engage. Overall participants on the programme are at 83% of our target of 350 staff. Key improvements so far to address drop out:

- Added an application form that includes commitment from the line manager to provide the necessary release time. It will also require confirmation from both learners & managers to prevent withdrawals due to lack of awareness of nomination;
- Implemented entry points to allow us to frontload the core days to enable people to attend the introduction prior to their modules, thus making the process clearer from the start;
- Developed an extensive communications plan to promote the 2020 programme;
- Implemented application windows to apply within to prevent rushed decision-making.




| Dec-19 | Day shift | | Night Shift | |
|---|---|---|---|---|
| | RN/RM Fill rate | CA Fill rate | RN/RM Fill rate | CA Fill rate |
| Southmead | 94.8% | 95.8% | 100.9% | 107.4% |

The numbers of hours Registered Nurses (RN) / Registered Midwives (RM) and Care Assistants (CA), planned and actual, on both day and night shifts are collated. CHPPD for Southmead Hospital includes ICU, NICU and the Birth Suite where 1:1 care is required. This data is uploaded on UNIFY for NHS Choices and also on our Website showing overall Trust position and each individual gate level. The breakdown for each of the ward areas is available on the external webpage.

The safe staffing report now requires the wards to identify Nursing Associates including Trainees and AHP staff employed in an inpatient area. The current version of the roster system is unable to break this down, however changes are anticipated and will be back reported as soon as it is possible.

**Wards below 80% fill rate are:**

Gate 19: CA Days 60.8 % This area is reported as it has been open as escalation capacity for more than three consecutive nights. The fill rate is due to vacancy across the gate which includes the labs, the base template is currently under review. The area will only admit patients to the number of staff available, and is being closely monitored to the SOP by the matron to maintain patient safety.

Ward 33b: CA Days 69.2%. Low fill rate due to vacancies. However RN fill rate at 119% to ensure safe staffing.

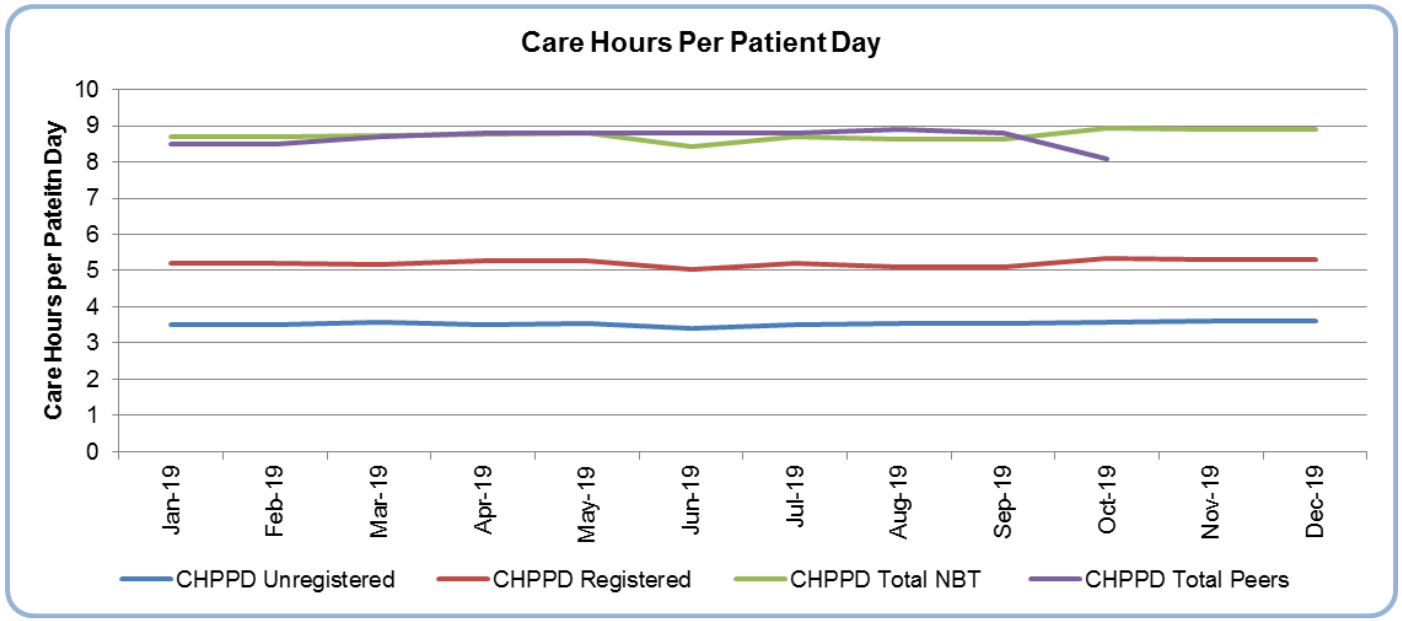
NICU CA Days (73.7%) CA Nights (64.7%). Low fill due to sickness level and when required cover is provided by registered nursing.

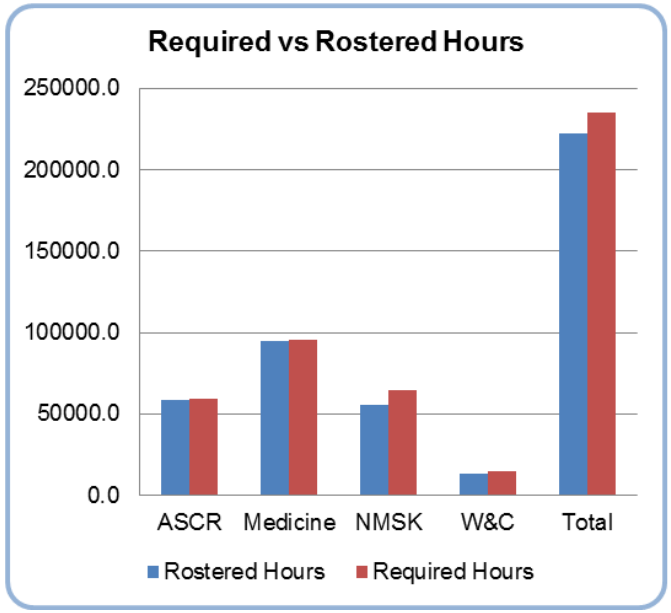
Quantock CA Days (78.4%) CA Nights (75.9%) Mendip CA Days 67.8%. Low fill due to long and short term sickness levels.

**Ward over 150% fill rate:**
25b CA Night 151.5%
26a CA Night 152.8%
26b CA Night 152.8%

All wards fill rates represent the need for additional staff overnight to support patient who have cognitive impairments and are a significantly high risk of falls. The patients are risk assessed daily to ensure patient safety needs are addressed. In addition there has also been an increase in medical specialty patients in accordance with the Trust winter bed plan.

Cotswold CA Nights 150.3%. The fill rate is due to an increase in bed capacity. This will be reviewed in the February Safe Staffing review and business planning.



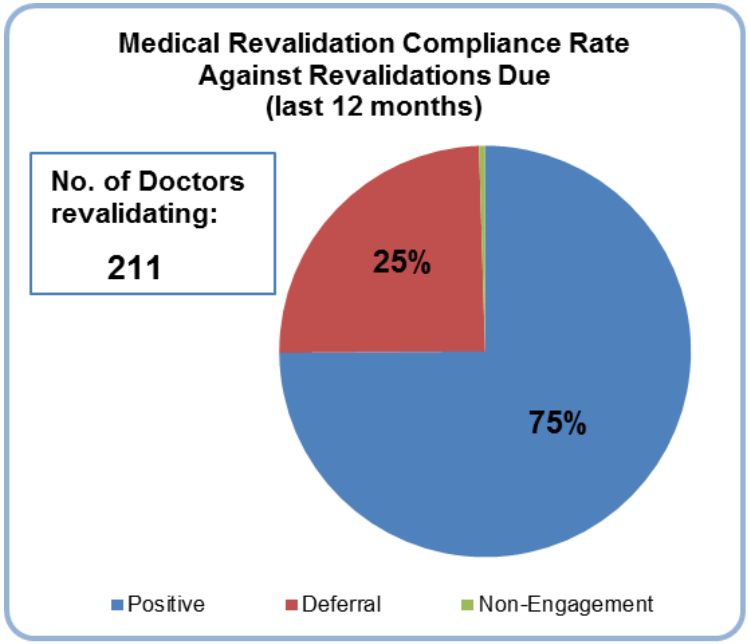



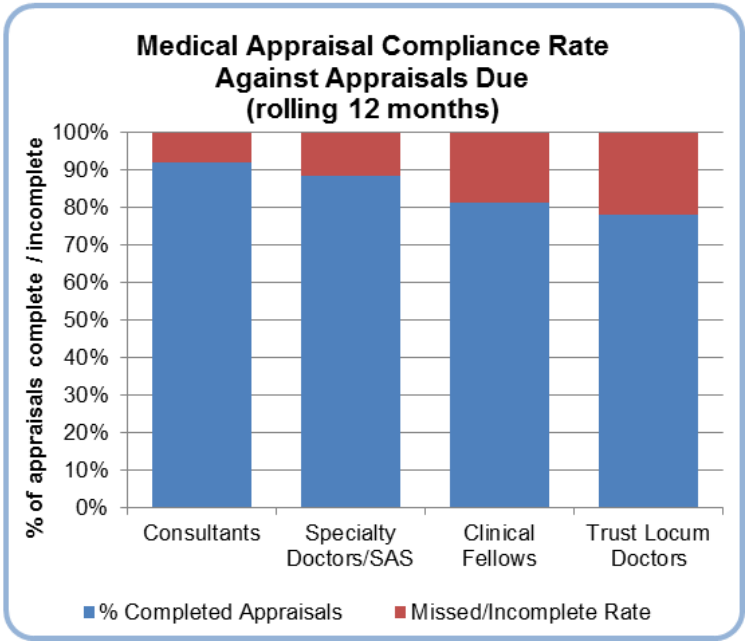

**Care Hours per Patient Day (CHPPD)**
The chart shows care hours per patient day for NBT total and is split by registered and unregistered nursing. The chart shows CHPPD for our Model Hospital peers (all data from Model Hospital. Peer values are only available to Feb 2019).

**Safe Care Live (Electronic Acuity Tool)**
The acuity of patients is measured three times daily at ward level.

The Safe Care data is triangulated with numbers of staff on shift and professional judgement to determine whether the required hours available for safe care in a ward/unit aligns with the rostered hours available.

Staff will be redeployed between clinical areas and Divisions following daily staffing meetings involving all Divisions, to ensure safety is maintained in wards/areas where a significant shortfall in required hours is identified, to maintain patient safety.




**Medical Appraisal**

The current appraisal year runs between 1st April 2019 - 31st March 2020. At the end of December, 89% of the appraisals that were due are now completed. 61 appraisals remain incomplete and 164 appraisals are due between January and March. The 61 individuals with an overdue appraisal are being managed through the missed appraisal process.

The Trusts missed appraisal escalation process includes a number of emails from the system and the Deputy Medical Director. Failure to engage beyond this point will lead to a non-engagement communication from the GMC which provides a final deadline.

There are also a further 14 doctors who are new to the Trust and we are awaiting past ARCPs / appraisals from them in order to establish whether they are compliant with the process.

The doctors connected to the Trusts Designated Body for appraisals and revalidation includes consultants, specialty doctors, associate specialists, clinical fellows and trust locum doctors. The Trust also provides an appraisal service for an additional 11 doctors who have connections to other Designated Bodies. Junior doctors in training are revalidated by Health Education England.

568 of the doctors connected to NBT's Designated Body obtained their primary medical qualification within the UK. 61 obtained their qualification within the EEA and 122 were obtained internationally.

The Trust has currently deferred 25% of all revalidation recommendations due over the past 12 months. From March 2019, the GMC has been collecting further information for the reasons of each deferral.

In June 2019 a non-engagement recommendation was made for a doctor who works abroad but holds an honorary contract with NBT. The individual was deferred in February 2019 and had made insufficient progress by June 2019. The GMC have approved the non-engagement recommendation and the individuals licence to practice has been withdrawn. There was no appeal.

Fourteen Fish now continues to be the system used in the Trust for appraisal and revalidation and is mandatory for all non-training grade doctors to use.

# Finance

## Board Sponsor: Director of Finance
## Catherine Phillips

| | Position as at 31 December 2019 | | Full Year Forecast (as at December 2019) | |
|---|---|---|---|---|
| | Actual | Variance (Adverse) / Favourable | Full year Forecast | Variance (Adverse) / Favourable |
| | £m | £m | £m | £m |
| Contract Income | 394.0 | (3.7) | 525.1 | (4.2) |
| Other Income | 65.3 | 2.0 | 88.9 | 4.4 |
| **Total Income** | **459.3** | **(1.7)** | **614.0** | **0.2** |
| **Pay** | **(287.0)** | **2.2** | **(385.1)** | **1.2** |
| **Non-Pay** | **(139.8)** | **(0.6)** | **(187.7)** | **(2.2)** |
| Depreciation | (18.4) | 0.0 | (24.2) | 0.3 |
| PFI Operating Costs | (4.6) | 0.2 | (6.3) | 0.0 |
| PFI Interest | (25.7) | (0.1) | (34.0) | 0.2 |
| Other Financing costs | (3.7) | 0.2 | (5.0) | 0.3 |
| Loss on Disposal | (0.2) | (0.2) | (2.1) | 0.0 |
| **Adjusted surplus / deficit for NHS accountability (exc PSF)** | **(20.0)** | **0.1** | **(30.4)** | **0.0** |
| FRF | 16.3 | 0.0 | 25.0 | 0.0 |
| **Adjusted surplus / deficit for NHS accountability (inc PSF)** | **(3.7)** | **0.1** | **(5.4)** | **0.0** |
| Gain on disposal | 0.6 | 0.6 | 0.6 | 0.1 |
| **Control total** | **(3.1)** | **0.7** | **(4.8)** | **0.1** |

## Statement of Comprehensive Income

### Assurances

The financial position at the end of December shows a deficit of £3.7m, £0.1m favourable to plan.

### Key Issues

Contract income is £4.2m adverse to plan largely due to under-performance in elective and the mix of long / short stay non-elective inpatient activity. The Trust has forecast it will meet its control total. This reflects anticipated improvements in both elective inpatient activity and in non-elective case-mix. Under-performance of income and under achievement of savings represent risks to the delivery of the Trust's control total.

| 31 March 2019 £m | Statement of Financial Position as at 31st December 2019 | Plan £m | Actual £m | Variance above / (below) plan £m |
|---|---|---|---|---|
| | **Non Current Assets** | | | |
| 558.1 | Property, Plant and Equipment | 554.0 | 552.2 | (1.9) |
| 17.0 | Intangible Assets | 14.9 | 12.2 | (2.7) |
| 8.5 | Non-current receivables | 8.5 | 3.1 | (5.4) |
| **583.6** | **Total non-current assets** | **577.4** | **567.5** | **(9.9)** |
| | **Current Assets** | | | |
| 12.8 | Inventories | 11.2 | 12.0 | 0.8 |
| 35.5 | Trade and other receivables NHS | 49.4 | 31.3 | (18.1) |
| 37.1 | Trade and other receivables Non-NHS | 20.2 | 34.0 | 13.8 |
| 10.2 | Cash and Cash equivalents | 8.0 | 23.8 | 15.8 |
| **95.7** | **Total current assets** | **88.8** | **101.2** | **12.4** |
| 0.0 | Non-current assets held for sale | 0.0 | 0.0 | 0.0 |
| **679.3** | **Total assets** | **666.2** | **668.7** | **2.5** |
| | **Current Liabilities (< 1 Year)** | | | |
| 9.4 | Trade and Other payables - NHS | 9.4 | 7.6 | (1.8) |
| 64.8 | Trade and Other payables - Non-NHS | 59.5 | 68.0 | 8.5 |
| 70.8 | Borrowings | 70.1 | 142.9 | 72.7 |
| **145.0** | **Total current liabilities** | **139.0** | **218.5** | **79.5** |
| **(49.3)** | **Net current assets/(liabilities)** | **(50.1)** | **(117.3)** | **(67.2)** |
| **534.3** | **Total assets less current liabilites** | **527.2** | **450.2** | **77.0** |
| 7.8 | Trade payables and deferred income | 7.5 | 6.9 | (0.7) |
| 517.8 | Borrowings | 513.2 | 435.4 | (77.8) |
| **8.7** | **Total Net Assets** | **6.5** | **8.0** | **1.4** |
| | **Capital and Reserves** | | | |
| 243.9 | Public Dividend Capital | 245.5 | 246.0 | 0.5 |
| (375.2) | Income and expenditure reserve | (381.6) | (381.6) | 0.0 |
| (6.4) | Income and expenditure account - current year | (3.8) | (2.8) | 1.0 |
| 146.5 | Revaluation reserve | 146.5 | 146.5 | 0.0 |
| **8.7** | **Total Capital and Reserves** | **6.5** | **8.0** | **1.4** |

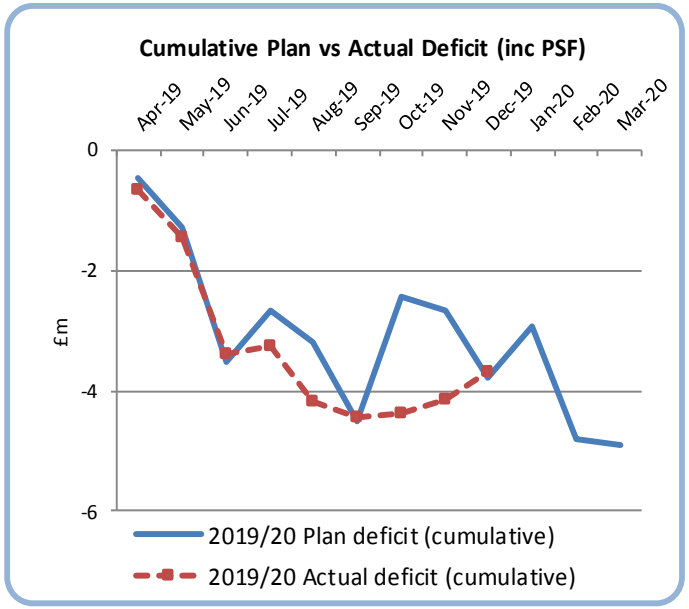
## Statement of Financial Position

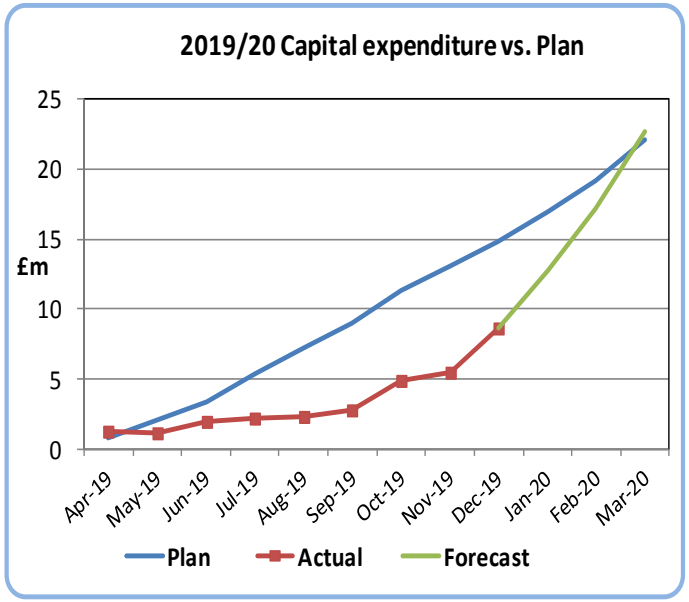
### Assurances

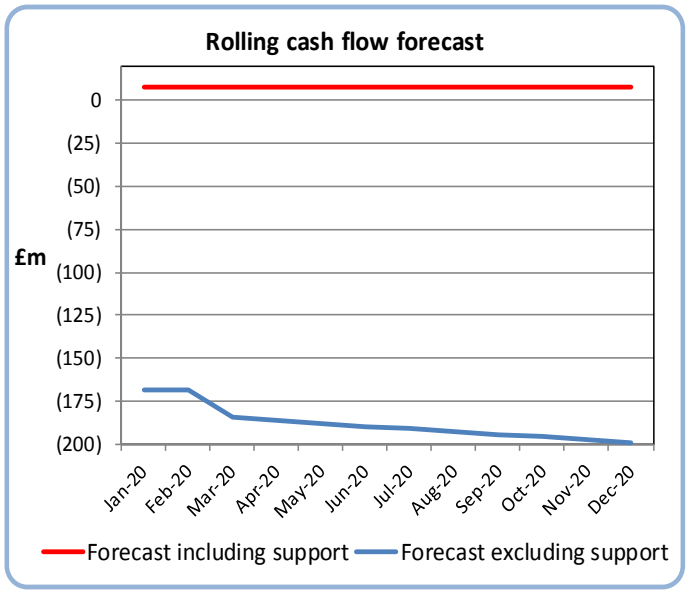
The Trust has repaid net loan financing for the year to date of £2.0m in line with plan. This brings total borrowing from the DOH to £176.3m.The Trust ended the month with a cash balance of £23.68m, compared with a plan of £8.0m. This higher balance is partly due to £8.3m of year to date slippage on the capital expenditure plan, along with 2018/19 over performance monies received in year.

### Key Issues

The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for the year which is 78% by volume of payments made within 30 days against the target of 95%. By value the performance is 84% (86% excluding NHS). The focus going into 2019/20 continues to be on improving payments to achieve the BPPC, achieving the remaining capital plan, reducing the level of outstanding debts and ensuring cash financing is available to achieve the Trusts' objectives.




| Weighting | Metric | Year to date | Forecast |
|---|---|---|---|
| 0.2 | Capital service cover rating | 4 | 4 |
| 0.2 | Liquidity rating | 4 | 4 |
| 0.2 | I&E margin rating | 3 | 3 |
| 0.2 | I&E margin: distance from financial plan | 2 | 1 |
| 0.2 | Agency rating | 2 | 2 |
| | **Overall finance risk rating** | **3** | **3** |

## Rolling Cash Forecast, In-year Surplus/Deficit, Capital Programme Expenditure and Financial Risk Ratings

The overall financial position shows a £3.7m deficit, £0.1m favourable to plan.

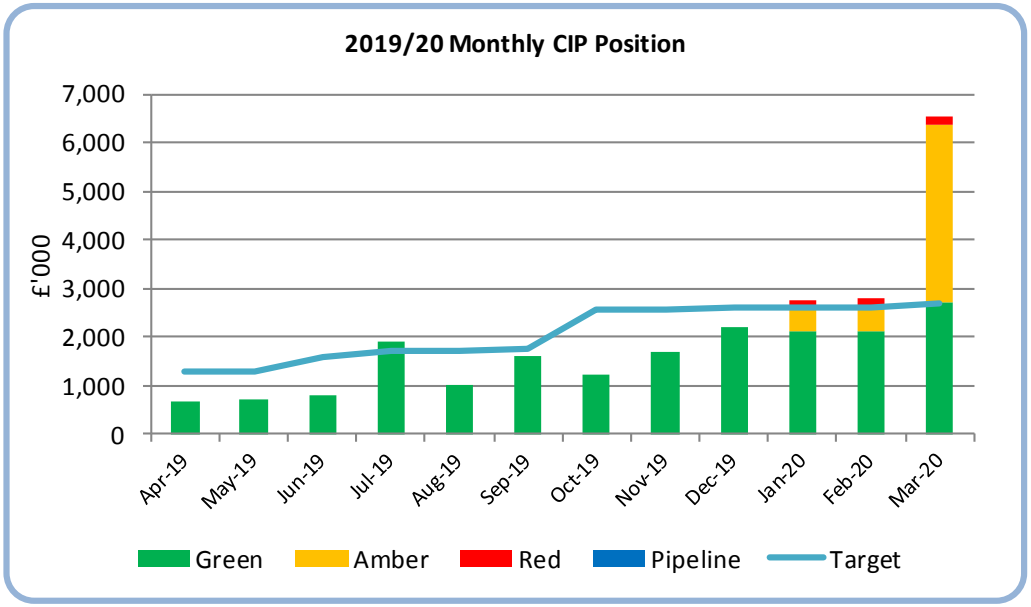
The capital expenditure for the year to date is £8.6m. Whilst there is currently slippage of capital spend there work is underway to ensure that the plan is delivered. The revised capital expenditure forecast for 2019/20 is £22.7m.

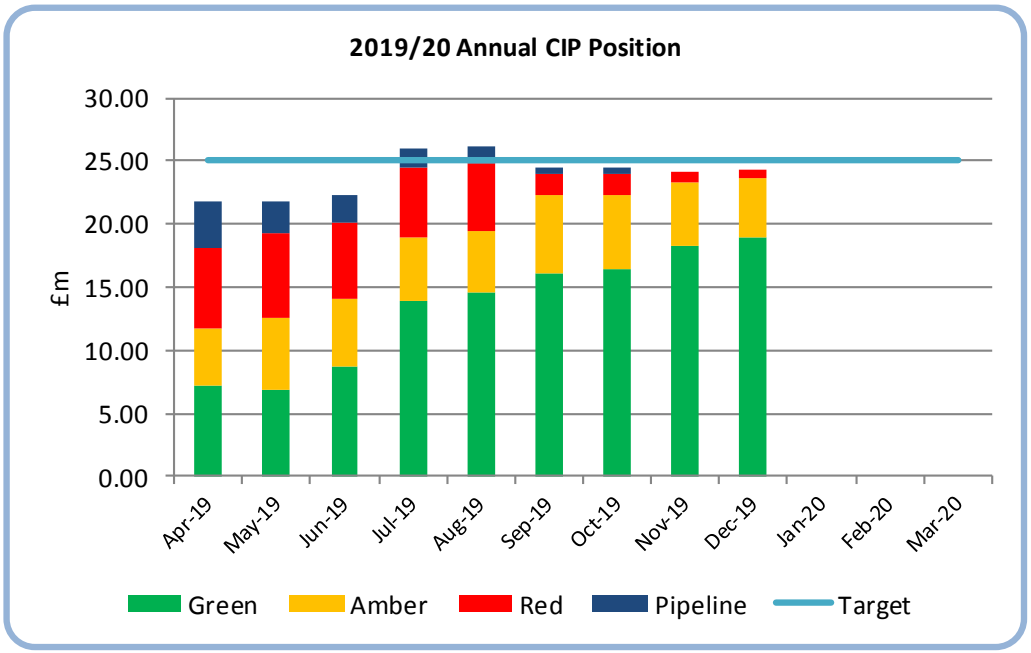
## Assurances and Actions

- Ongoing monitoring of capital expenditure with project leads.
- Cash for our planned deficit for the year to date has been made available to the Trust via DH borrowing.

## Concerns & Gaps

The Trust has a forecast rating of 3 out of 4 (a score of 1 is the best) in the overall finance risk rating metric.




## Savings

## Assurances

The savings target for 2019/20 is £25m against which £24.3m has been identified as at the end of December.

## Concerns & Gaps

The graph shows the phased forecast in-year delivery of the £24.3m identified schemes. £23.7m of these are rated as green or amber.

Savings delivery is £11.8m as at the end of December, £5.3m adverse against a plan of £17.1m.

Of the £24.3m identified savings in 2019/20, £15m is recurrent with a full year effect of £18.4m.

## Actions Planned

Maintain focus on identifying opportunities and improving the rate at which ideas and opportunities are turned into full plans for delivery.

Continued monitoring of actions required to deliver identified savings for 2019/20.

NHS North Bristol NHS Trust

# Regulatory

# Board Sponsor: Chief Executive
# Andrea Young

# Monitor Provider Licence Compliance Statements at December 2019
## Self-assessed, for submission to NHSI

| Ref | Criteria | Comp (Y/N) | Comments where non compliant or at risk of non-compliance |
|---|---|---|---|
| G4 | Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions) | Yes | A Fit and Proper Person Policy is in place.<br>All Executive and Non-Executive Directors have completed a self assessment and no issues have been identified. Further external assurance checks have been completed on all Executive Directors and no issues have been identified. |
| G5 | Having regard to monitor Guidance | Yes | The Trust Board has regard to NHS Improvement guidance where this is applicable. |
| G7 | Registration with the Care Quality Commission | Yes | CQC registration in place. The Trust received a rating of Good from its inspection reported in September 2019. A number of mandatory actions were identified which are being addressed through an action plan. The Trust will receive updates on these actions via its Quality and Risk Management Committee. |
| G8 | Patient eligibility and selection criteria | Yes | Trust Board has considered the assurances in place and considers them sufficient. |
| P1 | Recording of information | Yes | A range of measures and controls are in place to provide internal assurance on data quality. Further developments to pull this together into an overall assurance framework are planned through strengthened Information Governance Assurance Group. |
| P2 | Provision of information | Yes | The trust submits information to NHS Improvement as required. |
| P3 | Assurance report on submissions to Monitor | Yes | Scrutiny and oversight of assurance reports to regulators is provided by Trust's Audit Committee and other Committee structures. |
| P4 | Compliance with the National Tariff | Yes | NBT complies with national tariff prices. Scrutiny by CCGs, NHS England and NHS Improvement provides external assurance that tariff is being applied correctly. |
| P5 | Constructive engagement concerning local tariff modifications | Yes | Trust Board has considered the assurances in place and considers them sufficient. |
| C1 | The right of patients to make choices | Yes | Trust Board has considered the assurances in place and considers them sufficient. |
| C2 | Competition oversight | Yes | Trust Board has considered the assurances in place and considers them sufficient. |
| IC1 | Provision of integrated care | Yes | Range of engagement internally and externally. No indication of any actions being taken detrimental to care integration for the delivery of Licence objectives. |

# Appendix 1: Glossary of Terms

Unless noted on each graph, all data shown is for period up to, and including, 31 December 2019.

All data included is correct at the time of publication.
Please note that subsequent validation by clinical teams can alter scores retrospectively.

**Target lines**
**Improvement trajectories**
**National Performance**

**Upper Quartile**

**Lower Quartile**

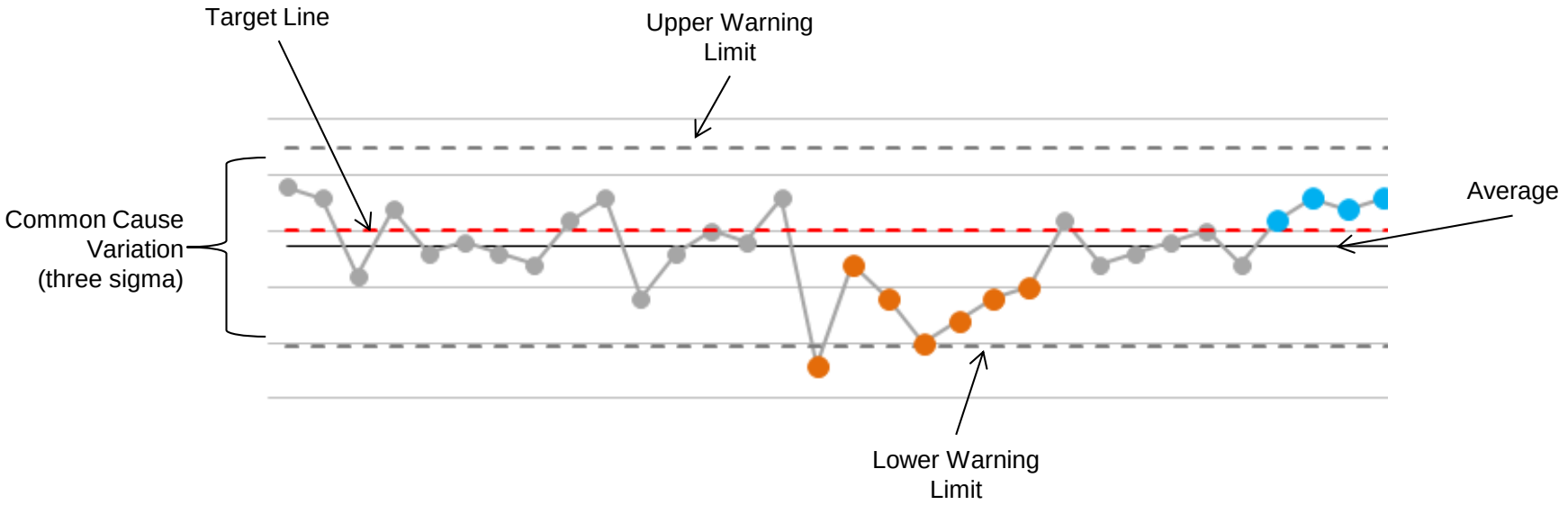
## NBT Quality Priorities 2019/20

| | |
|---|---|
| **QP1** | Supporting patients to get better faster and more safely |
| **QP2** | Meeting the identified needs of patients with Learning Disabilities /Autism |
| **QP3** | Improving our response to deteriorating patients |
| **QP4** | Learning & improving from Patient & Carer feedback (e.g. FFT, complaints, compliments, surveys) |
| **QP5** | Learning & improving from statutory & regulatory quality systems (e.g. incidents, mortality reviews, inquests, legal claims, audits) |

## Abbreviation Glossary

| | |
|---|---|
| **ASCR** | Anaesthetics, Surgery, Critical Care and Renal |
| **ASI** | Appointment Slot Issue |
| **CCS** | Core Clinical Services |
| **CEO** | Chief Executive |
| **Clin Gov** | Clinical Governance |
| **CT** | Computerised Tomography |
| **DTOC** | Delayed Transfer of Care |
| **ERS** | E-Referral System |
| **GRR** | Governance Risk Rating |
| **HoN** | Head of Nursing |
| **IMandT** | Information Management |
| **LoS** | Length of Stay |
| **MDT** | Multi-disciplinary Team |
| **Med** | Medicine |
| **MRI** | Magnetic Resonance Imaging |
| **NMSK** | Neurosciences and Musculoskeletal |
| **Non-Cons** | Non-Consultant |
| **Ops** | Operations |
| **P&T** | People and Transformation |
| **PTL** | Patient Tracking List |
| **RAP** | Remedial Action Plan |
| **RAS** | Referral Assessment Service |
| **RCA** | Root Cause Analysis |
| **SI** | Serious Incident |
| **TWW** | Two Week Wait |
| **WCH** | Women and Children's Health |
| **WTE** | Whole Time Equivalent |

# Appendix 2: Statistical Process Charts (SPC) Guidance




**Orange dots signify a statistical cause for concern.** A data point will highlight orange if it:
A) Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.
B) Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance.
C) Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend.

**Blue dots signify a statistical improvement.** A data point will highlight blue if it:
A) Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance.
B) Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance.
C) Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend.

**Special cause variation** is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.

**Further reading:**
SPC Guidance: https://improvement.nhs.uk/documents/2171/statistical-process-control.pdf
Managing Variation: https://improvement.nhs.uk/documents/2179/managing-variation.pdf
Making Data Count: https://improvement.nhs.uk/documents/5478/MAKING_DATA_COUNT_PART_2_-_FINAL_1.pdf

| | | | | |
|---|---|---|---|---|
| **Report To:** | Trust Board Meeting | | **Agenda Item:** | 14. |
| **Date of Meeting:** | 30 January 2020 | | | |
| **Report Title:** | Audit Committee Report | | | |
| **Report Author & Job Title** | Kate Debley, Deputy Trust Secretary | | | |
| **Executive/Non-executive Sponsor (presenting)** | Jaki Meekings-Davis, Chair of Audit Committee, Non-executive Director | | | |
| **Purpose:** | **Approval/Decision** | **Review** | **To Receive for Assurance** | **To Receive for Information** |
| | **X** | | X | |
| **Recommendation:** | The Trust Board is recommended to receive the report for assurance, and:<br>• note in particular, the new declarations of interest policy; and<br>• Ratify the amendments to the Standing Orders and Standing Financial Instructions. | | | |
| **Report History:** | The report is a standing item to each Trust Board meeting following an Audit Committee meeting. | | | |
| **Next Steps:** | The next report to Trust Board will be to its meeting in April 2020. | | | |

| **Executive Summary** | |
|---|---|
| The report provides assurances received, issues escalated to the Trust Board and any new risks identified from the Audit Committee Meeting held on 22 January 2020. | |
| **Strategic Theme/Corporate Objective Links** | Links to all strategic themes. |
| **Board Assurance Framework/Trust Risk Register Links** | None identified. |
| **Other Standard Reference** | Links to the CQC Well Led domain and key lines of enquiry. |
| **Financial implications** | None within this report. |
| **Other Resource** | No other resource implications associated with this report. |

| | |
|---|---|
| **Implications** | |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | None identified. |
| **Appendices:** | Appendix 1 – Standing Orders & Standing Financial Instructions |

## 1. Purpose

To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Audit Committee meetings held on 22 January 2020.

## 2. Background

2.1. The Audit Committee is a sub-committee of the Trust Board. It meets five times a year and reports to the Board after each meeting. The Committee was established to receive assurance on the Trust's system of internal control by means of independent review of financial and corporate governance, risk management across the whole of the Trust's activities and compliance with law, guidance and regulations governing the NHS.

## 3. Meeting of 22 January 2020

3.1. The Committee received an update on the Trust's plans for managing Conflicts of interest. This included sight of the new declaration of interests policy and process and review of the current register of interests. The Committee:

- Approved the draft policy (this is included in the *reading room*);
- Noted the proposed new declarations process, which was supported by auditors and counter-fraud; and
- Noted the register of interests.

The Committee asked that processes be considered that will strongly encourage compliance by staff, including linking declarations of interest with appraisal and revalidation where appropriate.

3.2. The Trust's external auditors provided a progress report on 2019/20 plan, which is on track with all matters raised in the last audit report having been addressed by management. The Committee discussed the outline work-plan for the 2020/21 plan including audit of 2019/20 accounts, charitable accounts and quality accounts.

3.3. The counter-fraud officer updated on the recent counter-fraud awareness month which involved a lot of positive engagement with staff, and a staff survey, with the results to be included in the counter-fraud annual report. Updates were provided on new referrals and ongoing cases.

3.4. Counter-fraud also presented the outcomes of their review of the overseas visitors function at the Trust. This identified a number of areas where additional training is required for staff, and the need for a formal policy and procedure for overseas patients. Nine recommendations were identified in total which have been accepted by the Trust, with delivery of most actions expected by April 2020 and the final actions by September 2020. This will be revisited by counter-fraud in 2020/21 in the context of the UK's exit from the EU.

3.5. Internal auditors provided an update on the agreed 2019/20 audit plan which is progressing as expected. There was a review of recommendations from previous internal audit reports. This identified that there are no recommendations with "no response", which is an improved position.

3.6. The following internal audit reports were presented:

Embeddedness of Perform (Partial Assurance with improvements required) - the Committee recognised that this report provides a timely opportunity to review and refresh how Perform is used across the organisation. They requested that this report be reviewed in detail by the People & Digital Experience Committee.

Financial Systems (Partial assurance with improvements required) – the Committee were reassured that the recommendations have all been accepted by management and asked that an update on the actions be brought to the next Finance & Performance Committee meeting.

Incident Governance (Partial Assurance with improvements required) – this will be reviewed by Quality & Risk Management Committee.

Incidence Governance – Serious Incidents (Significant assurance with minor improvement opportunities) – this will be reviewed by Quality & Risk Management Committee.

Divisional Management (Significant Assurance with minor improvement opportunities) – this was noted as a very positive report, with evidence that previous recommendations had all be actioned. Recommendations from this review identified some improvement opportunities in the KPIs used within the divisional accountability framework.

Budget Setting & Reporting (Significant assurance with improvement opportunities)

Strategy Refresh (Significant assurance)

Clinical Governance Improvement Programme (Significant assurance) – this will be reviewed at the Quality & Risk Management Committee.

3.7. The Committee received an update on the External Agency Reviews register. The Committee welcomed the emerging register, which will become a standing agenda item, and asked that an additional entry be made to track the NHSI undertakings.

3.8. Updates were received on:

- Single Tender Actions in the last quarter; and
- Losses & Salary Overpayments in the last quarter

The Committee did not identify any areas of concern.

3.9. An update on the Welsh debt position was provided. This showed a significant improvement in both the debt from 2018/19 and 2019/20. Work is ongoing to put in place contracts for activity from key Welsh health boards.

3.10. A number of minor amendments to the Trust's standing orders and standing financial instructions were reviewed and approved, and are recommended to Trust Board for ratification (see *Appendix 1*).

3.11. The Committee discussed STP governance and agreed that there is not yet a clear role for Audit Committee but that this should remain under review. The Committee agreed that the Trust Board obtains an appropriate level of assurance on system matters via the monthly board update from the Chief Executive and the Trust Chair.

## 4. New risks or items for escalation

4.1. No new risks were identified for Trust Board attention.

## 5. Recommendations

5.1. The Trust Board is recommended to receive the report for assurance, and:

- note in particular, the new declarations of interest policy; and
- Ratify the amendments to the Standing Orders and Standing Financial Instructions.

# Trust Standing Orders

North Bristol NHS Trust

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# Foreword to Standing Orders

NHS Trusts are required by law to make Standing Orders (SOs), which regulate the way in which the proceedings and business of the Trust will be conducted. Regulation 19 of the NHS Trusts (Membership and Procedure) Regulations, 1990 (as amended) requires the meetings and proceedings of an NHS trust to be conducted in accordance with the rules set out in the Schedule to those Regulations and with Standing Orders made under Regulation 19(2).

These Standing Orders and associated documents are extremely important. High standards of corporate and personal conduct are essential in the NHS. As the NHS is publicly funded, it is accountable to Parliament for the services it provides and for the effective and economical use of taxpayers' money. The Standing Orders, Standing Financial Instructions, procedures and the rules and instructions made under them provide a framework and support for the public service values which are essential to the work of the NHS of:

- Accountability – the ability to stand the test of Parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- Probity – an absolute standard of honesty in dealing with the assets of the Trust; integrity in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
- Openness – transparency about NHS activities to promote confidence between the organisation and its staff, patients and the public.

Additional documents, which form part of these "extended" Standing Orders are:

- Standing Financial Instructions, which detail the financial responsibilities, policies and procedures to be maintained by the Trust.
- Schedule of Decisions Reserved to the Board of the Trust
- Scheme of Delegated Authorities, which sets out delegated levels of authority and responsibility

These extended Standing Orders set out the ground rules within which Board directors and staff must operate in conducting the business of the Trust. Observance of them is mandatory. Such observance will mean that the business of the Trust will be carried out in accordance with the law, Government policy, the Trust's statutory duties and public service values. As well as protecting the Trust's interests, they will also protect staff from any possible accusation of having acted less than properly.

All executive and Non-Executive Directors and senior staff are expected to be aware of the existence of these documents, understand when they should be referred to and, where necessary and appropriate to their role, make themselves familiar with the detailed provisions.



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# Introduction

I. The North Bristol NHS Trust (the Trust) is a body corporate which was established under The North Bristol National Health Service Trust (Establishment) Order (the Establishment Order), Statutory Instrument number 625, 1999, made on 8th March 1999.

II. The principal place of business of the Trust is Trust Headquarters, Southmead Hospital, BS10 5NB.

III. NHS Trusts are governed by statute, mainly the National Health Service Act 2006 and the Health and Social Care Act, 2012.

IV. The statutory functions conferred on the Trust are set out in the NHS Act 2006 (Chapter 3 and Schedule 4) and in the Establishment Order.

V. As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health. The Trust also has a common law duty as a bailee for property held by the Trust on behalf of patients.

VI. ~~The (DH, revised April 2013) requires that boards draw up a schedule of decisions reserved to the Board and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior managers. The Code of Accountability makes various requirements concerning possible conflicts of interest of Board directors. The Membership and Procedure Regulations, 1990 requires the establishment of audit and remuneration committees with formally agreed terms of reference.~~The Membership and Procurement Regulations required the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individual officers of the Trust, and must establish audit and remuneration committees with formally agreed terms of reference.

VII. ~~The Code of Practice on Openness in the NHS (NHS Executive, 1995), as revised by the~~ The Freedom of Information Act, 2000 and the Environmental Information Regulations, 2004 sets out the requirements for public access to information on the NHS.

VIII. Through these Standing Orders, the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of the Standing Orders; or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Secretary of State for Health may direct.

### *Interpretation*

IX. The Chair of the Trust is the final authority in the interpretation of Standing Orders on which the Chief Executive, guided by the Trust Secretary, shall advise ~~him~~ her and in the case of Standing Financial Instructions by the Director of Finance.

X. The following definitions apply for this document.

Legislation definitions:

- the **2006 Act** is the National Health Service Act, 2006



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- the **2012 Act** is the Health and Social Care Act, 2012



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- **Membership and Procedure Regulations** are the National Health Service Trust (Membership and Procedure) Regulations 1990 (SI(1990)2024), as amended.

Other definitions:

- **Accountable Officer** is the officer responsible and accountable for funds entrusted to the Trust; and is responsible for ensuring the proper stewardship of public funds and assets. The Chief Executive, or their appointed replacement, is the Accountable Officer for this Trust.
- **Budget** is the plan, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
- **Chair of the Trust** is the person appointed by the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall, if the Chair is absent from the meeting or otherwise unavailable, be deemed to include the Vice-Chair of the Trust, or other Non-Executive Director as is appointed in accordance with Standing Order 12.
- **Chief Executive** is the chief officer of the Trust.
- **Committee** is committee appointed by the Trust Board.
- **Committee Members** are formally appointed by the Trust Board to sit on, or to chair specific committees.
- **Clinical Directors** are specialty leads reporting to and accountable to the Chief ~~Executive~~Operating Officer, with professional oversight from the Medical Director. They are ***excluded*** from the term "Director" for the purposes of this document, unless specifically stated otherwise.
- **Directors** are the Non-Executive Directors and the Executive Directors
- **Director of Facilities** is the Director of Estates Facilities and Capital Planning
- **Director of Finance** is the Director of Finance; and is the chief finance officer of the Trust.
- **Establishment Order** is the North Bristol National Health Service Trust (Establishment) Order 1999, Statutory Instrument number 625.
- **Executive Director** is an officer of the Trust. Up to five will be voting members of the Trust Board, appointed in accordance with the Membership and Procedure Regulations, 1990. The remainder will not be eligible to vote on the Trust Board.
- **Funds Held on Trust** are 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 Part 11 (eleven) of the NHS Act 2006. Such funds may or may not be charitable.
- **Motion** is a formal proposition to be discussed and voted on during the course of a Trust Board or Committee meeting.
- **NHS Improvement (NHSI)** is responsible for the oversight of NHS trusts and has delegated authority from the Secretary of State for Health for the



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appointment of the Non-Executive Directors, including the Chair of the Trust

- **Nominated Officer** is the officer charged with the responsibility for discharging specific tasks within the Standing Orders and Standing Financial Instructions.
- **Non-Executive Director** is a person appointed by the Secretary of State for Health, to help the Trust Board to deliver its functions.
- **Officer** (or **staff**) means an employee of the Trust or any other person holding a paid appointment or office with the Trust. (This includes all employees or agents of the Trust, including medical and nursing staff and consultants practising upon the Trust's premises and shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust)..
- **SFIs** are the Standing Financial Instructions.
- **SOs** are the Standing Orders.
- **Standards of Business Conduct** is the Trust's "Policy Standards of Business Conduct, incorporating anti-bribery policy; and the recognition and treatment of conflicting interests, gifts and hospitality" or as amended
- **Trust** is the North Bristol NHS Trust.
- **Trust Board** (or the **Board**) is the Chair and Non-Executive Directors and Executive Directors
- **Trust Secretary** is the officer appointed to provide advice on corporate governance issues to the Board and the Chair; and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance.
- **Vice Chair** means the Non-Executive Director appointed by the Trust to take on the Chair's duties if the Chair is absent for any reason.
- **Working day** means any day, other than a Saturday, Sunday or legal holiday

XI. Any reference to an Act of Parliament, Statutory Instrument, Direction or Code of Practice shall be construed as a reference to any modification, replacement or re-enactment for the time being in force.

XII. All reference to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.



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# Standing Orders for the regulation of the proceedings of North Bristol National Health Service Trust

## Part I – Membership

### 1. *Name and business of the Trust*

1.1. All business shall be conducted in the name of North Bristol NHS Trust ("the Trust").

1.2. All funds received in trust shall be in the name of the Trust as corporate trustee. The powers exercised by the Trust as corporate trustee, in relation to funds held on trust, shall be exercised separately and distinctly from those powers exercised as a Trust.

1.3. The Trust has the functions conferred on it by Schedule 4 of the 2006 Act.

1.4. Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Secretary of State for Health. Accountability for non-charitable funds held on trust is only to the Secretary of State for Health.

1.5. The Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session, which may include members participating by video or telephone. These powers and decisions are set out in the Schedule of Decisions Reserved for the Trust Board in Appendix 1 to these Standing Orders and have effect as if incorporated into the Standing Orders.

### 2. *Composition of the Trust Board*

2.1. The voting membership of the Trust Board shall comprise the Chair and six Non-Executive Directors, together with up to five Executive Directors. At least half of the voting membership of the Trust Board, excluding the Chair, shall be independent Non- Executive Directors.

2.2. In addition to the Chair, the Non-Executive Directors shall normally include:

2.2.1. one appointee nominated to be the Vice-Chair

2.2.2. one appointee nominated to be the (shadow) Senior Independent Director. ~~This role will become fully established once the Trust has achieved Foundation Trust status~~

2.2.3. in accordance with the Establishment Order, one appointee from the University of Bristol, in recognition of the Trust's status as a teaching hospital

2.2.4. one or more appointees who have recent relevant financial experience.

~~2.2.4.~~ Appointees can fulfil more than one of the roles identified.

**Comment [XB1]:** May need to amend this i the event that Associate Non-Executive Directors are recruited.

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2.3. The Executive Directors shall include:

- 2.3.1. Chief Executive
- 2.3.2. Director of Finance, or equivalent
- 2.3.3. Medical Director
- 2.3.4. Director of Nursing, or equivalent
- 2.3.5. Chief Operating Officer

2.4. The Board may appoint additional Executive Directors, in crucial roles in the Trust, to be non-voting members of the Trust Board.

## *3. Appointment of the Chair and directors*

3.1. The Chair and Non-Executive Directors of the Trust are appointed by the NHSI, on behalf of the Secretary of State for Health.

3.2. The Chief Executive shall be appointed by the Chair and the Non-Executive Directors.

3.3. Executive Directors shall be appointed by a committee comprising the Chair, the Non-Executive Directors and the Chief Executive.

3.4. Where more than one person is appointed jointly to an Executive Director post in the Trust, those persons shall become appointed as an Executive Director, jointly. Where the post has voting rights attached, the joint appointees will have the power of one vote; and shall count for the purpose of Standing Order 2 as one person.

## *4. Vice-Chair*

4.1. To enable the proceedings of the Trust to be conducted in the absence of the Chair, the Trust Board may elect one of the Non-Executive Directors to be Vice- Chair, for a period that does not exceed the remainder of their appointed term as a Non-Executive Director of the Trust.

4.2. Any Non-Executive Director so elected may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair. The appointment as Vice- Chair will end with the termination for any reason of that Non-Executive Director's period of office as a director. On such resignation or termination the Trust Board may then appoint another Non-Executive Director as Vice-Chair, in accordance with the provision of this Standing Order.

4.3. When the Chair is unable to perform his duties due to illness or absence for any reason, ~~his~~ her duties will be undertaken by the Vice-Chair.

## *5. Tenure of office*

5.1. The regulations governing the period of tenure of office of the Chair and Non-Executive Directors and the termination or suspension of office of the Chair and Non-Executive Directors are contained in the Membership and Procedure Regulations



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and as directed by NHSI, under its delegated authority from Secretary of State for Health.

### *6. Code of Conduct and Accountability and the Trust's commitment to openness*

6.1. All directors shall subscribe and adhere at all times to the principles contained in the Trust's "Policy Standards of Business Conduct~~, incorporating anti-bribery policy; and the recognition and treatment of conflicting interests, gifts and hospitality~~" (the Policy Standards of Business Conduct) and any other relevant Trust policies.

### *7. Functions and roles of Chair and directors*

7.1. The function and role of the Chair and members of the Trust Board is described within these Standing Orders and within those documents that are incorporated into these Standing Orders.

## Part II – Meetings

### *8. Ordinary meetings of the Trust Board*

8.1. All ordinary meetings of the Trust Board shall be held in public and shall be conducted in accordance with relevant legislation, including the Public Bodies (Admission to Meetings) Act 1960, as amended and guidance issued by the Secretary for State for Health. Members of the public and representatives of the press shall be afforded facilities to attend.

8.2. Ordinary meetings of the Trust Board shall be held at regular intervals at such times and places as the Trust Board may from time to time determine. A minimum of six meetings shall be held each year.

8.3. The Chair shall give such directions as she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press; to ensure that the Trust Board's business may be conducted without interruption and disruption.

8.4. Without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and representatives of the press will be required to withdraw upon the Trust Board resolving as follows: "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"

8.5. Business proposed to be transacted when the press and public have been excluded from a meeting as provided in Standing Order 8.4, shall be confidential to members of the Board.

8.6. Members and Officers or any employee or representative of the Trust in attendance at a private meeting or private part of a meeting, shall not reveal or disclose the contents of papers, discussions or minutes of the items taken in private, outside of the Trust Board meetings without the express permission of the Trust Board.



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8.7. Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Trust Board.

8.8. The Chair may invite any member of staff of North Bristol NHS Trust, any other NHS organisation, an officer of the local council(s), or any other individual acting in an advisory capacity to attend meetings. These invitees shall not count as part of the quorum or have any right to vote at the meeting.

8.9. An annual public meeting shall be held on or before 30th September in each year for the purpose of presenting audited accounts, annual reports and any report on the accounts.

8.10. The Trust Board may, by resolution, exclude the public from a part or the whole of a meeting whenever publicity would be prejudicial to public interest by reason of the confidential nature of the business to be transacted

8.11. The provisions of these Standing Orders relating to meetings of the Trust Board shall refer only to formal Trust Board meetings, whether ordinary or extraordinary meetings. The provisions shall not apply to seminars or workshops or other meetings attended by members of the Trust Board.

## *9. Extraordinary meetings of the Trust Board*

9.1. The Chair may call a meeting of the Trust Board at any time. Directors may ask the Chair to call a meeting of the Trust Board at any time.

9.2. A meeting may be called forthwith, by the directors who are eligible to vote, if the Chair refuses to call a meeting after such a request has been presented to ~~him~~her, signed by at least one third of the whole number of directors who are eligible to vote (including at least one executive and one Non-Executive Director); and has been presented to ~~him~~ her at the Trust's principal place of business. The directors who are eligible to vote may also call a meeting forthwith, if, without refusing, the Chair does not call a meeting within seven days after receipt of such request.

## *10. Notice of meetings*

10.1. The Trust shall set dates and times of regular Trust Board meetings for the forthcoming calendar year by the end of November of each year.

10.2. A notice of the meeting, specifying the business proposed to be transacted, shall be posted before each meeting of the Trust Board. This notice shall be signed by the Chair, or by a director or officer of the Trust authorised by the Chair to sign on his behalf. The notice shall be delivered to every director, by the most effective route, including being sent by post to the usual place of residence of the director, ~~or~~ sent electronically to the usual e-mail address of the director, or circulated via an agreed online board paper portal. The notice shall be delivered to each director at least three working days before 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.

10.3. Lack of service of such notice on any individual director shall not affect the validity of a meeting. However, failure to serve such a notice on at least three directors who are eligible to vote will invalidate the meeting.

10.4. In the case of a meeting called by directors in default of the Chair, see Standing Order 9, the notice shall be signed by those directors and no business shall be



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transacted at the meeting other than that specified in the notice.

10.5. Where a part or the whole of a meeting is to be open to the public, official notice of the time, place and agenda of the meeting shall be announced in public. Notice will be given by one or more of: an announcement in the local press, on the Trust's internet website, displaying the notice in a conspicuous place in the Trust's hospitals or other facilities, or displaying the notice in other public places. The Trust Board may decide to limit publication to details of the items on the meeting agenda that will be considered in the part of the meeting to be held in public. A copy of the notice including the agenda may also be sent to local organisations that will have an interest in the decisions of the Trust Board. These organisations include bodies responsible for commissioning acute NHS services locally, patient and public representative groups and local councils.

10.6. Notice will be given at least three working days before the meeting. Failure to do so will render the meeting invalid.

## *11. The agenda and Supporting Papers*

11.1. The Trust Board may determine that certain matters will appear on every agenda for an ordinary meeting of the Trust Board; and that these will be addressed prior to any other business being conducted at the discretion of the Chair. On agreement by the Trust Board, these matters may change from time to time.

11.2. A director may request that a matter is included on an agenda. This request should be made in writing, including by electronic means, to the Chair, Chief Executive, or the Trust Secretary at least seven working days before the meeting, subject to Standing Order 10. Requests made less than seven working days before the meeting may be included on the agenda at the discretion of the Chair, or to the extent that this discretion is delegated to the Chief Executive and the Trust Secretary.

11.3. Notwithstanding Standing Order 17 a director may with the consent of the Chair of the meeting, add to the agenda of any meetings any item of business relevant to the responsibilities of the Trust, under "Any Other Business".

11.4. The Agenda will be sent to Directors five working days before the meeting and supporting papers, whenever possible, shall accompany the Agenda but will certainly be despatched no later than three clear working days before the meeting, save in an emergency.

## *12. Chair of meetings*

12.1. The Chair shall preside at any meeting of the Trust Board, if present. In ~~his~~ her absence, the Vice Chair shall preside.

12.2. If the Chair and Vice-Chair are absent, the directors present, who are eligible to vote shall choose a Non-Executive Director who shall preside. An Executive Director may not take the chair.

12.3. The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and ~~his~~ her interpretation of the Standing Orders shall be final. In this interpretation she shall be advised by the Chief Executive and the Trust Secretary and in the case of Standing Financial Instructions she shall be advised by the Director of Finance.



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## 13. Voting

13.1. It is not a requirement for decisions to be subject to a vote. The necessity of a vote shall be indicated by the agreement of at least one third of those attending and eligible to vote. The Chair shall be responsible for deciding whether a vote is required and what form this will take.

13.2. Where it is necessary to take a vote to determine an issue, the decision shall be determined by a majority of the votes of the directors present and eligible to vote. If the result of the vote is equal, the Chair of the meeting shall have a second or casting vote.

13.3. 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 be held, if a majority of the directors present and eligible to vote so request. Unless specifically agreed beforehand, the voting record of each individual director in a paper ballot will not be made public, or recorded.

13.4. The voting record, other than by paper ballot, of any question will be recorded to show how each director present voted or did not vote, if at least one-third of the directors present and eligible to vote so request.

13.5. If a director so requests, his vote will be recorded by name. Such a request will not be accepted if doing so would reveal the votes of other directors that do not wish to have their vote recorded.

13.6. In no circumstances may an absent director vote by proxy.

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

13.8. Where the office of a director who is eligible to vote is shared jointly by more than one person:

- 13.8.1. either or both of those persons may attend and take part in the meetings of the Trust Board.
- 13.8.2. if both are present at a meeting they will cast one vote if they agree.
- 13.8.3. in the case of disagreement no vote will be cast.
- 13.8.4. the presence of either or both of those persons will count as the presence of one person for the purpose of establishing a quorum.

13.9. 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.



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## 14. Quorum

14.1. No business shall be transacted at a meeting unless at least six of the directors who are eligible to vote (including at least three Executive Director with voting powers and three Non-Executive Director) are present

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

14.3. A director will not count towards the quorum on a matter where he is ruled to be ineligible to participate in the discussion, or vote, due to the declaration of a conflict of interest, see Standing Order 21 and 22. If a quorum is not available for the passing of a resolution on any matter, that matter may be discussed further at the meeting, but no resolution can be made. That position shall be recorded in the minutes of the meeting. The meeting shall then proceed to the next business.

## 15. Record of attendance

15.1. The names of the directors and others invited by the Chair, in accordance with Standing Order 8, present at the meeting, shall be recorded in the minutes.

15.2. 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.

## 16. Minutes

16.1. The minutes of the proceedings of a meeting shall be drawn up, entered in a record kept for that purpose and submitted for agreement at the next meeting.

16.2. There should be no discussion on the minutes, other than as regards their accuracy, unless the Chair considers discussion appropriate.

16.3. Any amendment to the minutes as to their accuracy shall be agreed and recorded at the next meeting and the amended minutes shall be regarded as the formal record of the meeting.

## 17. Notice of motion

17.1. Subject to the provision of Standing Order 20, a director of the Trust desiring to move a motion shall give notice of this, to the Chair, at least seven working days before the meeting. The Chair shall insert all such notices that are properly made in the agenda for the meeting. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

## 18. Motions

18.1. When a motion is under discussion or immediately prior to the discussion it shall be open to a director to move:

18.1.1. an amendment to the motion.

18.1.2. the adjournment of the discussion or the meeting.



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18.1.3. that the meeting proceed to the next business.

18.1.4. the appointment of an ad hoc committee to deal with a specific item of business.

18.1.5. that the motion be now put

18.1.6. a motion resolving to exclude the public (including the press).

18.2. The proposer may withdraw a motion or amendment once moved and seconded with the concurrence of the seconder and the consent of the Trust Board.

## *19. Right of reply*

19.1. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment to it.

## *20. Motion to rescind a decision of the Trust Board*

20.1. Notice of a motion to rescind any decision of the Trust Board (or general substance of any decision) which has been passed within the preceding six calendar months, shall bear the signature of the director who gives it and also the signature of four other directors who are eligible to vote.

20.2. When the Trust Board has debated any such motion, it shall not be permissible for any director, other than the Chair to propose a motion to the same effect within a further period of six calendar months.

## *21. Declaration of Interests and Register of Interests*

### Declaration of Interests

21.1. In addition to the statutory requirements relating to pecuniary interests dealt with in Standing Order 22, the Trust's Policy Standards of Business Conduct requires directors to declare interests which are relevant and material to the Trust Board. All existing directors and any senior officers who may act up into an Executive Director post should declare such interests on an annual basis, or as otherwise recommended in the Policy. Any directors and senior officers appointed subsequently should declare these interests on appointment.

**Comment [XB2]:** Will need to be updated once new CoI policy is approved.

21.2. Interests, which would be regarded as "relevant and material", are:

21.2.1. directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).

21.2.2. ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

21.2.3. majority or controlling share-holdings in organisations likely or possibly seeking to do business with the NHS.

21.2.4. a position of authority in a charity or voluntary organisation in the field of health and social care.



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21.2.5. any connection with a voluntary or other organisation contracting for NHS services.

21.3. Subject to the requirements stated in Standing Order 22, the interests of directors' spouses, partners, or other family members must be disclosed where these maybe in conflict with the Trust.

21.4. If directors have any doubts about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust Secretary. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that the potential level of influence, rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

21.5. Annual declarations of interests should be considered by the Trust Board and retained as part of the record of the Trust Board meeting. Any changes in interests should be declared at the next Trust board meeting following the change occurring.

21.6. If a conflict of interest is established during the course of a Trust Board meeting, whether arising from a declared interest or otherwise, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The declared conflict of interest should be recorded in the minutes of the meeting. When a Director has declared an interest arising solely from a position with a charity or voluntary body under this Standing Order, the Trust Board may resolve that the director may remain in the meeting and take part in the discussion, but not vote on the relevant item. A record of this decision shall be made in the minutes.

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

### Register of Interests

21.8. The Trust Secretary will ensure that a Register of Interests is established and maintained to record formally declarations of interests of directors. The Register of Interests will include details of all directorships and other relevant and material interests which have been declared by both executive and Non-Executive Directors.

21.9. These details will be kept up to date by means of an annual review of the Register of Interests in which any changes to interests declared during the preceding twelve months will be incorporated.

21.10. The Register of Interests will be available to the public and open to inspection at the Trust's usual place of business at any time during normal business hours (between 09:00am and 17:00pm on any working day).

21.11. With the exception of the requirement to report interests in the Annual Report (Standing Order 21.7), 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).



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### *22. Disability of directors in proceedings on account of pecuniary interest*

22.1. Subject to Standing Order 21 and the provisions of this Standing Order, if 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, he shall at the meeting and 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.

22.2. The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this Standing Order, in any case where it appears to him to be in the interests of the NHS that the disability should be removed.

22.3. The Trust Board, or any committee or sub-committee may, if it thinks fit, provide for the exclusion of a director from a meeting while any contract, proposed contract or other matter in which that person has a pecuniary interest, direct or indirect, is under consideration.

22.4. Any remuneration, compensation or allowances payable to a director by virtue of paragraph 233, Part 11 of the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

22.5. For the purpose of this Standing Order a director shall be treated, subject to Standing Order 2 as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

22.5.1. he, or a nominee of his, 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,

22.5.2. he is a partner 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;

22.5.3. and in the case of persons living together as a couple, whether married or not, the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

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

22.6.1. of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body;

22.6.2. of an interest in any company, body or person with which he is connected as mentioned in Standing Order 22.5 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.



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22.7. This Standing Order shall not prohibit a director from taking part in the consideration or discussion of the contract or other matter, or from voting on any question with respect to it, if:

22.7.1. he 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**

22.7.2. 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**

22.7.3. 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 the class.

This does not affect his duty to disclose the interest

22.8. 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).

## *23. Standards of Business Conduct*

23.1. All staff must comply with the Trust's current adopted Policy Standards of Business Conduct, which reflects national guidance, including ~~HSG(93)5 'Standards of Business Conduct for NHS staff', 'Code of Conduct for NHS Managers' 2002 and~~ the seven principles set out by the Committee on Standards in Public Life, published by the Professional Standards Authority, November 2012. The following provisions should be read in conjunction with the Trust Policy.

**Comment [XB3]:** Needs to be updated to include new CoI policy once approved.

23.2. All staff shall declare any relevant and material interest, such as those described in Standing Order 21. The declaration should be made on appointment or, if the interest is acquired, or recognised subsequently, at that time to the Executive Director, clinical director, or senior manager to whom they are accountable. Such director or senior manager shall ensure that such interests are entered in a Register of Interests, kept for that purpose.

23.3. Officers who are involved in, have responsibility for, or are able by virtue of their role or functions to influence ~~the placing of contracts by the~~the expenditure of taxpayer monies ~~Trust~~, may be required by the Trust to give statements from time to time, or in connection with particular contracts, confirming that they have no relevant or material interest to declare.

23.4. If an officer becomes aware of a potential or actual contract in which he has an interest of the nature described in Standing Orders 21 and 22 and this Standing Order, he shall immediately advise the Director of Finance formally in writing. This requirement applies whether or not the officer is likely to be involved in administering the proposed, or awarded contract to which he has an interest.

23.5. Gifts and hospitality shall only be accepted in accordance with the Trust's Policy Standards of Business Conduct. Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value.

**Comment [XB4]:** Needs to be updated to reference new CoI policy once approved.

23.6. All gifts and hospitality, other than those that are of clearly minimal value (as determined in the Trust Policy Standards of Business Conduct), should be declared in

**Comment [XB5]:** As above



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a Register of Gifts and Hospitality kept by the Chief Executive~~, and departmental managers~~ and Trust Secretary for that purpose. Acceptance of gifts by way of inducements or rewards is a criminal offence under the Fraud Act, 2006 and the Bribery Act 2010.

23.7. In addition to Standing Orders 21 and 22 and this Standing Order, an officer must also declare to the Chief Executive or Trust Secretary any other employment, business or other relationship of his, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with interests of the Trust, unless specifically allowed under that officer's contract of employment.

## Part III – Arrangements for the exercise of functions by delegation and committees

### *24. Exercise of functions*

24.1. Subject to Standing Order 3 and any such directions as may be given by the Secretary of State for Health, the Trust Board may delegate any of its functions to a committee or sub-committee appointed by virtue of Standing Order 25, or to a director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the board thinks fit.

#### Emergency powers

24.2. The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair acting jointly and, if possible, after having consulted with at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Trust Board for ratification.

#### Delegation to committees

24.3. The Trust Board shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The Trust Board shall approve the constitution and terms of reference of these committees and their specific powers.

#### Delegation to officers

24.4. Those functions of the Trust, which have not been retained as reserved by the Trust Board or delegated to a committee of the Trust Board, shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive shall determine which functions she will perform personally and shall nominate officers to undertake the remaining functions for which he will still retain accountability to the Trust Board.



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### Schedule of Decisions Reserved for the Trust Board

24.5. The Trust Board shall adopt a Schedule of Decisions Reserved for the Trust Board setting out the matters for which approval is required by the Trust Board. The Schedule that is current at the date of adoption of these Standing Orders is contained in Appendix 1 and shall be regarded as forming part of these Standing Orders.

24.6. Subject to Standing Order 44, the Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule in Appendix 1 after each review.

24.7. The Schedule of Decisions Reserved for the Trust Board shall take precedence over any terms of reference or description of functions of any committee or sub-committee established by the Trust Board. The powers and functions of any committee or sub-committee shall be subject to and qualified by the reserved matters contained in that Schedule.

### Scheme of Delegated Authorities

24.8. The Trust Board shall adopt a Scheme of Delegated Authorities setting out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters; and in a director's or officer's absence, the director or officer who may act for them. The Schedule that is current at the date of adoption of these Standing Orders is contained in Appendix 3 and shall be regarded as forming part of these Standing Orders

24.9. Subject to Standing Order 44, the Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule in Appendix 3 after each review.

24.10. The direct accountability, to the Trust Board, of the Director of Finance and other Executive Directors to provide information and advise the Trust Board in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities.

## *25. Appointment of committees*

25.1. Subject to Standing Order 3 and such directions as may be given by, or on behalf of, the Secretary of State for Health, the Trust may, and if directed by him, shall appoint committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust. Committees will be subject to review by the Trust Board from time to time.

25.2. A committee appointed under Standing Order 25 may, subject to such directions as may be given by, or on behalf of, the Secretary of State for Health or the Trust Board, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the committee (whether or not they include directors of the Trust).

25.3. The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration, to meetings of any committee or sub-committee.



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25.4. The Trust Board shall approve the terms of reference of each such committee. Each committee shall approve the terms of reference of each sub-committee reporting to it. The terms of reference shall include details of the powers vested and conditions, including reporting back to the committee, or Trust Board. Such terms of reference shall have effect as if incorporated into the Standing Orders and be subject to review every two years, at least, by that committee; and adoption by the Trust Board.

25.5. Committees may not delegate their powers to a sub-committee unless expressly authorised by the Trust Board.

25.6. The Board shall approve the appointments to each of the committees and sub-committees that it has formally constituted. Where the Board determines that a committee shall include members who are neither directors nor officers, the Board shall determine the terms of such appointment. The payment of travelling and other allowances shall be in accordance with the rates as may be determined by the Secretary of State for Health, with the approval of the Treasury (see Part 11, paragraph 233 of the 2006 Act).

25.7. Minutes, or a representative summary of the issues considered and decisions taken, of any committee appointed under this Standing Order are to be formally recorded and submitted for inclusion onto the agenda of the next possible Trust Board meeting. Minutes, or a representative summary of the issues considered and decisions taken of any sub-committee shall be submitted for inclusion onto the agenda of the next committee meeting to which it reports.

25.8. The committees to be established by the Trust will consist of statutory and mandatory; and non-mandatory committees.

### Statutory and Mandatory Committees

**Role of Audit Committee**

25.9. The Trust Board shall appoint a committee to undertake the role of an audit committee. This role shall include providing the Trust Board with a means of independent and objective review of the financial systems and of general control systems that ensure that the Trust achieves its objectives, the reliability of the financial information used by the Trust and of compliance with law, regulations, guidance and codes of conduct. This Committee will pay due regard to good practice guidance, including, in particular, the NHS Audit Committee Handbook.

25.10. The terms of reference of the Audit Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

**Role of Auditor Panel**

25.11. The Trust Board shall nominate its Audit Committee to act as its Auditor Panel in line with schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

25.12. The Auditor panel shall advise the Trust Board on the selection and appointment of the external auditor.

25.13. The terms of reference of the Auditor Panel shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust


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Board.

**Role of Remuneration and Nominations Committee**

25.14. The Trust Board shall appoint a committee to undertake the role of a remuneration and nominations committee. This role shall include providing advice to the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (Regulations 17-18, Membership and Procedure Regulations), as well as advising the Trust Board on the terms of service of other senior officers, and ensuring that the policy of the Trust Board on remuneration and terms of service is applied consistently.

25.15. The Committee shall advise the Trust Board on the size, structure and membership and succession plans for the Trust Board and maintain oversight of the performance of the Chief Executive and Executive Directors.

25.16. The terms of reference of the Remuneration and Nominations Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

**Charity Committee**

25.17. The Trust Board, acting as Corporate Trustee, shall appoint a Committee to be known as the Southmead Hospital Charity Committee~~-~~, whose role shall be to advise the Trust on the appropriate receipt, use and security of charitable monies.

25.18. The terms of reference of the Southmead Hospital Charity Committee shall have effect as if incorporated into these Standing Orders and shall be recorded in the appropriate minutes of the Trust Board, acting as Corporate Trustee, and may be varied from time to time by resolution of the Trust Board, acting in this capacity.

Non mandatory committees

25.19. The Trust Board shall appoint such additional non-mandatory committees as it considers necessary to support the business and inform the decisions of the Trust Board (Regulations 15-16, Membership and Procedure Regulations).

25.20. The terms of reference of these committees shall have effect as if incorporated into these Standing Orders. The approval of the terms of reference shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

25.21. The membership of these committees may comprise Non-Executive Directors or Executive Directors, or a combination of these. The membership and voting rights shall be set out in the terms of reference of the committee and shall be subject to approval by the Board.

25.22. The current non-mandatory committees in place are (October 2018):

- Quality and Risk Management Committee
- Finance and Performance Committee
- ~~Trust Management Team~~
- ~~Workforce~~ People and Digital Committee
- Patient and Carer Experience Committee

These are subject to change at the discretion of the Trust Board. All new~~,~~ or amended



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non-mandatory committees will have the same standing and will be subject to the same standing orders.



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### *26. Proceedings in committee to be confidential*

26.1. There is no requirement for meetings of Trust Board committees and sub-committees to be held in public, or for agendas or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act, 2000 and there is no legal justification for non-disclosure.

26.2. Committee members should normally regard matters dealt with, or brought before the committee as being subject to disclosure, unless stated otherwise by the Chair of the committee. The Chair shall determine whether specific matters should remain confidential until they are reported to the Trust Board.

26.3. A director of the Trust or a member of a committee shall not disclose any matter reported to the Trust Board, or otherwise dealt with by the committee if the Trust Board resolves that it is confidential.

26.4. Regardless of this Standing Order 26, individual directors and officers of the Trust have a right and a duty to raise with the Trust any matter of concern they may have about health service issues concerned with the delivery of care or services.

### *27. Election of Chair of committee*

27.1. Each committee shall appoint a Chair; and may appoint a vice-Chair from its membership. The terms of reference of the committee shall describe any specific rules regarding who the Chair should be. Meetings of the committee will not be recognised as quorate, if the Chair, or vice Chair, or other suitably qualified, nominated member of the committee is not present to undertake the role.

27.2. Each committee shall review the appointment of its Chair, as part of the annual review of the committee's role and effectiveness.

### *28. Special meetings of committee*

28.1. The Chief Executive shall require any committee to hold a special meeting, on the request of the Chair, or on the request, in writing of any two members of that committee.

## Part IV – Custody of seal and sealing of documents

### *29. Custody of seal*

29.1. The common seal of the Trust shall be kept by the Chief Executive in a secure place.

### *30. Sealing of documents*

30.1. The Seal of the Trust shall only be attached to documents where the sealing has first been approved by the Trust Board, or the Chair, or the Chief Executive, or their designated acting replacement, in accordance with the Scheme of Delegated Authorities.



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30.2. The seal shall be affixed in the presence of the signatories.

### *31. Bearing witness to the affixing of the Seal*

31.1. A recommended wording for the witnessing of the use of the Seal is “The Common Seal of the North Bristol National Health Service Trust was hereunto affixed in the presence of….”

### *32. Register of sealing*

32.1. An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose. The entry shall be signed by the persons who approved and authorised the sealing of the document; and who attested the seal.

32.2. A report of all sealing shall be made to the Trust Board, or a committee delegated to oversee the register at periods of its discretion. The report shall contain details of the seal number, the description of the document and date of sealing.

## Part V – Appointment of directors and officers of the Trust

### *33. Canvassing of, and recommendations by, directors*

33.1. Canvassing of any director of the Trust or member of a committee of the Trust directly or indirectly for any appointment under the Trust, shall disqualify the candidate from such appointment. Where the Chair or any such director or committee member is so canvassed he shall notify the Chief Executive in writing. The purpose of this Standing Order shall be included in any form of application or otherwise brought to the attention of candidates.

33.2. No director of the Trust shall solicit for any person any appointment under the Trust or recommend any person for such appointment; but this shall not preclude a director from sharing knowledge about the availability of potential candidates prior to the commencement of recruitment, nor from giving a written testimonial of a candidate’s ability, experience or character for submission to the appropriate panel or committee of the Trust Board.

### *34. Relatives of directors or officers of the Trust*

34.1. Candidates for any appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any director or senior officer of the Trust. Failure to disclose such a relationship is likely to disqualify a candidate and, if appointed, render him liable to instant dismissal.

34.2. Every director and senior officer of the Trust shall disclose to the Chief Executive any relationship between himself and a candidate of whose candidature that director or senior officer is aware. It shall be the duty of the Chief Executive to report to the committee with responsibility for oversight of remuneration and terms of service any such disclosure made.



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34.3. Where the relationship to the director or senior officer of the Trust is disclosed, Standing Order 21 (Interest of directors in contracts and other matters) shall apply.

34.4. This Standing Order applies to circumstances where a candidate or candidate's partner or spouse is an immediate family relation or dependent of the director or senior officer of the Trust, or their partner or spouse.

## Part VI – Tendering and contracting procedures

### *35. General*

35.1. The Trust will develop a longer-term procurement strategy in conjunction with the Trust's procurement service supplier, Bristol and Weston Purchasing Consortium (BWPC). Click here for the BWPC website : BWPC - Home (http://nww.bwpc.nhs.uk/default.htm)

35.2. Every contract made by or on behalf of the Trust shall comply with the procedures and requirements of:

35.2.1. these Standing Orders

35.2.2. the Trust's Standing Financial Instructions

35.2.3. any direction by the Trust Board

35.3. Wherever possible and provided it protects the Trust's position adequately, contracts made will reflect the most up to date and relevant model Standard Conditions that are provided by the Department of Health. These models may be amended to develop bespoke contracts.

35.4. Directives of the Council of the European Union (EU) for awarding all forms of contracts shall take precedence over all other procedural requirements and guidance and shall have effect as if incorporated in these Standing Orders. The EU Procurement Rules apply to public authorities under the, Public Contracts Regulations 2015 for England, Wales and Northern Ireland. The regulations cover fully regulated procurements and 'light touch regime'. The rules set out detailed procedures for contracts where the value equals or exceeds specific thresholds. These thresholds are exclusive of VAT and relate to the full life of the contract. The Chief Executive shall be responsible for ensuring the best value for money can be demonstrated for all services provided under contract or in-house. The Trust Board may also determine from time to time those in-house services should be market tested by competitive tendering.

35.5. Contract procedures shall take account of the Trust's Policy Standards of Business Conduct and the necessity to avoid any possibility of collusion or allegations of collusion between contractors and suppliers; or between contractors and suppliers and staff of the Trust.

35.6. The application of the provisions of this part of the Standing Orders to contracts and purchases may be varied by resolution of the Trust Board from time to time.



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### *36. Delegated authority to enter into contracts*

36.1. The Trust Board shall have power to accept tenders and to authorise the conclusion of contracts. It may delegate such authority subject to financial limits set in accordance with Standing Order 36.2 to:

- 36.1.1. a committee appointed under sections 24 and 25 of these Standing Orders
- 36.1.2. the Chief Executive
- 36.1.3. to the Chief Executive jointly with the Chair
- 36.1.4. the directors or nominated officers
- 36.1.5. officers of the Trust's procurement service supplier, in accordance with that organisation's standard operating procedures.

36.2. The financial limits determining whether quotations (competitive or otherwise) or sealed bid tenders must be obtained shall be set in accordance with the procedure in the Standing Financial Instructions the current thresholds being set out in the Trust Scheme of Delegated Authorities (Appendix 3).

### *37. Competition in purchasing or disposals – procedures*

37.1. The Trust Board shall from time to time adopt procedures which shall be regarded as being incorporated into these Standing Orders and which shall take account of Standing Financial Instructions, the Trust's Procurement rules and regulations including implementing EC Directives on Public Procurement and which shall deal with:

- 37.1.1. Tender process selection
- 37.1.2. methods for inviting tenders
- 37.1.3. the manner in which tenders are to be submitted
- 37.1.4. the receipt and safe custody of tenders
- 37.1.5. the opening of tenders
- 37.1.6. evaluation
- 37.1.7. re-tendering
- 37.1.8. such other matters in connection with tendering as the Board considers appropriate

### *38. Disposals of land and buildings*

38.1. Land and buildings that are owned by the Trust, or are otherwise recorded as being part of the estate of the Trust, shall be disposed of in accordance with the most recent rules and guidance issued by the Department of Health. Disposal will require the approval of the Trust Board.



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## Part VII – Miscellaneous

### *39. Suspension of Standing Orders*

39.1. Except where this would contravene any statutory provision or any direction made by the Secretary of State for Health, any one or more of the Standing Orders, except for Standing Order 40 which may not be suspended, may be suspended at any meeting, provided that at least two-thirds of the directors of the Trust are present and the majority of those present vote in favour of suspension.

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

39.3. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

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

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

### *40. Variation of Standing Orders*

40.1. These Standing Orders shall be varied only if:

- 40.1.1. A notice of motion under Standing Order 17 has been given **and**
- 40.1.2. no fewer than half of the appointed Non-Executive Directors vote in favour of such variation **and**
- 40.1.3. at least two-thirds of the directors who are eligible to vote are present **and**
- 40.1.4. the variation proposed does not contravene a statutory provision or direction made by the Secretary of State for Health.

40.2. Standing Order 40 (this Standing Order) may not be varied.

40.3. Any financial limits in these Standing Orders and the Schedule of Decisions Reserved for the Trust Board and the Scheme of Delegated Authorities may be varied by resolution of the Trust Board at any time.

40.4. Where financial limits are varied the Director of Finance will advise the Audit Committee, and internal and external audit.

### *41. Availability of Standing Orders*

41.1. The Trust Secretary shall make available a copy of the Standing Orders to each director of the Trust and to such other employees as the Chief Executive considers appropriate.

41.2. A copy of these Standing Orders will be held, with unrestricted access to all staff, on the Trust's intranet site.



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### *42. Signature of documents*

42.1. Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall be signed by the Chief Executive, or by any Executive Director of the Trust duly authorised for that purpose by the Board in accordance with the Scheme of Delegated Authorities, unless any enactment otherwise requires or authorises differently.

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

### *43. Standing Financial Instructions*

43.1. Standing Financial Instructions adopted by the Trust shall have effect as if incorporated in these Standing Orders.

### *44. Review of Standing Orders*

44.1. Standing Orders shall be reviewed annually, or earlier, if developments within or external to the Trust indicate the need for a significant revision to the Standing Orders. The requirement to review extends to all documents having the effect as if incorporated in Standing Orders.

44.2. Any change will be reviewed by the Audit Committee before a recommendation is made to the Trust Board for adoption.

**ENDS**

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North Bristol NHS Trust Board

# Appendix 1 – Schedule of decisions reserved to the Trust Board

## Introduction

Standing Order 1 provides that "the Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session." These powers and decisions are set out in this Schedule.

*1. Structure and governance of the Trust, including regulation, control and approval of Standing Orders and documents incorporated into the Standing Orders*

1.1. Approve, including variations to:

- 1.1.1. Standing Orders for the regulation of its proceedings and business (SO40).
- 1.1.2. this Schedule of matters reserved to the Trust Board (SO 24).
- 1.1.3. Standing Financial Instructions (SO 44, SFI 2)
- 1.1.4. Scheme of Delegated Authorities, including financial limits in delegations, from the Trust Board to officers of the Trust (SO 24, SO 40).
- 1.1.5. suspension of Standing Orders (SO 39)

1.2. Determine the frequency and function of Trust Board meetings (SO 8), including:

- 1.2.1. administration of public and private agendas of Board meetings (SO 8)
- 1.2.2. calling extra-ordinary meetings of the Board (SO 9)

1.3. Ratify the exercise of emergency powers by the Chair and Chief Executive (SO 24)

1.4. Establish Board committees including those which the Trust is required to establish by the Secretary of State for Health or other regulation (SO 25); and:

- 1.4.1. delegate functions from the Board to the committees (SO 24)
- 1.4.2. delegate functions from the Board to a director or officer of the Trust (SO 24)
- 1.4.3. approve the appointment of members of any committee of the Trust Board or the appointment of representatives on outside bodies (SO 25)
- 1.4.4. receive reports from Board committees and take appropriate action in response to those reports (SO 25)
- 1.4.5. confirm the recommendations of the committees which do not have executive decision making powers (SO 25)



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1.4.6. approve terms of reference and reporting arrangements of committees (SO 25).

1.4.7. approve delegation of powers from Board committees to sub-committees (SO 25)

1.5. Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust; and modifications thereto.

1.5.1. Appoint the Chief Executive (SO 3)

1.5.2. Appoint the Executive Directors (SO 3)

1.6. Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests (SO 21).

1.7. Agree and oversee the approach to disciplining directors who are in breach of statutory requirements or the Trust's Standing Orders.

1.8. Approve the disciplinary procedure for officers of the Trust.

1.9. Approve arrangements for dealing with and responding to complaints.

1.10. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on Trust (SO 25)

1.11. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

## *2. Determination of strategy and policy*

2.1. Approve those Trust policies that require consideration by the Trust Board. These will be determined by the individual directors responsible for adopting and maintaining the policies.

2.2. Approve the Trust's strategic direction:

2.2.1. annual budget, strategy and business plans

2.2.2. definition of the strategic aims and objectives of the Trust.

2.2.3. clinical and service development strategy

2.2.4. overall, programmes of investment to guide the letting of contracts for the supply of clinical services.

2.3. Approve and monitor the Trust's policies and procedures for the management of governance and risk.



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### *3. Direct operational decisions*

3.1. Approve capital investment plans:

- 3.1.1. the annual capital programme
- 3.1.2. all variations to approved capital plans over £500,000 (SoDA 13f)
- 3.1.3. to acquire, dispose of, or change of use of land and/or buildings (SO 38, )
- 3.1.4. capital investment over £1 million in value, supported by a business case and in line with the approval guidance issued by the NTDA. (SoDA 13c, 13d)
- 3.1.5. contracts for building works, which exceed the pre-tender estimate by over 10% (minimum £100k). (SoDA 10j)

3.2. Introduce or discontinue any significant activity or operation which is regarded as significant (if it has a gross annual income or expenditure, before any set off, in excess of £1 million.

3.3. Approve individual contracts and commitments to pay, other than Commissioning Contracts, of a revenue nature amounting to, or likely to amount to over £1 million:

- 3.3.1. Tenders and quotations over the lifetime of the contract (SoDA 8a)
- 3.3.2. Revenue funded service developments, in line with the approval guidance issued by the NTDA (SoDA 8f)
- 3.3.3. Orders processed through approved supply arrangements (SoDA 10c)
- 3.3.4. Orders processed through non-approved supply arrangements (SoDA 10d)
- 3.3.5. Receipt of loans and trials equipment and materials (SoDA 10e)
- 3.3.6. Prepayment agreements for services received (SoDA 10g)

3.4. Decide the need to subject services to market testing (SO 35)

### *4. Quality, financial and performance reporting*

4.1. Appraise continuously the affairs of the Trust through receipt of reports, as it sees fit, from directors, committees and officers of the Trust.

4.2. Monitor returns required by external agencies; and significant performance reviews carried out by, including, but not exclusively limited to:

- 4.2.1. The Care Quality Commission
- 4.2.2. NHS Improvement

4.3. Consider and approve of the Trust's Annual Report including the annual accounts.

4.4. Approve the Annual report(s) and accounts for funds held on trust.

4.5. Approve the Quality Account



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### 5. *Audit arrangements*

5.1. Approve audit arrangements recommended by the Audit Committee (including arrangements for the separate audit of funds held on trust).

5.2. Receive reports of the Audit Committee meetings and take appropriate action.

5.3. Receive and approve the annual audit reports from the external auditor in respect of the Financial Accounts and the Quality Account.

5.4. Receive the annual management letter from the external auditor and agree action on recommendations of the Audit Committee, where appropriate.

5.5. Endorse the Annual Governance Statement for inclusion in the Annual Report

**ENDS**



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North Bristol NHS Trust Standing Financial Instructions

# Appendix 2 – Standing Financial Instructions

## 1. Interpretation

1.1. The Chair of the Trust is the final authority in the interpretation of Standing Orders on which the Chief Executive and Trust Secretary shall advise herim. In the case of the Standing Financial Instructions she will be advised by the Director of Finance.

1.2. The definitions applied to the Standing Orders apply also for these Standing Financial Instructions. The following additional definitions apply:

***Legislation definitions:***

No additional legislation

***Other definitions:***

- **Budget manager** is the director or employee with delegated authority to manage the finances (Income and Expenditure) and resources for a specific area of the Trust.
- **Commissioning** is the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
- **Contracting and procuring** is the process of 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.
- **Divisional Operations Directors (Corporate Manager)** are the senior operational managers; and their formally nominated deputies, for the division or specialty, as designated by the Executive Director.
- **Procurement Service provider** is the group that manages the Trust's procurement strategy and processes. The current service provider: Bristol and Weston NHS Purchasing Consortium (BWPC) is hosted by the Trust
- **Shared Business Service (SBS)** is the NHS Shared Business Services, which is contracted by the Trust for general ledger provision and maintenance, core accounting for accounts payable and receivable and VAT processes.

1.3. Any reference to an Act of Parliament, Statutory Instrument, Direction or Code of Practice shall be construed as a reference to any modification, replacement or re-enactment for the time being in force.

1.4. All reference to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.



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## 2. Introduction

2.1. These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of the Trust, its directors and officers in relation to all financial matters with which they are concerned.

2.2. The SFIs explain the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

2.3. They identify the financial responsibilities which apply to everyone working for the Trust; and shall be used in conjunction with the Schedule of Decisions Reserved to the Board (appendix 1) and the Scheme of Delegated Authorities (appendix 3) which both also form part of the Trust's Standing Orders.

2.4. Detailed procedural advice, which shows how the SFIs should be applied, is maintained in departmental and financial procedure notes.

2.5. These SFIs do not refer to all legislation or regulations and advice issued by the Department of Health applicable to the Trust. Any uncertainty regarding the application of these SFIs should be discussed with the Director of Finance, prior to action.

2.6. The SFIs apply to all staff, including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Trust. Failure to comply with the SFIs could lead to disciplinary action, up to and including dismissal.

### Compliance with these SFIs

2.7. These SFIs prevail over any division and service guidance or procedural documents. They also prevail over any guidance or instruction issued by other organisations conducting business with the Trust. All staff should notify the Director of Finance of any conflicts between the local guidance and instruction and the SFIs, if the conflict cannot be resolved satisfactorily locally.

2.8. **All staff** have a duty to disclose, as soon as possible, to the Director of Finance, any failure to comply with these SFIs. Full details of the non-compliance including an assessment of the potential impact; and any mitigating factors shall be reported by the Director of Finance to the next formal meeting of the Audit Committee for referring action or ratification.

### Responsibilities and delegations

2.9. These SFIs have been compiled under the authority of the Trust Board. They are reviewed by the **Audit Committee** and approved by the Trust Board.

2.10. **The Trust Board** exercises financial supervision and control by:



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2.10.1. approving the financial strategy

2.10.2. requiring the submission and approval of budgets that deliver the financial targets set for the Trust within approved allocations and overall income

2.10.3. approving specific responsibilities placed on directors and employees as indicated in the Scheme of Delegated Authorities

2.10.4. approving the method of providing financial services.

2.11. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Schedule of Decisions Reserved to the North Bristol NHS Trust Board (appendix 1). All other powers have been delegated to the Board's appointed committees; and the directors and officers of the Trust.

2.12. **The Chief Executive** is the Accountable Officer of the Trust and:

2.12.1. is legally accountable to Parliament for all of the actions of the Trust

2.12.2. is accountable to the Trust Board for ensuring that the Board of Directors meets its obligation to perform the Trust's functions within the available financial resources

2.12.3. holds overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that its financial obligations and targets are met

2.12.4. is responsible overall for the maintenance of the Trust's systems of internal control

2.12.5. is responsible for ensuring that all members and staff of the Trust are aware of and understand their responsibilities within these SFIs

2.13. Save for the decisions and actions reserved to the Trust Board, the Chief Executive has full operational authority to approve the financial transactions of the Trust and to delegate such powers to post-holders within the Trust management. The Chief Executive will, as far as possible, delegate detailed responsibilities, as described in these SFIs and, in more detail in the Scheme of Delegated Authorities (appendix 3).

2.14. **The Director of Finance** is responsible for:

2.14.1. maintaining and implementing the Trust's financial policies

2.14.2. maintaining an effective system of internal financial control including ensuring that adequate and effective financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained

2.14.3. ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time



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2.15. **All staff**, including Board members are responsible for:

2.15.1. the security of the property of the Trust

2.15.2. avoiding loss

2.15.3. achieving economy and efficiency in the use of resources

## 3. Financial framework

3.1. The **Director of Finance** shall ensure that members of the Board are aware of the financial aspects of the NHS Improvement's Single Oversight Framework, within which the Trust is required to operate.

## 4. Business and budget plans

4.1. The **Chief Executive** shall submit to the Board and external regulators as required, strategic and operational plans, as suggested by relevant guidance, to meet the needs of the Board. These plans will include an annual Business Plan, which takes into account financial targets and forecast limits of available resources.

4.2. The plans will include:

4.2.1. description of the significant assumptions on which planning is based

4.2.2. details of major changes in workload, delivery of services or resources required to achieve the plans.

4.3. Prior to the start of each financial year, the **Director of Finance** shall prepare and submit budgets for approval by the Board. Such budgets will:

4.3.1. be in accordance with and reconcilable, at a summary level, to the aims and objectives set out in the annual Business Plan

4.3.2. reconcile to financial plans to be provided to relevant external regulators, such as the NHS Improvement (NHSI)

4.3.3. reflect resource plans, including workload and workforce plans

4.3.4. be prepared within the limits of available funds

4.3.5. show how the plans will deliver against the financial targets and obligations set externally by the Secretary of State and relevant regulatory bodies; and set internally by the Trust

4.3.6. provide a forecast of the Trust's performance over the year against key financial indicators, as determined by the Trust and by relevant regulatory bodies

4.3.7. include summary financial projections for the longer term



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4.3.8. identify and assess significant financial risks.

4.4. **All staff** who have been given delegated authority to manage and administer budgets shall be expected to contribute to the preparation of the annual budget.

## 5. Management of the financial resource

5.1. The **Chief Executive** shall require directors and authorised budget managers to seek to deliver the financial outturn targets set by the Trust Board within the approved annual budget plan and the adjustments to those targets reflected in the re-forecasts performed during the year.

5.2. The **Chief Executive** may change the financial outturn targets of any divisions, or services.

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5.3. **Directors** and **authorised budget holders** shall seek to deliver their service responsibilities within the limits of the financial outturn targets set for them. Financial and other resources shall only be used for the purposes for which they are provided, as approved by the Chief Executive and the Board.

### Setting the annual financial plan

5.4. The **Chief Executive** shall be responsible for providing the Trust Board with the annual financial plan, taking into account financial targets and forecast income and service developments. The plan will identify the significant assumptions on which it is based; and provide details of significant changes to service and workforce plans and how these will impact on the Trust's financial targets. The plan will identify how the Trust will achieve the annual efficiency savings set by the Department of Health.

5.5. The **Director of Finance** shall be responsible overall for the design and delivery of the annual integrated financial budget plan.

5.6. All **Executive Directors** shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

5.7. **Budget holders** shall provide all financial, statistical and other relevant information, including service, capacity, workforce and efficiency plans, as required by the Director of Finance to enable budgets to be compiled.

5.8. All budget managers should sign up to their allocated budgets at the start of each financial year.

### Managing and reporting the financial position during the year

5.9. The **Director of Finance** shall be responsible overall for the design and delivery of adequate systems of financial budgetary control. These systems will include processes for:

5.9.1. identifying the level of earned income directly attributable to each budget area



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5.9.2. identifying the target (gross or net) allowable expenditure for each budget area, that will enable each budget holder to deliver their annual financial target contribution to the overall Trust target

5.9.3. updating the forecast income and allowable expenditure, during the year, to reflect changes in contracted income, service capacity and delivery.

5.9.4. monitoring and reporting financial performance against plans and forecasts

5.9.5. delivering monthly integrated financial reports to meet the requirements of the Project Management Office, Finance and Performance Committee and the Trust Board in a form approved by the Board.

5.10. All **Executive Directors** shall be responsible for establishing monitoring and reporting systems for workforce, service delivery and quality, service capacity and activity, and efficiency planning to enable budget holders to deliver an integrated analysis of their service performance.

5.11. **All staff** to whom responsibility is delegated to incur expenditure, or generate income shall comply with the requirements of those systems.

5.12. Designated **budget holders** shall be responsible for maintaining expenditure within the limits of earned available income.

5.13. Designated budget holders shall monitor and analyse the integrated financial performance of their service during the year. This shall include assessment of:

5.13.1. progress towards delivering the required financial position for the budget area

5.13.2. the impact of resources used, including workforce, progress of service delivery and achievement of efficiency plans

5.13.3. trends and projections

5.13.4. where relevant, plans and proposals to recover adverse performance

5.14. The **Director of Finance** shall ensure that budget holders are provided with advice and support from suitably qualified finance staff, to enable them to perform their budget management role adequately.

5.15. The **Director of Finance** shall be required to compile and submit to the Board of Directors such financial estimates and forecasts, on both revenue and capital account, as may be required from time to time.

5.16. The **Director of Finance** shall keep the Trust Board informed of:

5.16.1. significant in-year variance from the business plan and advise the Board on actions to be taken to address the variance

5.16.2. financial consequences of changes in Trust policy

5.16.3. financial implications of external determinations, such as national pay awards and changes to the pricing of clinical services

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5.17. The **Director of Finance** shall:

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5.17.1. ensure that budget managers receive adequate training on an on-going basis to help them comply with expectations and to manage successfully

5.17.2. issue timely, accurate and comprehensible advice and financial reports to each budget manager, covering the areas for which they are responsible

## 6. Annual accounts, reports and returns

6.1. The **Director of Finance** shall:

6.1.1. prepare financial returns in accordance with the accounting policies and guidance provided by the Department of Health (DHSC) and the Treasury, the Trust's accounting policies, and accounting practice as determined by the accounting bodies in the UK.

6.1.2. prepare and submit annual financial reports to the DHSC certified in accordance with current guidelines

6.1.3. submit financial returns to the DHSC for each financial year in accordance with the timetable prescribed by the DHSC

6.1.4. submit periodic monitoring and financial returns to external organisations, such as NHSI, in accordance with the timetables set by those organisations

6.2. The Trust's annual accounts must be audited by an auditor appointed by the Trust. The Trust's audited annual accounts shall be presented to a public meeting and made available to the public, within the timescales set by the DHSC.

6.3. The **Chief Executive** shall publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the current DHSC requirements and guidance.

## 7. Income, including contracts for the provision of healthcare, fees and charges

7.1. The **Director of Finance** is responsible for:

7.1.1. designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due

7.1.2. the prompt banking of all monies received.

7.2. Where such income matters are dealt with by the Shared Business Service, such arrangements will be incorporated in a Service Level Agreement with the Shared Business Service.



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### Fees and charges for the provision of healthcare

7.3. The **Director of Finance** shall:

7.3.1. follow the up to date Department of Health's guidance and regulations for setting prices for providing NHS services

7.3.2. approve and regularly review the level of all fees and charges set, other than those determined by the DHSC or by statutory regulation

7.3.3. take independent professional advice on matters of valuation, as necessary.

7.4. The **Director of Finance** shall approve all property and non-clinical equipment leases, property rentals and tenancy agreements. The **Director of Facilities** shall advise on these arrangements.

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7.5. **All employees** shall inform the **Director of Finance** promptly of money due to the Trust arising from transactions which they initiate, or deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

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### NHS service agreements for the provision of services

7.6. The **Chief Executive** is responsible for ensuring that the Trust enters into suitable Commissioning Contracts with service commissioners for the provision of NHS services to patients, in accordance with the business plans; and for establishing the arrangements for providing extra-contractual services.

7.7. The **Director of Finance** shall provide up to date advice on:

7.7.1. Standard NHS contractual terms and conditions, issued by the DHSC

7.7.2. costing and pricing of services

7.7.3. payment terms and conditions

7.7.4. amendments to contracts, SLAs and extra-contractual arrangements

7.8. The **Director of Finance** shall ensure that SLAs and other contractual and extra- contractual arrangements:

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7.8.1. are devised so as to limit the risk to the Trust, whilst enabling opportunities to generate income

7.8.2. are financially sound; and that any contractual arrangement pricing at marginal cost are approved by the Director of Finance and reported to the Trust Board



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7.9. The **Director of Finance** is responsible for ensuring that systems and processes are in place to record patient activity, raise invoices and collect monies due under the agreements for the provision of healthcare services.

7.10. The **Director of Finance** shall produce regular reports, to the Trust Board or its committees detailing the Trust's forecast financial performance.

7.11. **Budget holders** with responsibilities for managing delivery against service agreements must ensure they understand and use the contract monitoring information for the financial management of their service areas.

### Research and development

7.12. All applications for research funding shall be considered and approved by the Research and Innovation department. This applies to applications to NHS institutions such as grant requests to the National Institute for Health Research, and non-NHS organisations, including commercial sponsorship organisations, charitable bodies and research councils.

### Sponsorship and concession agreements

7.13. The **Director of Finance**, or a nominated deputy shall maintain a register of sponsorship received by the Trust.

7.14. Sponsorship arrangements may be entered into subject to the limits set out in the Scheme of Delegated Authorities. Where sponsorship income (including items in kind such as clinical goods or loans of equipment) is considered~~, the DH guidance "Commercial Sponsorship – Ethical Standards in the NHS", 2000 shall be followed~~ the most recent NHS guidance on manging conflicts of interest and sponsorship should be followed.

7.15. The **Director of Facilities** shall review and propose plans for all concession agreements proposed for the Trust, including arrangements that do not incur an immediate direct cost for the Trust, but can expose it indirectly to significant liability. The Director of Finance shall authorise all concession agreements entered into by the Trust.

## 8. Procurement, tendering and contracting procedure

8.1. The Trust may enter into contracts within the statutory powers delegated to it. The procedure for setting contracts shall comply with those powers and these SFIs. Delegated powers of authorisation are granted to Trust officers according to the Scheme of Delegated Authorities. A contractual arrangement must be in place for all goods and services procured by the Trust. The nature of the contract or agreement will depend on the goods, services or works being provided. The Director of Finance is responsible for signing all contracts and agreements with delegated responsibilities given within the scheme of delegation (see Appendix 3)

8.2. All contracts made shall ensure best value for money using the Trust's



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Comment [XB6]: Tthis can be incorporated into the new conflicts of interest policy and process, so will need to be referenced here once approved.

procurement service provider (BWPC) and processes established by the Director of Finance. For each contract a Trust Officer shall be nominated and hence responsible for overseeing and managing the contract on behalf of the Trust.

### European Union and Government directives regarding public procurement

8.3. The Trust shall comply with all European Union and Government directives regarding public sector purchasing and the procedures set out for awarding all forms of contracts.

8.4. Contracts above specified thresholds for supply and service contracts (awarded by central government bodies subject to the World Trade Organisation Government Procurement Agreement) shall be advertised and awarded in accordance with EU and other directives and relevant equivalent UK government legislation. Works contracts above separate specified thresholds shall also be awarded in accordance with EU and other directives and relevant UK government legislation.

8.5. The Trust shall comply as far as is practicable with all guidance and advice issued by the Department of Health and the NHS Trust Development Authority in respect of procurement, capital investment, estate and property transactions and management consultancy contracts.

### Competitive tendering and quotations

8.6. The **Director of Finance** shall advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds shall be incorporated in Standing Orders through the Scheme of Delegated Authorities; and shall be reviewed regularly.

8.7. The **Trust Board** shall ensure that, wherever possible, competitive tenders, or quotations are invited, in line with the thresholds set out in the Scheme of Delegated Authorities, for:

8.6.1. the supply of goods, materials and manufactured articles

8.6.2. services, including management consultancy services from non-NHS organisations

8.6.3. design, construction and maintenance of building and engineering works, including construction and maintenance of grounds and gardens

8.8. The **Trust Board** shall allow for exceptions to the requirement for formal tendering procedures where:

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8.7.1. the estimated contract value is not reasonably expected to exceed £25,000 over the anticipated term of the contract and will be determined through formal quotations

8.7.2. the supply is proposed under special arrangements negotiated by the DH, in which event the special arrangements must be complied with

8.7.3. It is a government directive that tenders over the value of £25,000 must be advertised in 'Contracts Finder'



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8.7.4. the supply is a measured term contract which has been put in place following a formal tendering process carried out by its procurement services provider.



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8.9. The **Trust Board** shall allow for the requirement for formal tendering procedures to be waived where:

- the **Chief Executive** decides that formal tendering procedures would not be practicable
- the supply requirement is covered by an existing contract
- NHS or Government procurement agreements are in place and their use, in accordance with the Trust's Procurement Strategy, has been approved by the Board
- a consortium arrangement is in place and a member organisation has been appointed to carry out tendering activity on behalf of the consortium members
- available timescales genuinely mean that competitive tendering is not a realistic option. Failure to plan the work properly should not be regarded as a justification for waiving tendering procedures
- specialist expertise, goods and services are required and available from only one source. Evidence of the unique status will be required to support any exemption.
- the task is essential to complete the project, and arises as a consequence of an existing or recently completed assignment; and engaging different suppliers for the new task would be counter-productive
- there is a clear benefit to be gained from maintaining continuity with an earlier supply. In such cases, the benefits of such continuity must outweigh any potential advantage to be gained from competitive tendering

Note that section 8.4 takes precedence over the above list of waived exemptions to competitive tendering. The Trust should take the advice of BWPC when enacting any of the aforementioned exemptions. Approval of any exemptions should be carried out with reference to SoDa (Single Tender Actions)

8.10. The **Chief Executive** shall provide formal approval, which may be retrospective where time constraints apply, in each instance where competitive tendering requirements are waived. These instances will be reported to each meeting of the Audit Committee.

8.11. The **Director of Finance** shall ensure that:

8.11.1. any fees paid to an organisation to administer the competitive tendering exercise are reasonable and within commonly accepted rates for such work

8.11.2. waivers to competitive tendering procedures are not used to avoid competition, for administrative convenience, or to award further work to a supplier originally appointed through a competitive procedure.

8.11.3. contracts that were initially expected to be below the value limits set in this SFI; and for which formal tendering procedures were not used, which subsequently prove to have a value above such limits shall be reported to the

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Audit Committee and be recorded in an appropriate Trust record

8.12. The Trust's Procurement Service provider shall ensure that, for contracts under the EU threshold, it maintains a record of competitive tenders and subsequent contract awards. ~~invited to provide tenders or quotations for the supply of goods or services , notwithstanding the requirement to also advertise in Contracts Finder for contracts over £25,000~~. The Procurement Service provider shall take advice from technical experts, as required and assess the suitability of suppliers to be included in that record. The assessment of potential suppliers shall include reviews of technical and financial competence; as well as the specific skills and assurances required in the scope of the goods and/or services to be supplied through the tendered contract.

8.13. The Facilities Directorate in agreement with the Trust's procurement service provider, shall refer to the Government Register of Contractors in considering suppliers suitable to be invited to provide tenders or quotations for their requirements.

8.14. All suppliers invited to submit quotations or tenders shall be informed that they are expected to comply with the Human Rights Act, 1998; the Equality Act, 2010; the Health and Safety at Work Act, 1974; procurement sustainability, fair and equitable trade policy and all other legislation concerning employment and the health, safety and welfare of workers and other persons.

8.15. The Director of Finance shall, through the Trust's Procurement Service provider (BWPC), ensure that:

8.15.1. invitations to tender are sent to a sufficient number of suppliers to promote fair and adequate competition in accordance with Appendix 3, SoDa BWPC will ensure sufficient market research has taken place to ensure the right suppliers are engaged in competition via market development and engagement exercises.

8.15.2. the suppliers invited to tender, or requested to provide a quote, are suitably pre-qualified by BWPC . BWPC must fully assess the viability and suitability of any framework agreement before any procurement exercises are conducted through a mini-competition or directly awarded via a framework

8.15.3. the tender process and rules are in accordance with up-to-date and relevant specialist guidance, which is recognised, or recommended by the DH

### Tendering procedure

8.16. The **Director of Finance** shall ensure that procedural guidance from the Procurement Service provider is kept up to date. The guidance will include the rules, requirements and records to be maintained for each key stage of the tendering process. Separate procedural guidance and rules shall be maintained for:



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8.16.1. contracts awarded through the Procurement Service's electronic tendering evaluation and contract award system, which will be subject to the controls built into the system regarding the receipt, storage of records and provision of audit trail for all relevant procurements.

8.17. These procedures shall include, but not be limited to, requirements for:

8.17.1. record of issue of invitations to tender

8.17.2. submission, storage and audit trail for receipt of tenders

8.17.3. process and record of opening tenders

8.17.4. evaluation of tenders (inc. completeness, accuracy, compliance with prescribed format etc)

8.17.5. admissibility of tenders, including treatment of tenders received after the deadline, but prior to other bids being "opened"

8.17.6. reasons behind decision to award the contract

### Quotations: competitive and non-competitive

8.18. The **Trust Board** shall approve the value range whereby formal tendering procedures are not adopted, but quotations will be required. This range is currently for intended expenditure that is reasonably expected to exceed £25,000.

8.19. The **Director of Finance** shall determine the procedures to be followed in respect of competitive and non-competitive quotations. These will include:

8.20.1. types of service or supply to be sought through quotations

8.20.2. minimum number of competitive quotes to seek, currently set at three

8.20.3. requirement for written quotations

8.20.4. retention of records

8.20.5. treating all records of the process as confidential

8.20.6. recording the decision to go to contract

### Temporary suspension of procedures in exceptional circumstances



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8.20. The **Trust Board** shall allow the SFIs to be suspended temporarily in exceptional circumstances, where the circumstance is:

8.21.1. a Trust wide problem, rather than a directorate specific issue.

8.21.2. of sufficient scale that failure to act quickly and decisively would put the Trust at significant financial and reputational risk

8.21.3. unforeseen and rapidly developing

8.21.4. such that following normal procedures would hinder the recovery of the situation

8.21. The **Director of Finance** shall identify specific procedures to be followed in the instance of a recognised event of exceptional circumstance.

## 9. Contracts and purchasing

9.1. The **Trust Board** shall only enter into contracts on behalf of the Trust that are within the statutory powers delegated to it by the Secretary of State and shall comply with:

9.1.1. the Trust's Standing Orders and Standing Financial Instructions

9.1.2. EU Procurement Directives and other statutory provisions

9.1.3. any relevant directions issued, or recognised by the DH

9.1.4. such of the NHS standard contract conditions as are applicable

9.2. In all contracts made by the Trust, the Trust Board shall:

9.2.1. seek to obtain best value for money

9.2.2. for contracts subjected to tendering, or quotation, ensure that the contracts contain the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.3. The **Chief Executive** and **Executive Directors** shall nominate managers to oversee and manage each contract on behalf of the Trust

9.4. The Procurement Service shall maintain a record of the details of all requisitions and orders placed. No requisition or order shall be placed for items for which there is no provision in an authorised budget.

### Longer term commitments

9.5. All contracts, leases, tenancy agreements and other commitments, which might result in a long-term liability, must be notified to; and authorised, in accordance with the limits set out in the Scheme of Delegated Authorities, in advance of any commitment being made.



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### Healthcare Service Agreements

9.6. The **Director of Finance** shall ensure that SLAs and extra-contractual arrangements agreed with other NHS trusts, for provision of services to the Trust, are agreed in accordance with the current guidance set out by the DH.

### In-house services

9.7. The **Trust Board** shall determine which in-house services should be market tested by competitive tendering; and the frequency with which this should be done. In instances where competitive tendering is required, the Board shall nominate suitably qualified staff to administer the process and ensure that EU procurement and competition laws, legislation and DHSC guidance are applied correctly, including:

9.7.1. setting clearly defined specifications for the service

9.7.2. clear separation between the in-house service provider tender team and the Trust's commissioning team

9.7.3. independent evaluation process

9.8. The **Chief Executive** shall ensure that best value for money can be demonstrated for all services provided on an in-house basis and shall nominate officers to oversee and manage the contract on behalf of the Trust, separate from those that are providing the service.

## 10. Non-pay expenditure

10.1. Requisitions and orders are subject to the delegations and limits set out in SFI 8 and SFI 9.

10.2. The **Director of Finance** shall:

10.2.1. maintain the list of managers who are authorised to place requisitions and orders for the supply of goods and services

10.2.2. set the maximum value of each requisition or order and the system for authorisation above that level

10.2.3. set out procedures for seeking of professional advice regarding the supply of goods and services

10.3. These delegation limits are maintained in the Scheme of Delegated Authorities.

### Requisitioning and ordering goods and services

10.4. The **Director of Finance** shall maintain adequate systems and procedures for the ordering (including requisitions) of goods and services. These shall include:



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10.4.1. procedural instructions and guidance on the obtaining of goods, works and services incorporating the thresholds identified in the Scheme of Delegated Authorities

10.4.2. recognition of the Trust's approved supply arrangements, including, but not limited to the following:

- recognised Trust wide procurement systems, (EROS and NHS Supply Chain) which incorporate automatic system controls to ensure adherence to approval and authorisation requirements
- other recognised controlled ordering systems for specific service areas (Pharmacy, Estates, Catering, Disablement Services) providing that they can evidence a secure audit trail
- framework agreements made by the Trust, or by the Procurement Service, including approved suppliers of temporary, locum and interim staff placements; and contractual arrangements for on-going ad-hoc support from chosen service suppliers (eg emergency maintenance and repair services for medical equipment)

**10.5.** **Employees** responsible for placing requisitions and orders; and **managers** responsible for authorising the orders shall ensure that:

10.5.1. approval is obtained in advance from the Director of Finance for any contractual arrangement that may involve taking on an ongoing obligation, or legal responsibility.

10.5.2. sufficient budget exists to pay for the item ordered, or if insufficient budget is available, the **Director of Finance** has authorised the purchase

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10.5.3. a Purchase Order is raised on an approved electronic ordering system prior to the goods or services being received.

10.5.4. orders are not split, or otherwise manipulated to circumvent authorisation and delegation limits

10.5.5. goods and equipment are not accepted on trial, or on loan, where there is an associated risk or commitment to current or future expenditure, unless specifically approved by the **Director of Finance** as advised by BWPC.

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10.6. Employees shall use the Trust's approved supply arrangements wherever possible.

10.7. Where the service is provided by or maintained by the Shared Business Service, the arrangements shall be set out in the SLA.



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### Ordering and purchasing using non-approved supply arrangements

10.8. The **Director of Finance**, or their nominated deputy shall maintain adequate systems and controls; and procedural rules for commitments and purchases made outside of the Trust's approved supply arrangements.

10.9. **Employees** should seek to minimise the use of non-approved supply arrangements. Where this is unavoidable, they should ensure that any expenditure incurred through non-approved supply arrangements delivers value for money and is controlled so that there are no additional or consequential financial risks to the Trust

### Receipt of goods and services and system of payment and payment verification

10.10. The **Director of Finance** shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or with national guidance (such as the Better Payments Practice Code).

10.11. Such requirements will be specified in any SLA with the Shared Business Service provider.

10.12. The **Director of Finance** shall:

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10.12.1. ensure the prompt payment of all properly authorised accounts and claims

10.12.2. maintain an adequate system of verification, recording and payment of all amounts payable, including relevant thresholds. The system will include:

- a record of Trust employees, including specimens of their signatures and/or facilities for secure electronic certification, authorised to raise requisitions and certify invoices
- certification that:
  - goods have been duly received, examined and are in accordance with specification and the prices are correct
  - work done or services rendered have been satisfactorily completed in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct
  - contractual measurement units, such as time, materials or expenses are accurate, meet contractual requirements; are supported by appropriate confirmation; and are charged at the agreed rates
  - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained
  - the account is arithmetically correct
  - the account is in order for payment

10.12.3. identify procedures to follow for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.12.4. maintain instructions to employees regarding the handling and payment of accounts within the Finance Department.



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### Prepayments and payments on account

10.13. The **Director of Finance** shall specify the circumstances under which goods and services can be paid in advance of receipt, through the use of prepayments. These circumstances will include instances where one or more of the following apply:

10.13.1. the **Director of Finance** has approved that the pre-payment, in part, or in full, is specified in the agreed contractual arrangement

10.13.2. the proposed arrangement is compliant with EU public procurement rules, where the contract is above a stipulated financial threshold

10.13.3. the financial advantages are shown to outweigh the disadvantages and risks

10.13.4. it is customary for the payment in advance for a service that is provided for a specific period of time (eg rates, rentals, service and maintenance contracts, insurance, utilities standing charges)

10.14. The **budget holder** shall confirm that the goods and services due under a prepayment arrangement are received satisfactorily and in accordance with the contractual arrangements.

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### Payments to contractors by instalments

10.15. The **Director of Finance** shall identify adequate procedures to address interim payments made on-account in contracts for building and engineering works. These will include arrangements for receipt of independent and appropriate certificates and confirmations of work completed, to the required standards.

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10.16. Final payments certificates shall only be issued after the Trust's nominated contract manager has certified the accuracy and completeness of the value of the final account submitted by the contractor; and has confirmed that the procedure set out in the contract terms has been followed properly.

10.17. Overruns to contracts shall be reported in accordance with the Scheme of Delegated Authorities.

10.18. With reference to Appendix 3 (SoDA 8x), all planned (including Capital funded) procurements with a projected value of over £100k* must have a signed off Options Appraisal and/or Business Case report for the Procurement which is produced in conjunction with BWPC. This should be noted only applies to planned procurements with exceptions only via the Single Tender Action process.

10.19. All Options Appraisals, and ultimately procurement Business Case's must include Whole Life Costs estimates as well as identification of projected savings.

10.20. The above process also applies to Extensions and Variations with a projected value which exceeds £100k

*A genuine pre-estimate of contract value must be ascertained and should not automatically be based on previous years expenditure, but also based on an estimate of future demand, and any additional value gained by the supplier.



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### Variations and extensions to contracts

10.21. Contracts may be designed to allow for variations to the sum agreed, or the goods and services to be delivered. These variations shall be clearly identified and subject to specific limits; and shall be approved as part of the contract process. Further, or new variations shall be subject to the authorisation process in place for new contracts. Variations shall be authorised in advance of commencement.

10.22. Where variations are needed in emergency, approval should be sought from a relevant authorising officer; and shall be confirmed and authorised, using the relevant contract procedure, on the next working day.

10.23. Extensions to contracts shall be confirmed in writing and authorised in accordance with the Scheme of Delegated Authorities. Contract Extensions should not exceed the maximum term permitted under the terms of the contract defined when the contract was let.

### Joint finance arrangements with local authorities and voluntary bodies

10.24. Payments to local authorities and voluntary organisations shall comply with procedures laid down by the Director of Finance which shall be in accordance with current legislation.

## 11. Terms of service and payment of members of the Trust Board and employees

### Board members, directors and specified senior managers

11.1. The **Trust Board** shall be accountable for taking decisions on the remuneration and terms of service of directors and senior managers not on Agenda for Change terms and conditions. The Board shall establish a Remuneration and Nominations Committee responsible for determining the remuneration of; and appointment of directors and senior staff in accordance with Standing Orders.

11.2. The **Remuneration and Nominations Committee** shall:

11.2.1. advise the Board about appropriate remuneration and terms of service for the Chief Executive, other directors and any staff remunerated outside of the Agenda For Change arrangements, (as described in the terms of reference of the Committee), employed by the Trust:

- all aspects of salary (including any performance-related elements and bonuses)
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms

11.2.2. advise the Board on the remuneration and terms of service of directors and any staff remunerated outside of the Agenda for Change arrangements to ensure they are fairly rewarded for their contribution to the Trust, whilst having proper regard to the Trust's circumstances and performance; and to the provisions of any national arrangements for such members and staff where appropriate



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11.2.3. monitor and evaluate the performance of individual directors and senior employees

11.2.4. advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate

11.3. The Trust shall pay allowances to the Chair and Non-Executive Directors of the Board in accordance with instructions issued by the DH.

### Other employees

11.4. The Trust Board shall consider and approve proposals presented by the **Director of People & Transformation** for the setting of remuneration and conditions of service for those employees not covered by the Remuneration and Nominations Committee.

### Funded establishment and staff appointments

11.5. The staff establishment plans incorporated within the annual plans approved by the Trust Board shall be regarded as the funded establishment. The funded establishment of any department should reflect the Trust's approved workforce plans, which form part of the Trust's budget plans submitted to the NHS TDA.

11.6. The **Director of People and Transformation** shall ensure adherence to the Agenda for Change rules and approved policies and procedures and terms and conditions for employees paid on alternative contractual arrangements, including the consultant contract. These procedures shall address:

11.6.1. setting starting pay rates and conditions of service, for employees

11.6.2. approving plans to engage, re-engage employees, either on a permanent or temporary nature, or hire agency staff

11.6.3. agreeing to changes in any aspect of remuneration, including re-grading, within the Agenda for Change allowed rules.

11.6.4. ensuring that all employees are issued with a contract of employment in a form which complies with employment legislation

11.7. The **Budget Holder** shall ensure that the cost of the appointment, or change in conditions can be met within the limit of their approved budget and funded establishment.

### Processing payroll

11.8. The **Director of Finance** shall maintain procedural instructions for delivery of the Trust's payroll function. These procedures shall be compliant with employment legislation, the Data Protection Act and HM Revenues and Customs regulations.

11.9. The **Director of Finance** shall ensure that the arrangements for providing the payroll service are supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures; and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies

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11.10. Under the delegated authority of the Director of Finance, the **Head of Payroll** shall:

11.10.1. specify timetables for submission of properly authorised time records and other notifications

11.10.2. agree the final determination of pay and allowances

11.10.3. arrange to make payment on agreed dates

11.10.4. agree allowed methods of payment.

11.11. **Nominated managers** shall ensure that the electronic staff record, including the approved staff establishment, is kept up to date. Nominated managers shall ensure that all staff are keeping their records complete, including requirements to:

11.11.1. submit time records, and other notifications in accordance with agreed timetables

11.11.2. complete time records and other notifications in accordance with the Director of Finance's instructions

11.11.3. submit forms notifying change in circumstances and termination of employment in the prescribed form, as soon as these changes are reported to them

### Travel and subsistence expenses

11.12. Reimbursement of expenses incurred by Trust staff shall be made by the Payroll Service in accordance with the Trust's relevant current policy and procedures; and subject to verification and authorisation of the claim by an officer with delegated authorisation for this purpose.

### Use of self-employed management consultants and contractors

11.13. The ~~**Workforce and Organisation Development**~~**People Division** shall establish procedures to ensure that the Trust's interests are protected in the contractual arrangements entered into with self-employed consultants and contractors. These procedures shall ensure that the contractual arrangements do not contravene HM Revenues and Customs' requirements regarding the avoidance of tax and national insurance contributions through the use of intermediaries, such as service companies or partnerships, known as Intermediaries Legislation, or "IR 35".

11.14. All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.

## 12. Insurance, including risk pooling schemes administered by the NHS Litigation Authority

12.1. The **Trust Board** shall determine the Trust's arrangements for insurance cover, including the option to insure through the risk pooling schemes administered by the



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NHS ~~Litigation Authority~~Resolution; or to self-insure for some or all of the risks covered by the risk pooling schemes.

12.2. If the Trust Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers and third party liability) covered by the scheme, this decision shall be reviewed annually.

12.3. The **Director of Finance** shall ensure that:

12.3.1. documented procedures cover the Trust's insurance arrangements, including for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed

12.3.2. the arrangements entered into are appropriate and complementary to the risk management programme.

12.3.3. the Trust Board is informed of the nature and extent of the risks that are self-insured in the event that the Board decides not to use the risk pooling schemes administered by the ~~NHSLA~~ NHSR for one or other of the risks covered by the schemes

12.4. The Director of Finance shall determine the level of insurance cover to be held by the Trust in the three discrete areas where the Trust can use commercial insurers:

12.4.1. insuring motor vehicles owned by the Trust including insuring third party liability arising from their use

12.4.2. where the Trust is involved with a consortium in a PFI contract and the other consortium members require that commercial insurance arrangements are entered into

12.4.3. where income generation activities take place, which are not covered by the NHSR~~LA~~ risk pool

## 13. Capital investment, private financing, fixed asset registers and security of assets

13.1. The **Director of Finance** is responsible for compiling and submitting for Board approval an annual capital programme, which is affordable within available resources over the lifetime of the investment.

13.2. The **Director of Finance** shall report to the Board, the progress of delivery of the capital programme, against plan, during the year.

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13.3. The **Chief Executive** shall ensure that:

13.3.1. there is an adequate appraisal and approval process in place for determining capital expenditure priorities and supporting systems to identify and assess the financial effect of each proposal on business plans

13.3.2. all stages of capital schemes are managed and controlled adequately; and that schemes are delivered on time and to cost



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13.3.3. capital investment is risk assessed against the declared commissioning strategic plans of significant commission organisations and is consistent with the Trust's long term strategic plans

13.4. For every capital expenditure proposal, the Chief Executive shall ensure that a business case, or statement of need, is produced in accordance with the Trust's approved procedures and is considered by the **Finance and Performance Committee**, where required. The business case shall set out, as a minimum:

13.4.1. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs

13.4.2. the involvement of appropriate Trust personnel and external agencies

13.4.3. appropriate project management and control arrangements

13.5. The approval of a capital programme shall not constitute approval for expenditure on any scheme.

13.6. The **Director of Finance** shall:

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13.6.1. review the costs and revenue analysis, including revenue consequences included in the business case

13.6.2. ensure that, in higher cost, or higher risk investments, advice has been sought from the NTDA; and that appropriate Risk Evaluation for Investment Decisions (REID) analysis has been completed

13.7. For approved capital schemes, the Director of Finance shall:

13.7.1. issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes

13.7.2. agree arrangements for managing stage payments

13.7.3. maintain procedures for monitoring and reporting on the progress of delivery of contracts; and capital expenditure and commitments against plans and against the Trust's capital programme

13.8. The Trust's **Procurement Service** shall advise the Director of Finance, on the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.9. Authorisations issued to the manager(s) responsible for any scheme shall be made in accordance with the value limits set out in the Scheme of Delegated Authorities:

13.9.1. specific authority to commit expenditure;

13.9.2. authority to proceed to tender

13.9.3. approval to accept a successful tender



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### Private Finance Initiatives (PFI)

13.10. The **Director of Finance** should normally test for PFI when considering capital procurement. If this test supports a proposal to use finance which is to be provided through PFI arrangements, the Director of Finance shall:

13.10.1. demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector

13.10.2. refer any investment proposal over £1 million to the NTDA for a risk assessment and decision to approve the borrowing

13.11. Any PFI proposal shall be specifically agreed by the **Trust Board**.

13.12. Where a capital scheme is funded using the PFI, any variations to the contract will be dealt with under procedures for variations in capital contracts and shall be authorised by the Trust Board.

### *Instructions specific to the Southmead Hospital PFI*

13.13. The **Trust Board** shall approve and authorise the schedule of payments payable by the Trust to the PFI Project Co (Hospital Company (Southmead) Limited), as documented in the Project Agreement made between the Trust and the PFI Project Co dated 25 February 2014 ("Project Agreement").

13.14. The Schedule of Service Payments (Project Agreement, Schedule 18, Appendix I) shall be fixed for the duration of the Project Term save in respect of

13.14.1. inflationary adjustments

13.14.2. procurement of additional works (i.e. Small Works etc.)

13.14.3. variations in accordance with Schedule 22 of the Project Agreement.

13.15. Inflationary adjustments shall be calculated annually and presented to the Trust Board for approval. Arrangements for the procurement of additional works and variations shall be dealt with in accordance with the procedures for variations in capital contracts and shall be authorised by the Trust Board.

13.16. During the Operational Term, the **Director of Facilities** shall be responsible for monitoring the proper performance and implementation of the Project Agreement by the Project Co and the Trust. In accordance with the monthly reporting arrangements, the Director of Facilities will be responsible for ensuring the invoices issued by the Project Co are analysed to ensure compliance with the terms of the Project Agreement. This will include verifying records of:

13.16.1. performance failures

13.16.2. unavailability events

13.16.3. service failure points

and associated "deductions" against Trust records.



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13.17. The **Director of Facilities**, or their nominated deputy shall authorise payment of invoices submitted by the Project Co in accordance with Schedule 18 of the Project Agreement, provided that:

13.17.1. they are satisfied that the appropriate level of Deductions have been applied

13.17.2. the invoice complies with the requirements of Schedule 18

13.17.3. the Trust does not dispute all or any part of the invoice

where all or any part of an invoice is to be withheld, approval of the Director of Finance is required

13.18. The **Director of Finance,** or in their absence, the **Chief Executive** shall approve any decision to withhold, or delay payment of invoices, at the risk of incurring penalties and interest charges for the late payment of amounts due.

13.19. The **Assistant Director of Finance (Financial Services)**, or their nominated deputy, shall process payments of invoices submitted by the Project Co in accordance with Schedule 18, subject to the approval of the Director of Facilities and, where appropriate, the Director of Finance.

13.20. The **Director of Facilities** shall oversee procedures for determining variations to the Project Agreement. Any such variations shall be subject to authorisation in accordance with the limits set out in the Scheme of Delegated Authorities.

### Asset registers

13.21. The **Director of Finance** shall maintain registers of assets and shall maintain procedures for keeping the registers up to date, including provision for arranging for physical confirmation of the existence of assets against the asset register to be conducted once a year.

13.22. The **Director of Finance** shall maintain procedures for verifying additions and amendments to the assets recorded in the asset register. These procedures and records will include:

13.22.1. additions to the fixed asset register clearly identified to an appropriate budget manager

13.22.2. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties

13.22.3. records of costs incurred within the Trust, on stores, requisitions and labour including appropriate overheads

13.22.4. lease agreements in respect of assets held under a finance leases

13.23. The **Director of Finance** shall maintain procedures for controlling the disposal of assets and updating of asset registers and financial records to reflect the event. These procedures will include the requirement for the authorisation and validation of the de-commissioning and disposal of the asset.

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13.24. The **Director of Finance** shall approve procedures for:

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13.24.1. applying depreciation charges and indexation valuation adjustment to assets, using methods and rates as specified in the Manual for Accounts issued by the DH

13.24.2. reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers

### Security of assets

13.25. The **Chief Executive** shall maintain procedures for controlling the security of assets, including fixed assets, cash, cheques and negotiable instruments. The procedures will include:

13.25.1. recording managerial responsibility for each asset

13.25.2. identification of additions and disposals

13.25.3. identification of all repairs and maintenance expenses

13.25.4. physical security of assets

13.25.5. periodic verification of the existence of, condition of, and title to, assets recorded

13.25.6. identification and reporting of all costs associated with the retention of an asset

13.25.7. reporting, recording and safekeeping of cash, cheques, and negotiable instruments

13.26. **All employees** are responsible for the security of property of the Trust and for following such routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices, or damage and losses to Trust property shall be reported in accordance with agreed procedures.

13.27. Where practical, assets should be marked as Trust property.

### Disposals and condemnations

13.28. The **Director of Finance** shall prepare procedures for the disposal of assets including condemnations and ensure that these are notified to managers. The procedures will include arrangements to be followed for:

13.28.1. condemning and disposing of unserviceable and redundant assets

13.28.2. maintaining records of assets disposed of, including confirmation of destruction of condemned assets

13.28.3. specific processes to be followed in instances where assets are passed on for future use to another organisation



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13.28.4. the sale of assets, including through competitive bids and negotiated bids; and sales linked to larger contracts for work, such as assets arising from works of construction, demolition or site clearance

13.29. The **departmental manager** responsible for the decision to dispose of an asset shall advise the Director of Finance of the estimated market value of the asset, taking account of professional advice where appropriate.

## 14. Bank accounts and Government Banking Service accounts

14.1. The **Trust Board** shall:

14.1.1. approve the banking arrangements for the Trust.

14.1.2. As the Corporate Trustee, approve separate banking arrangements for the Trust's Charitable Funds

14.2. The **Director of Finance** is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of bank accounts. This advice will take into account guidance and Directions issued by the Department of Health.

14.3. The **Director of Finance** shall:

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14.3.1. establish and maintain necessary commercial bank accounts and Government Banking Service (GBS) accounts

14.3.2. establish separate bank accounts for non-exchequer funds, including charitable funds

14.3.3. advise the Trust's bankers, formally in writing, of the conditions under which each account will be operated (the bank mandate)

14.3.4. seek to limit the use of commercial bank accounts and the value of cash balances held within them

14.3.5. conduct the Trust's main banking services and financial transactions using accounts provided by the GBS

14.4. Only the **Director of Finance**, or their nominated representative, is authorised to open, operate and control a bank account, where monies owned by the Trust, including charitable funds, are received or expended. All such accounts must be held in the name of the Trust. It is a disciplinary offence for any other officer of the Trust to establish and operate such an account.

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14.5. The **Director of Finance** shall:

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14.5.1. Ensure that payments made from bank or GBS accounts do not exceed the amount credited to the account

14.5.2. monitor compliance with DHSC guidance on the level of cleared funds.

Where such processes are undertaken by a Shared Business Service (SBS) these will be specified in a Service Level Agreement with the SBS.



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### Banking procedures

14.6. The **Director of Finance** shall prepare detailed instructions on the operation of bank and GBS accounts which shall include:

14.6.1. the conditions under which each bank and GBS account is to be operated

14.6.2. details of those authorised to sign cheques or other orders drawn on the Trust's accounts

14.6.3. details of limits to delegated authority, including the number of authorised signatories required, and arrangements for authorising alternative mechanisms for 'signing' cheques and orders

### Tendering and review

14.7. The **Director of Finance** shall review the commercial banking arrangements of the Trust at regular intervals to ensure they continue to reflect best practice and represent best value for money.

14.8. Competitive tenders should be sought at least every five years. The **Director of Finance** shall report to the Trust Board the reason(s) for continuing existing banking arrangements for longer than five years, without competitive review.

14.9. The **Director of Finance** shall report the results of any tendering exercise to the Board. This review is not necessary for GBS accounts.

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### Trust credit cards

14.10. The **Director of Finance** shall approve the allocation and operation of credit cards on behalf of the Trust; implement arrangements to monitor whether the credit cards are being used appropriately; and take action where inappropriate use is identified.

### Security of cash, cheques and other negotiable instruments

14.11. The **Director of Finance** shall:

14.11.1. approve the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable

14.11.2. maintain adequate systems for ordering and securely controlling any such stationery

14.11.3. provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, and procedure notes for the safe storage of keys, and for coin operated machines

14.11.4. prescribe systems and procedures for handling cash and negotiable securities on behalf of the Trust



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14.12. Where such issues are undertaken by the Shared Business Service, detailed requirements will be specified in a Service Level Agreement with The Shared Business Service.

14.13. The Trust's money shall not under any circumstances be used for the encashment of private cheques.

14.14. All cheques, postal orders, cash etc, shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

14.15. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisations or individuals absolving the Trust from responsibility for any loss.

## 15. Investments

15.1. Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board. The current rules require that surplus funds are held in the Trust's GBS accounts.

15.2. The **Director of Finance** shall advise the Charity Committee on investments made with endowment funds held; and prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

## 16. Management of debtors

16.1. The **Director of Finance** shall:

16.1.1. maintain effective processes for the appropriate recovery action on all outstanding debts

16.1.2. deal with instances of income not received, in accordance with losses procedures

16.1.3. maintain effective processes to prevent, or detect overpayments and initiate recovery when this occurs

## 17. Stores and receipt of goods

17.1. The **Director of Finance** shall determine procedures for the management stocks of resources, defined in terms of controlled stores and departmental stores. These will address the procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses; and include the principles that stocks are::



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17.1.1. managed so that best value for money can be achieved whilst maintaining minimum safe stock levels

17.1.2. subjected to annual stock take as a minimum, where rolling stock checks are not in place

17.1.3. valued at the lower of cost and net realisable value

17.2. The **Director of Facilities** shall:

17.2.1. delegate responsibility for the management of stores to relevant, suitably qualified departmental managers

17.2.2. (taking expert advice where necessary) define the security arrangements and the custody of keys for any stores and locations in writing. Wherever practicable, stocks should be marked as health service property

17.2.3. approve alternative arrangements for the management of stores where a complete system of stores control is not justified

17.2.4. identify those authorised to requisition and accept goods supplied

17.3. The **designated store manager** shall:

17.3.1. Maintain stocks in line with clearly defined local procedures that are consistent with the overall requirements set out by the Trust

17.3.2. implement periodic review of slow moving and obsolete items; and for condemnation, disposal, and replacement of all unserviceable articles

17.3.3. report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice in the management and use of stocks

## 18. External borrowing and Public Dividend Capital

18.1. The **Director of Finance** shall advise the Board on the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance shall also provide periodic reports to the Board concerning the PDC debt and all loans.

18.2. The **Trust Board** shall agree the list of employees authorised to make short term borrowings on behalf of the Trust. This shall include the Chief Executive and the Director of Finance.

18.3. The Director of Finance shall prepare detailed procedural instructions concerning applications for loans and shall ensure that:

18.3.1. all short-term borrowings are kept to the minimum period of time possible, consistent with the Trust's overall cashflow position, represent good value for money, and comply with the latest guidance from the DH



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18.3.2. the Trust Board is made aware of all short term borrowings at the next meeting

18.4. The **Finance and Performance Committee** shall ensure that all proposed long-term borrowing is consistent with the Trust's financial plans; and is approved by the Trust Board.

## 19. Losses and special payments

19.1. The **Director of Finance** shall prepare procedural instructions for maintaining a register of losses and special payments, including write-offs, condemnations and ex-gratia payments; and on the recording of and accounting for losses and special payments, including ex-gratia payments. The records will include:

19.1.1. the nature, gross amount (or estimate if an accurate value is not available), and the cause of each loss

19.1.2. the action taken, total recoveries and date of write-off where appropriate

19.1.3. the category in which each loss is to be noted

19.2. The **Director of Finance** shall determine the nature and/or value of losses which must be reported immediately to the **Director of Finance** or **Chief Executive**:

19.2.1. where fraud or bribery is suspected, this shall be reported to the Local Counter Fraud Specialist, in accordance with the Trust Counter Fraud and Bribery Policy

19.2.2. where a criminal offence is suspected, the **Director of Finance** must immediately inform the Local Security Management Specialist who may inform the police if theft or arson is involved

19.2.3. where losses, other than those that are clearly trivial, are apparently caused by theft, arson, neglect of duty or gross carelessness, the Director of Finance must immediately notify the external auditor and the Trust Board

19.3. **Any employee** discovering or suspecting a loss of any kind shall immediately inform their head of department and ensure that the loss is recorded in accordance with instructions.

19.4. The **Trust Board** shall approve the write off of losses, compensations and ex-gratia payments, within the limits delegated to it by the Department of Health.

19.5. The **Audit Committee** shall receive regular reports of losses, compensations and ex-gratia payments made.

19.6. The **Director of Finance** and the Shared Business Service shall be authorised to:

19.6.1. take any necessary steps to safeguard the Trust's interests in the event of bankruptcies and company liquidations

19.6.2. investigate whether any insurance claim can be made

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## 20. Patients' property

20.1. The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival (see "Guidance for NHS organisations on the secure management of patients' property", NHS Protect, July 2012; and Health and Social Care Act 2008, (Regulated Activities) regulations 2010).

20.2. The **Chief Executive** shall ensure that patients or their guardians, as appropriate, are clearly and suitably informed before or on admission into hospital that the Trust will not accept responsibility or liability for patients' property brought into NHS premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

20.3. The **Director of Finance** shall provide procedural instructions on the collection, custody, banking, recording, safekeeping, and disposal of patients' property. (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. These instructions will include arrangements for:

20.3.1. managing large amounts of money handed over by longer stay patients

20.3.2. restricting the use of patients' monies for purposes specified by the patient, or their guardian

20.4. In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

20.5. **Departmental and senior managers** shall inform staff of their responsibilities and duties for the administration of the property of patients.

## 21. Funds held on Trust

21.1. The **Trust Board**, as Corporate Trustee, is responsible for the management of funds it holds on trust and for meeting the requirements of the Charities Commission.

21.2. The **Trust Board's** corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

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21.3. Trustee responsibilities for non-exchequer funds for charitable and non-charitable purposes shall be discharged separately and full recognition shall be given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.



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21.4. The Charity Committee shall ensure that each trust fund for which the corporate trustee is responsible is managed appropriately in terms of its purpose and requirements.

## 22. Retention of records

22.1. The **Chief Executive** is responsible for managing all NHS records, regardless of how they are held; and shall require policy and procedures to be followed that ensure compliance with the current DHSC best practice guidelines on records management. These procedures will include arrangements for:

22.1.1. managing archives of all records required to be retained in accordance with DHSC guidelines

22.1.2. records held in archives to be accessible for retrieval by authorised persons

22.1.3. destruction of records in accordance with the DHSC "Records Management: NHS Code of Practice" Part 1 (30 March 2006) and Part 2 (8 January 2009)

22.2. Where documents are held by a Shared Business Service detailed records storage requirements will be set out in a SLA with the Shared Business Service.

## 23. Information Technology and data security

23.1. The **Director of Finance** shall be responsible for the accuracy and security of the performance and financial data of the Trust and shall devise and implement any necessary procedures to ensure:

23.1.1. computer assets and data programmes are protected from theft or damage

23.1.2. adequate and reasonable protection of the Trust's data from deletion or modification; accidental or intentional disclosure to unauthorised persons, having due regard for the Data Protection Act 1998

23.1.3. adequate controls operate over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data

23.1.4. controls exist such that the computer operation is separated from development, maintenance and amendment

23.1.5. adequate audit trails exist through the computerised system; and that these are subjected to periodic reviews as the Director may consider necessary

23.2. Where computer systems have an impact on corporate financial systems, the Director of Finance shall ensure that new systems and amendments to existing financial systems are developed in a controlled manner and thoroughly tested prior to implementation. The Director of Finance shall gain assurance that:

23.2.1. systems acquisition, development and maintenance are delivered in line with contractual agreements and Trust procedures



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23.2.2. new systems that have an impact on, or are replacing existing financial systems are developed in a controlled way and thoroughly tested before they are put into practice. External organisations providing this service will need to provide assurances that what they do is adequate

23.2.3. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management audit trail exists

23.2.4. finance staff have the necessary levels of access to such data

23.2.5. such computer audit reviews as are considered necessary are being carried out

23.3. The **Chief Executive** shall maintain a Freedom of Information (FOI) Publication Scheme, consistent with models approved by the Information Commissioner.

### Contracts for computer services with other health bodies or outside agencies

23.4. The **Director of Finance** shall ensure that any contract for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract shall also ensure rights of access for audit purposes.

23.5. Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

### Risk assessment

23.6. The **Chief Information Officer** shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered; and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

## 24. Risk management

24.1. The **Chief Executive** shall ensure that the Trust has adequate procedures for managing risk and meeting current DHSC requirements for assurance frameworks, which shall be approved and monitored by the Trust Board.

24.2. The programme of risk management shall include:

24.2.1. arrangements for identifying and quantifying risks and potential liabilities

24.2.2. promotion, to all levels of staff, of a positive attitude towards the identification and management of risk

24.2.3. procedures to ensure all significant risks and potential liabilities are assessed and addressed, including through maintenance of effective systems of internal



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control, cost effective insurance cover, and decisions on the acceptable level of retained risk

24.2.4. contingency plans to offset the impact of adverse events

24.2.5. arrangements for reviewing the effectiveness of the risk management processes in place, including: internal audit; clinical audit; and health and safety review

24.2.6. arrangements for reviewing the risk management programme

24.3. The Chief Executive shall ensure that the existence, integration and evaluation of the risk management system is used to inform the Annual Governance Statement within the Annual Report and Accounts as required by current DHSC guidance.

## 25. Audit

25.1. In accordance with Standing Orders, the Board shall formally establish an **Audit Committee**, with clearly defined terms of reference. The Committee will seek assurance for the Board on the range of issues in accordance with guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

25.1.1. overseeing internal and external audit services

25.1.2. reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments

25.1.3. reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

25.1.4. monitoring compliance with Standing Orders, Standing Financial Instructions, delegations and reservations

25.1.5. reviewing schedules of losses and compensations and advising the Board where necessary

25.1.6. reviewing the arrangements in place to support the application of the Assurance Framework on behalf of the Board and advising the Board accordingly.

25.2. Where the Audit Committee considers there is evidence of *ultra vires* transactions, or improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health (to the Director of Finance in the first instance).

25.3. It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided. The Audit Committee shall be involved in the selection process when the internal audit service provision is subjected to market testing.



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25.4. In the case of the Shared Business Service, the Director of Finance shall ensure that maintenance of an adequate internal audit service is specified in any service level agreement and shall further specify assurance arrangements between the Trust's internal and external auditors and the Shared Business Service's auditors.

25.5. The **Director of Finance** shall ensure that:

25.5.1. there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an independent and effective internal audit function

25.5.2. the Head of Internal Audit is sufficiently qualified and experienced to perform that role; to facilitate the effective discussion of the results of internal audit work with senior management

25.5.3. the internal audit service is adequate and meets the NHS Internal Audit Standards (DH, April 2011)

25.5.4. the internal audit service provides the Audit Committee with an annual report of the coverage and results of the work of the service. The report must address, as a minimum:

- a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health
- major internal financial control weaknesses identified
- progress on the implementation of internal audit recommendations
- progress against plan over the previous year
- strategic audit plan covering the forthcoming three years
- a detailed audit plan for the next financial year

25.5.5. the police are informed at the right time, in cases of misappropriation and other irregularities not involving fraud or bribery

25.5.6. there is effective liaison with the Trust's appointed Local Counter Fraud Specialist (LCFS), or NHS Counter Fraud Authority on all suspected cases of fraud and bribery and all anomalies which may indicate fraud or bribery

25.6. The **Director of Finance** and designated auditors are entitled to require and receive, without necessarily giving prior notice, the following:

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25.6.1. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature

25.6.2. access at all reasonable times to any land, premises or members of the Board or employees of the Trust

25.6.3. sight of any cash, stores or other property of the Trust under the control of any member of the Board or Trust employee

25.6.4. explanations concerning any matter under investigation



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## Internal Audit

25.7. The internal audit service shall:

25.7.1. provide an independent and objective assessment for the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance arrangements support the achievement of the Trust's objectives.

25.7.2. operate independently of the decisions made by the Trust and its employees; and of the activities which it audits. No member of the team providing the internal audit service will have executive responsibilities.

25.8. The **Head of Internal Audit** shall develop and maintain an Internal Audit Strategy for providing the Chief Executive with an objective evaluation of; and opinions on the effectiveness of the Trust's risk management, control and governance arrangements. The planned programme of work will inform the Head of Internal Audit's opinion. This will contribute to the framework of assurance that supports completion of the Annual Governance Statement, which forms part of the annual financial accounts.

25.9. The **Head of Internal Audit** shall ensure that the audit team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience needed to deliver the internal audit plan in line with the NHS Internal Audit Standards (DH, April 2011).

25.10. The **Head of Internal Audit** will normally attend Audit Committee meetings and has an independent right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

25.11. The **Head of Internal Audit** shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards.

25.12. The internal audit service will review, appraise and report upon:

25.12.1. the extent of compliance with and the financial effect of, relevant policies, plans and procedures

25.12.2. the adequacy and application of financial and other related management controls

25.12.3. the suitability of financial and other related management data

25.12.4. the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from

25.12.5. fraud and other offences

25.12.6. waste, extravagance and inefficient administration

25.12.7. poor value for money or other causes

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25.13. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

25.14. In obtaining third party assurance from other auditors, for example SBS's auditors, the Head of Internal Audit should follow the Internal Auditors Practitioners Group (IAPG) assurance guidance.

### External Audit

25.15. The **External Auditor** is appointed by the Trust's Auditor Panel and paid for by the Trust. The Audit Committee shall ensure that a cost-effective service is provided. If the Trust Board has concerns about the service provided by the External Auditor, which cannot be resolved by the Board, this should be raised with the External Auditor.

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### Counter Fraud and Bribery

25.16. In line with their responsibilities the Trust **Chief Executive** and **Director of Finance** shall ensure compliance with section 24 of the NHS Standard Contract;

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25.17. The **Director of Finance** shall ensure that:

25.16.1. the Trust's Counter Fraud and Bribery Policy is maintained and remains up to date;

25.16.2. an NHS accredited Local Counter Fraud Specialist is appointed to the Trust to deliver the requirements of the Policy in accordance with the NHS Counter Fraud Authority Standards;

25.18. The appointed **Local Counter Fraud Specialist** shall report to the Director of Finance and shall work with staff in NHS Counter Fraud Authority, when required;

25.19. The Local Counter Fraud Specialist will provide a written report to the Audit Committee, on an annual basis at least, on the counter fraud work completed within the Trust;

25.20. In accordance with the Trust's Counter Fraud Policy, any suspicions involving financial crime must be reported to the Local Counter Fraud Specialist, and/or the Director of Finance or via the NHS Fraud and Bribery Reporting Line.

All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010.

Where evidence of Fraud and/or is identified all available sanctions will be pursued against offenders. This may include internal and professional body disciplinary sanctions, criminal prosecution and civil action to recover identified losses.



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### Security Management

25.21. The **Director of Facilities** shall ensure that a qualified Local Security Management Specialist is appointed to provide security management services to the Trust, in accordance with the requirements of the NHS Standard Contract (currently 2013/14).

25.22. The **Local Security Management Specialist** will provide a written report to the Audit Committee, on an annual basis at least, on the security management work completed within the Trust.

**ENDS**



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# Appendix 3 – Scheme of Delegated Authorities

## 1. Trust Policies and procedural guidance

| SoDA | Delegated Matter | Authority Delegated to | Delegation Ref. |
|---|---|---|---|
| | **Adoption (and responsibility for currency of):**<br>- Trust Policies | Relevant Director to be appointed as Policy owner | SFI 2<br>*Policy on Policies* |
| | - Procedural guidance (Procedure notes, Standard Operating Procedures, Protocols, Guidance) | Officer nominated by the Relevant Director | SFI 2<br>*Policy on Policies* |
| | **Maintain and update Trust's financial procedures** (eg administrative procedure notes, desktop guides, guidance to Budget Managers) | Director of Finance | SFI 2.14 |



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## 2. Planning and budget management

| SoDA | Delegated Matter | Authority Delegated to | Delegation Ref. |
|---|---|---|---|
| | **Financial Framework**<br>Advising the Board on the financial framework within which the Trust operates | Director of Finance | SFI 3.1 |
| | Compliance with and update of Trust financial framework | Director of Finance | SFI 3.1 |
| | **Business and budget plans** | | SFI 4 |
| | Preparation of strategic and annual plans for the Trust | Chief Executive | SFI 4.1 |
| | Preparation of annual (and longer term) financial budget for the Trust | Director of Finance | SFI 4.3 |
| | Contribute to the preparation of annual budgets | All nominated Budget Managers | SFI 4.4 |
| | **Budget management (and responsibility levels)** | | SFI 5 |
| | i. at individual cost centre level | Budget Manager or nominated deputy | SFI 5 |
| | ii. at department level | Departmental Manager or nominated deputy | SFI 5 |
| | iii. division level | Clinical Director / Corporate Manager (some or all of the Division Management Team as authorised by the Clinical Director / Corporate Manager) | SFI 5 |
| | iv. at Executive Director level | Executive Director, or nominated deputy | SFI 5 |



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| SoDA | Delegated Matter | Authority Delegated to | Delegation Ref. |
|---|---|---|---|
| | | | |
| | **Recognition and adoption of the annual budget at cost-centre level** | Budget Managers | SFI 5.9 |
| | **Variations from reserves** (additional funds provided to address inflationary pressures and/or investments and/or risks)<br>*Report periodically to the Finance & Performance Committee* | Director of Finance or nominated deputy | SFI 5 |

*Approval of variation of budgets, including authority to vire*

| SoDA | Delegated Authority | Between budget lines | Capital to revenue & *vice versa* | SFI reference |
|---|---|---|---|---|
| | Within a cost centre | Budget manager **plus** one of: Head of Nursing, Matron, Divisional Operations Director, Assistant Department Manager | Agreement between Business Partner and Director of Operational Finance , with the express agreement of the Director of Finance | SFI 5.9 |
| | Within a department, or specialty; between cost centres | Department Manager **plus** one of: Director, Deputy Director, Head of Nursing, Matron, Divisional Operations Director | | SFI 5.9 |
| | Within a division; between departments and specialties | Director, **or** Deputy Director **or** Divisional Operations Director | | SFI 5.9 |
| | Between divisions, up to **£5,000** | Deputy Director of both divisions | | SFI 5.9 |
| | Between divisions, over **£5,000** | Executive Director of both divisions | | SFI 5.9 |



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*Preparation of financial reports and returns*

| SoDA | Delegated Matter | Authority Delegated to | Delegation Ref. |
|---|---|---|---|
| | **Preparation of annual financial accounts and associated financial returns**<br>For Board approval | Director of Finance | SFI 6.1 |
| | **Preparation of Annual Report (or equivalent)**<br>For Board approval | Chief Executive | SFI 6.3 |
| | **Preparation of monthly and quarterly financial returns to NHSI** | Director of Finance or nominated deputy | SFI 6.1 |



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## 3. Contracted Income and Expenditure[1]

| SoDA | Delegated Matter | Authority Delegated to | Delegation Ref. |
|---|---|---|---|
| | **Setting of fees and charges for NHS services** | | SFI 7 |
| | **Agree service level agreements, in accordance with NHS standard contract** | | SFI 7.6 |
| | i. under £1 million | i. Director of Finance, or nominated deputy | |
| | ii. over £1million | ii. Chief Executive and Director of Finance | |
| | **Subject to any required approvals being obtained, execute Agreements/Contracts (including Service Level Agreements and Deeds of Variation[2]) with NHS and non-NHS bodies for the purchase or provision of goods and/or services**<br>ii. under £1 million<br>iii. over £1million | i. Director of Finance<br>ii. Chief Executive and Director of Finance | SFI 7.6<br>SFI 7.7<br>SFI 7.8<br>SFI 9.5<br>SFI 9.6 |
| | **Contract management, monitoring and reporting** | Director of Finance or nominated deputy | SFI 7.9<br>SFI 7.10 |
| | **Private Patients**<br>i. set pricing policy and price structure | i. Director of Finance<br>ii. Director of Finance<br>iii. Director of Finance, Medical | SFI 7.3 |

[1] All legally binding documentation must be entered into in the name of "North Bristol NHS Trust" as the relevant legal entity
[2] If any variation is not included within the original Agreement/Contract, such variation shall require approval as if a new Agreement/Contract (SFI 10.18)



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| SoDA | Delegated Matter | Authority Delegated to | Delegation Ref. |
|---|---|---|---|
| | ii. set payment policy, including use of deposits, income guarantees, arrangements with insurance companies<br>iii. approve service coverage policy (i.e. clinical services offered) | Director, Chief Executive | |
| | **Overseas visitors**<br>i. set pricing policy and price structure<br>ii. set payment policy, including use of deposits, income guarantees | Director of Finance | SFI 7.3 |
| | **Authorise sponsorship deals**<br>i. Approve and execute Agreements to receive sponsorship from third parties (including funding of staff and loan of equipment):up to £15,000<br>ii. £15,000 to £50,000<br>iii. over £50,000 | i. Divisional Operations Director<br>ii. Director of Finance<br>iii. Chief Executive | SFI 7.13 |
| | **Authorise and execute concession arrangements** | Director of Finance | SFI 7.15 |
| | **Authorise research projects and clinical trials**, including approvals to apply for research funding and approvals to undertake research, once considered by the Research and Development Committee<br>i. execute required Agreements/Contracts and authorise grant submission<br>ii. execute documentation where the Trust Seal is required | i. Deputy Director of Research or nominated Deputy<br>ii. As per SFI 8e | SFI 7.12 |



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| SoDA | Delegated Matter | Authority Delegated to | Delegation Ref. |
|---|---|---|---|
| | **Authorise funded training posts** | Head of Learning and Development | Not within SFIs |
| | **Tenancy agreements and licences**<br>Prepare and execute all tenancy agreements and licences for staff (subject to Trust policy on accommodation)form of tenancy agreements<br>i. signature of individual tenancy agreements<br>ii. extensions to existing agreements | i. Director of Facilities<br>ii. Residences Manager<br>iii. Residences Manager | SFI 7.4<br>SFI 9.5 |
| | **Approve letting of premises to third parties (including leases and licences)**<br>i. execute documentation where the Trust Seal is not required<br>ii. execute documentation where the Trust Seal is required | i. Director of Finance<br>ii. As per SFI 8e | SFI 7.4 |
| | **Approve rent based on professional assessment** | Director of Finance or nominated deputy | SFI 7.4 |
| | **Legal Services**<br>i. authority to engage with legal advisors<br>ii. maintenance of framework arrangements with approved legal advisors<br>iii. approval of call off of services | i. Chief Executive<br>ii. Trust Secretary<br>iii. Trust Secretary (delegated to Commercial and Legal Services Manager) | SFI 8 |



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## 4. Approval of Business cases

Before any case can progress through the approval processes detailed below, divisional and corporate support is needed for both capital and revenue cases as follows:

.

| | |
|---|---|
| **Divisional support** | Prior to any scheme advancing the Divisional Management Board should consider and approve the case |
| ~~**Corporate and Peer support and scrutiny**~~ **Business Case Review Group** | The Business Case Review Group is a sub-committee of the Trust Management Team. The purpose of the Committee is to:<br>• Review all capital and revenue business cases of value greater than £100k (defined as annual cost for recurring commitments or over life-time of contractual commitments, combined capital and revenue values):<br>o To ensure trust-wide impacts have been understood within the case<br>o To maintain consistent quality standard for cases going through for approval<br>o Appendix A outlines the process for cases of value below £100k<br>• Provide an approval recommendation to TMT on finalised business cases;<br>• Monitor development and delivery of business case pipeline<br><br>~~All revenue and capital business cases (revenue cases >£100k, capital cases >£0) including all new consultant cases (i.e. that require additional funded consultant PAs), need to be reviewed and endorsed by the Business Case Review Group (BCRG), which includes corporate leads and divisional peers, before approval is sought. This should be an iterative process with early reviews of the strategic case to provide early advice and support and subsequent review of the completed business case~~ |

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The business case process outlined below applies to all contract renewals and extensions as well as new revenue spend

*Approval Process - Revenue Business Cases*

| | Full life cost of new expenditure | | | | |
|---|---|---|---|---|---|
| | **Under £100k** **~~Short~~ DoF business case template** | **£100k - £500k** **~~Short~~ Single-stage ~~-~~ business case template** | **£500k – £1m** **OBC and FBC business case templates** | **Over £1m~~-~~ £14,999k** **~~SOC,~~ OBC and FBC business case template** | **Over £15m** **SOC, OBC and FBC busines s case template** |
| **Director of Finance (or nominated deputy)** | Approval | Approval | Approval OBC & FBC | Approval SOC, OBC & FBC | Approval SOC, OBC & FBC |
| **Chief Executive** | - | Approval (via Trust Management Team) ~~SOC & OBC~~ | Approval (via Trust Management Team) OBC & FBC | Approval (via Trust Management Team) ~~SOC,~~ OBC & FBC | Approval (via Trust Management Team) SOC, OBC & FBC |
| **Finance & Performance Committee** | - | - | Approval OBC & FBC | Approval ~~SOC,~~ OBC & FBC | Approval SOC, OBC & FBC |
| **Trust Board** | - | - | - | Approval FBC | Approval FBC |

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| | | | | | |
|---|---|---|---|---|---|
| **NHSI** | | | | | Approval SOC, OBC & FPC |

*Approval Process – Capital Business Cases.*

| **Gross expenditure on project (Full life costs, including all internal staff costs attributable to the project)** | | | | | | |
|---|---|---|---|---|---|---|
| | **Up to £5k** | **£5k - £100k** | **£100k to £500k** | **£500k to £1m** | **over £1m - £14,999k** | **Over £15m** |
| | **Treat as revenue** | **Short DoF business case template** | **Short Single-stage business case template** | **OBC and FBC business case templates** | **SOC, OBC and FBC business case templates** | **SOC, OBC and FBC business case templates** |
| Assistant Director of Operational Finance (Financial Services) and Head of Sustainable Health and Capital Planning (via Capital Planning Group (CPG)) | N/A | Approval | Approval | Approve OBC and FBC | Approve SOC, OBC and FBC | Approve SOC, OBC and FBC |
| Director of Finance or nominated deputy | N/A | N/A | Approval | Approval of OBC and FBC | Approval of SOC, OBC and FBC at FPC | Approval of SOC, OBC and FBC at FPC |
| Finance & Performance Committee | N/A | N/A | N/A | Approve OBC and FBC | Approve SOC, OBC and FBC | Approve SOC, OBC and FBC |
| Trust Board | N/A | N/A | N/A | N/A | Approve FBC | Approve FBC |
| NHSI | N/A | N/A | N/A | N/A | N/A | Approve SOC, OBC and FBC |

**Key**
DoF – Director of Finance
SOC – Strategic Outline Case



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OBC – Outline Business Case
FBC – Full Business Case

**Order of Approvals**

Approvals are sequential and all steps in the process need to be followed in order i.e. for a revenue scheme of £1m+ the order of approvals are:

~~An example for a capital scheme of £510k is as follows:~~

**Joint Revenue and Capital Cases**

Where a case involves both revenue and capital consequences then both approval routes should be followed. For example a case for capital investment of £250k and revenue consequences of £495k should be approved as follows:

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## 5. Approvals to Award from Tenders and quotations (revenue and capital)



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| Definitions | |
|---|---|
| Non-Contracted spend | Spend that cannot be demonstrated as assigned to a valid contract<br><br>Spend that should the proposed action not be completed will become unsupported by a contract (ie. spend approaching contract expiry date or contract extension date) |
| Compliant Procurement Process: | A procurement activity that complies with PCR (Public Contracts Regulations) |
| Recommendation Report: | Report created by BWPC seeking approval of the outcome of a compliant procurement process, prior to contract award or extension<br><br>Value contained within recommendation report identifies the initial contract term, plus extensions. However, initial approve is ONLY for contract term, secondary recommendation report required to extend contract |
| Exception Report: | Report created by BWPC, seeking directional guidance on a procurement process where a non-compliant outcome is preferred by the Trust, prior to contract award or extension |
| STA: | A document used to seek approval, with justification, for award of contract or out-of-scope extension without documented proof of value of money via direct comparison |

| | |
|---|---|
| **BWPC remit** | As custodians of the Procurement Process, BWPC are tasked with two aspects of validation:<br>1. Adherence to Trust SFI's; in simplified terms a requirement to ensure due process has been performed that will prove value for money<br>2. Adherence to The Public Contracts Regulations 2015 and other relevant legislation<br>The intention of BWPC is to offer insight into the compliance of both aspects of validation for all relevant procurement activities<br>As the element of risk concerning exceptions to Trust SFI's &/or PCR/OJEU non-compliance resides with the individual Trust/s, BWPC remit remains one of guidance and not decision maker. |



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| Management of non-Contracted Spend | | | |
|---|---|---|---|
| | | | |
| | **Description** | **Consortium** | |
| **1. Up to £5,000** | *No requirement to evidence value for money* | 5,000 | Budget manager |
| **2. £5,000 to £25,000** | *Trusts responsible for quotation provision, BWPC operate a validation activity* | 25,000 | Divisional Operations Director or Executive Director or nominated Deputy |
| Written Quote Requirement | *The number of quotes required prior to a Purchase Order being progressed* | 3 | |

| **Procedure (between SFI threshold & £25K)** | **Procedure Detail** | | **Consortium** |
|---|---|---|---|
| | | | |
| Quotation Process | *3 or more valid quotes provided* | | PO Progressed |
| Quotation Process | *2 or less valid quotes* | | STA |
| | | | |
| **3. Above £25,000** | Outcome Detail | | Consortium |
| | | | |
| Tender Process (Local, OJEU, Quote) | *3 or more competitively priced bids received* | | Recommendation Report |
| Tender Process (Local, OJEU, Quote) | *Less than 3 competitively priced bids received* | | Recommendation report, followed by STA if approved |



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| | | | |
|---|---|---|---|
| Tender Process (Local, OJEU, Quote) | *Contract not awarded to process winner* | | Exception Report, followed by STA if exception awarded |
| Framework Agreement (External, Internal) | *Mini-Competition - 3 or more competitively priced bids received* | | Recommendation Report |
| Framework Agreement (External, Internal) | *Mini-Competition – Less than 3 competitively priced bids received* | | Recommendation report, followed by STA if approved |
| Framework Agreement (External, Internal) | *Compliant direct award (without proof/evaluation of competition)* | | Recommendation report, followed by STA if approved |
| Framework Agreement (External, Internal) | *Non-compliant direct award* | | Exception Report, followed by STA if exception awarded |
| VEAT Notice | *VEAT Notice* | | Recommendation report, followed by STA if approved |
| Contract Modification | *Contract Extension (In scope)* | | Recommendation Report |
| Contract Modification | *Contract Extension (Out of scope)* | | Exception Report, followed by STA if exception awarded |
| Contract Modification | *Contract Variation (In scope)* | | Recommendation Report |
| Contract Modification | *Contract Variation (Out of scope)* | | Exception Report, followed by STA if exception awarded |



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| | | | |
|---|---|---|---|
| Non-contracted to contracted spend | *Non-PO to PO (first 12 months/specified period)* | | Single Tender Action, with commitment to run procurement within 12 months |
| Non-compliant direct award | | | Single Tender Action |



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**STA & Exception report  Authorisation Financial Values**

**Up to £25k**
Director of Procurement

**£25k to £100K**
Director of Finance

**£100K to £1m**
Chief Executive

**£1m+**
Trust Board

**Recommendation Report - Authorisation Levels**

**up to £100K**
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Corporate Director

**£100K to £1m**
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Corporate Director **and**
Director of Finance

**£1m+**
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Corporate Director **and**
Director of Finance **and**
Trust Board



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**5 Contract Signature**

The following applies for contract signatures (after all relevant approvals have been given):

- **Up To EU threshold – Divisional Operations Director or relevant Corporate Director**
- **EU threshold to £500,000 – Director of Finance**
- **Over £500,000 - Chief Executive**

**Comment [XB7]:** This will need to be kept under review during the post-Brexit transition period and updated as UK specific rules are implemented.

## 6. Contract Management

*Other tendering and contractual arrangements*

| | Delegated matter | Authority delegated to | Delegation ref. |
|---|---|---|---|
| | **Approve insurance policies**<br>i. Schemes administered by the NHSR~~LA~~<br>ii. Other insurance arrangements | i. Director of Finance or nominated deputy.<br>ii. Director of Finance or | SFI 12.1<br>SFI 12.4 |



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| | | | |
|---|---|---|---|
| | | nominated deputy. | |
| | **Affix Trust Seal to contract documentation**<br>Including property documentation and contractual arrangements where there is no consideration | Chair and Chief Executive, or in their absence, the designated acting Chair or Chief Executive | SO 30 |

*Non-pay requisitions, orders and payment authorisation*

Financial thresholds in this section mirror the procurement limits and as such exclude VAT and/or delivery charges. Where there is an order/contract for more than one financial year, the total cost must be included not just the 12 months element.

| | Delegated Matter | Authority Delegated to | Delegation Ref. |
|---|---|---|---|
| | Maintain records of officers who are authorised to place requisitions and orders; and the maximum value of orders that they have the authority to place. | Director of Finance | SFI 10.2 |
| | Identify the Trust's approved supply arrangements (controlled procurement systems, framework agreements) | Director of Finance | SFI 10.4 |

*Trust-wide* ***(excepting elements of delegated authority for specific disciplines specified in the subsequent tables)***

## 7. Ordering limits (EROS)

| | |
|---|---|
| Up to £2,500 | Authorising manager approved by Divisional Operations Director/Corporate manager |
| Over £2,500 | Vetting manager approved by Divisional Operations Director/Corporate manager |



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## 8. Oracle Limits - Invoice processing

### a. General Oracle Limits

| | |
|---|---|
| Up to £25,000 | Budget holder/manager designated by Divisional Operations Director or equivalent |
| £25,000 to £100,000 | Divisional operations Director//Corporate Manager |
| £100,000 to £1m<br><br>Grouped NHS Supply Chain invoice up to £500K | Executive Director<br><br>Director of Procurement |
| Over £1m | Director of Finance/Chief Executive |



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**b. Subsidiary Systems**

Subsidiary Systems where grouped requisitions are used.

| | **Pharmacy** | **Capital Estates** |
|---|---|---|
| Grouped requisitions up to £500k per week | Director of Pharmacy or nominated deputy | Capital estates Mailbox |
| Grouped requisitions over £500k per week | Director of Pharmacy | Director of Facilities or nominated Deputy |

**c. In addition to the general oracle limits, additional limits are in place within the finance department which are used to process high value pre-approved invoices e.g Unitary Payment, loan repayments etc.**

| | |
|---|---|
| Up to £1m | Head of Financial ~~Accounts~~Control |
| £1m-£10m | Assistant Director of Finance (Financial Services)<br>or<br>Assistant Director of Finance (Planning & Income)<br>(or nominated deputies in their absence) |
| Over £10m | Director of Operational Services or Director of Finance |



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## 9. Workforce and payroll

*Appointment of Senior Medical Staff and team (investment may include capital elements)*

| | | Replacement posts | New posts / clinical teams[1] | |
|---|---|---|---|---|
| | | **Within existing budget** | **Up to £500k** | **Over £500k** |
| | **Approval / Sign-Off[2] by:** | | | |
| | Trust Management Team | | Agree project mandate and priority | |
| | Finance Business Partner | Sign | Sign | Sign |
| | HR advisor | Sign | Sign | Sign |
| | Divisional Operations Director or equivalent corporate manager | Sign | Sign | Sign |
| | Clinical Director | Sign | Sign | Sign |
| | Chief Operating Officer | - | Sign | Sign |
| | Director of Finance | - | Sign | Sign |
| | Consultant Post Panel | **Approve** | **Approve** | Recommend |
| | Finance & Performance Committee | | | OBC & FBC |
| | Trust Board | | | **Approve** FBC |

1 New clinical teams to deliver new services. Approach follows the same sign-off steps as for new service developments

2 Signature indicates sufficient understanding and confidence in the details of the business case to confirm responsibility for support for the



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proposal

~~*Procedure for senior medical appointments*~~

~~Role of the Consultant Post Panel (CPP) is to approve the post. Approval of funding and service development follows same process as other business cases. Business case for a new service follows same template as business case for revenue funded service developments up to £500k~~

| ~~Senior medical appointment~~ | |
|---|---|
| ~~Replacement for existing post~~ | ~~New post~~ |
| ~~Business Case template for senior medical appointments~~ | ~~Business Case narrative template and finance appraisal~~ |
| ~~⇩~~ | ~~⇩~~ |
| ~~CPP Approval~~ | ~~Follows revenue approval process~~ |
| | ~~⇩~~ |
| | ~~CPP Approval for post~~ |



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*Payroll authorities*

| | Approval / Sign-Off by: | Existing establishment<br>Within existing budget | New posts / Outside of establishment<br>With specifically allocated funding | <br>Without specifically allocated funding |
|---|---|---|---|---|
| | Fill funded post on establishment with permanent staff (subject to any vacancy review policy in place) | General / Corporate Manager **or** nominated deputy **and** finance Business Partner **and** HR advisor[1] | - | - |
| | Appoint staff to post not on formal establishment | - | General / Corporate Manager **or** nominated deputy **and** finance Business Partner **and** HR advisor[1] | General / Corporate Manager **or** nominated deputy **and** finance Business Partner **and** HR advisor[1] |
| | (Re)new fixed term contracts | General / Corporate Manager | General / Corporate Manager | General / Corporate Manager |
| | Engage non-medical, non-payroll consultancy staff (subject to contracting rules): | | | |
| | - Below **£100k** gross commitment | - | General / Corporate Manager or Executive Director | |
| | - **£100k** to **£500k** gross commitment | - | Director of Finance | |
| | - over **£500k** gross commitment | - | Chief | |



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| | | | |
|---|---|---|---|
| | | | Executive |
| | - over 6 months length of contract | - | Chief Executive |

[1]Need to ensure fit with workforce plans

| Bank, agency and locum staff | Within establishment | | Extra to establishment | |
|---|---|---|---|---|
| | Within budget | Without budget | Within budget | Without budget |
| **SoDA reference** | 11g | | 11h | |
| Nursing | (Deputy) Budget Manager | Director of Nursing **or** Medical Director and Director of Finance **or** Chief Executive | Budget Manager | Director of Nursing **or** Medical Director and Director of Finance **or** Chief Executive |
| Clerical support services | (Deputy) Budget Manager | | Budget Manager | |
| Medical | (Assistant) General / Corporate Manager | | Divisional Operations Director/ / Corporate Manager | |
| Through non-framework agency | As above, plus Executive Director approval | | As above, plus Executive Director approval | |



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*Approvals relating to staff on the payroll*

| | General approvals | Approval / sign off |
|---|---|---|
| | Grant additional increments to staff (outside of Department of Health national T&C) | Director of People & Transformation **and** Director of Finance |
| | Authorise (electronic and paper) timesheets and other positive reporting forms which will affect the amount of salary to be paid to confirm: attendance at work; sickness and absence records; overtime and unsocial hours | Line Manager **or** Authorised Signatories |
| | Authorise travel and subsistence claims (only available through e-expenses) | Line Manager |
| | **Approve departure under compromise agreement** (excluding mutually agreed resignation scheme (MARS) arrangements)<br>i. directors and very senior managers<br>ii. other staff | i. Remuneration and Nominations Committee and Director of Finance<br>ii. Director of People & Transformation and Director of Finance |
| | **Approve redundancy** (and mutually agreed resignation schemes, or similar arrangements)<br>**i.** payment up to **£100k**<br>**ii.** payment over **£100k** | i. Director of People and Transformation and Director of Finance<br>ii. Remuneration and Nominations Committee and Director of Finance |



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## 10 Approval for variations to capital plans

| Delegated authority | Variations to approved sum |
|---|---|
| | |
| ~~Up to **£10,000**~~ | ~~Capital Planning Group~~ |
| Up to **£100k** | Capital Planning Group |
| **£100k** to **£500k** | Finance & Performance Committee |
| **Over £500k** | Trust Board |



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*Funding capital investments through Private Finance Initiative*

| SoDA | Delegated matter | Authority delegated to | Delegation ref. |
|---|---|---|---|
| | Assess comparative merit of progressing scheme through PFI | Finance and Performance Committee, advised by Director of Finance | SFI 13.10 |
| | Authorise payment of the sums identified in the schedule of the unitary payment (being the annual service payment defined in Schedule 18 of the Project Agreement) to be made to the PFI partner over the lifetime of the scheme (project term).<br>Authorise annual Retail Price Index (all items) adjustment, in accordance with the PFI Project Agreement. | Trust Board | SFI 13.13 |
| | Oversee delivery of the PFI contract terms, ensuring appropriate delivery and monitoring of the PFI contract; and including agreement of fee adjustments resulting from facilities management service and performance issues, to verify the invoice total. | Director of Facilities | SFI 13.14<br>SFI 13.15 |
| | Approve decision to withhold, or delay payment of all or part of an invoice submitted by the PFI partner, at risk of incurring penalties and late payment charges | Director of Finance | SFI 13.16 |
| | Process payment of monthly account to the PFI partner, in accordance with the Trust Board authorisation. | Assistant Director of Finance (Financial Services), or nominated deputy | SFI 13.17 |



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*Fixed assets records and accounting for fixed assets*

| SoDA | Delegated matter | Authority delegated to | Delegation ref. |
|---|---|---|---|
| | **Maintain register of (fixed) assets**<br>Including verification of additions and disposals, revaluations, calculation of annual capital charges | Director of Finance | 13.19 to 13.22 |

## 11. Bank and cash and investments

| SoDA | Delegated matter | Authority delegated to | Delegation ref. |
|---|---|---|---|
| | **Day to day operation of bank accounts**<br>i. maintain list of approved signatories<br>ii. approval to pay | i. Shared Business Services (SBS), under terms of contract with the Trust<br>ii. SBS following confirmation of availability of cash required by Head of Financial Control~~Accounts~~ | SFI 14.5 |
| | Determine when to subject commercial bank service supplier to competitive tendering | Director of Finance | SFI 14.8 |
| | **Establish, or close a petty cash facility** | Director of Finance (or nominated deputy) | Not within SFIs |

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**Comment [JB8]:** Can this be nominated deputy eg director of operational finance?



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| | | | |
|---|---|---|---|
| | Approve the use of Trust credit cards (in the name of North Bristol NHS Trust only) | Director of Finance (or nominated deputy) | SFI 14.10 |

**Comment [JB9]:** Can this be nominated deputy eg director of operational finance?



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| SoDA | Delegated matter | Authority delegated to | Delegation ref. |
|---|---|---|---|
| | **Investment of funds**<br>i. surplus exchequer funds<br>ii. charitable fund cash balances | i. Director of Finance<br>ii. Investment advisors appointed by the Charity Committee | SFI 15 |

## 12. External borrowing and Public Dividend Capital

| SoDA | Delegated matter | Authority delegated to | Delegation ref. |
|---|---|---|---|
| | **Short-term borrowing (temporary borrowing limit)** | Trust Board | SFI 18.2<br>SFI 18.3 |
| | **Borrowing, including commercial loans** | Trust Board | SFI 18.4 |
| | **Borrowing of Public Dividend Capital** | Trust Board | SFI 18.1<br>SFI 18.4 |



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## 13. Disposals, write-offs losses and special payments

| SoDA | Delegated matter | Authority delegated to | Delegation ref. |
|---|---|---|---|
| | **Terminate lease and rental arrangements early at cost to the Trust** | Director of Finance **and** Director of Facilities | SFI 13.21 |
| | **Condemn and arrange for disposal of equipment assets**<br>Items that are obsolete, redundant, irreparable or cannot be repaired cost effectively<br>i. with a current or estimated purchase price up to £1,000<br>ii. with a current purchase price of £1,000 - £5,000<br>iii. with a current purchase price over £5,000. | i. Budget manager<br>ii. General / Corporate Manager<br>iii. Executive Director | SFI 13.26 |
| | **Dispose of x-ray films** | Radiology Departmental Manager\Clinical Director | SFI 13.26 |
| | **Disposal of mechanical engineering plant.**<br>With replacement value estimated at:<br>i. up to £10,000<br>ii. £10,000 to £100,000<br>iii. over £100,000 | i. Head of Estate Maintenance<br>ii. Director of Facilities<br>iii. Director of Facilities **and** Director of Finance | SFI 13.26 |
| | **Approve sale, or transfer (eg donation) of equipment assets to another organisation for continued use**<br>i. clinical equipment<br>ii. IT equipment<br>iii. other equipment | i. Medical Director<br>ii. Director of Finance<br>iii. Director of Finance **and** relevant Executive Director | SFI 13.26 |



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| SoDA | Delegated matter | Authority delegated to | Delegation ref. |
|---|---|---|---|
| | | | |
| | **Approve losses, write-offs and compensation payments due to / made under:**<br>• theft, fraud, overpayment of salaries and overpayment of third parties;<br>• fruitless payments, including abandoned capital schemes;<br>• bad debts and claims abandoned, including in respect of Private Patients, Overseas Visitors and other third parties;<br>• damage to buildings, fittings, furniture, equipment and property in stores and in use due to culpable cause (e.g. fraud, theft, arson);<br>• additional payments made to third parties in connection with or arising out of contractual liabilities, including sums payable under agreed settlements and court judgments;<br>• personal injury claims involving negligence (legal advice must be obtained and guidance applied);<br>• ex-gratia payments patients and staff for loss of personal effects;<br>i. up to £1,000<br>ii. £1,000 up to £50,000<br>iii. Over £50,000<br>*All to be reported to the Audit Committee.* | i. Assistant Director of Finance (Financial Services) or nominated deputy in their absence<br>ii. Director of Finance or deputy<br>iii. Audit Committee | SFI 19<br>Schedule of reservations 3 |



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| SoDA | Delegated matter | Authority delegated to | Delegation ref. |
|---|---|---|---|
| | **Report incidents to the Police**<br>i. general<br>ii. where a fraud is involved | i. departmental manager (inform General / Corporate Manager or Director as soon as possible. Also inform Local Security Management Specialist)<br>ii. Director of Finance or Local Counter Fraud Specialist | SFI 19<br>*Counter Fraud and Bribery Policy* |

## 14. Patients' property

Comment [JB10]: What about patients that die in hospital but have valuables? This comes under the bereavement team.

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| Delegated authority | Holding | Receive and safeguard valuables | Discharge patients' valuables |
|---|---|---|---|
| Valuable items | Ward safe | Any member of nursing staff | Any member of nursing staff |
| Cash under **£5k** | Ward safe | Ward Manager | Ward Manager |
| | | | |

## 15. Access to charitable funds

| Delegated authority | Approve expenditure from charitable funds |
|---|---|
| Up to £1,000 | One fund signatory |
| £1,000 to £10,000 | Two fund signatories |



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| Delegated authority | Approve expenditure from charitable funds |
|---|---|
| £10,000 to £50,000 | Two fund signatories plus the Director of Finance (or nominated deputy) |
| Over £50,000 | Two Fund signatories and the Charity Committee. |

Spending plans will be submitted to the Charity Committee for approval in March each year. Approval is delegated to approve additional spending plans that arise during the year as follows:

| Delegated authority | Approve expenditure from charitable funds |
|---|---|
| Up to £10,000 | Assistant Director of Finance (Financial Services) or nominated deputy in their absence |
| £10,000 to £50,000 | Director of Finance (or nominated deputy) |
| Over £50,000 | Charity Committee. |



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*Glossary of terms and acronyms*

| | |
|---|---|
| BC | **Business case** |
| CEO | **Chief Executive Officer** |
| Director | Non-Executive or Executive Director, with or without voting rights at Trust Board. The term excludes Clinical Directors, who are identified separately |
| | |
| DoF | **Director of Finance** |
| FBC | **Full Business Case** |
| Divisional Operations Director /Corporate Manager | The senior operational manager(s); and their formally nominated deputy, for the division or specialty, as designated by the Executive Director. |
| OBC | **Outline Business Case** |
| PMO | **Programme Management Office** |
| SBS | **Shared Business Services.** The Trust's provider of accounts transactions and ledger process |
| SFI | **Standing Financial Instruction.** Reference to the detail in the full SFIs |
| SOC | **Strategic Outline Case** |
| SoDA | **Scheme of Delegated Authorities**. Reference to the detail in the full SoDA |



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| | | | | |
|---|---|---|---|---|
| **Report To:** | Trust Board | | **Agenda Item:** | 15 |
| **Date of Meeting:** | 30 January 2020 | | | |
| **Report Title:** | People & Digital Committee Report | | | |
| **Report Author & Job Title** | Xavier Bell, Director of Corporate Governance & Trust Secretary | | | |
| **Executive/Non-executive Sponsor (presenting)** | Tim Gregory, Chair of the People & Digital Committee and non-Executive Director. | | | |
| **Purpose:** | **Approval/Decision** | **Review** | **To Receive for Assurance** | **To Receive for Information** |
| | **X** | | X | |
| **Recommendation:** | The Trust Board is recommended to receive the report for assurance and:<br>• Note and agree the proposed increase to the risk rating for BAF risk SER6 relating to recruitment; and<br>• Note and agree the revised wording on BAF risk SIR10 relating to capital planning and prioritisation. | | | |
| **Report History:** | The report is a standing item to each Trust Board meeting following a People & Digital Committee. | | | |
| **Next Steps:** | The next report to Trust Board will be to the March 2020 meeting. | | | |

| **Executive Summary** |
|---|
| The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the People & Digital Committee Meeting held on 18 December 2019.<br><br>It should be noted that a verbal update on key issues from the Committee was provided to Trust Board on 19 December 2019. |

| | |
|---|---|
| **Strategic Theme/Corporate Objective Links** | Reports received supported the delivery of the following strategic themes:<br>• Create an exceptional workforce for the future |

| | |
|---|---|
| | • Maximise the use of technology |
| **Board Assurance Framework/Trust Risk Register Links** | Reports received support the mitigation of the following BAF risks:<br>• SIR2 Workforce Stability. Risk score 4 x 4 = 16<br>• SIR5 Information. Risk score 4 x 2 = 8<br>• SIR10 Technology. Risk score 4 x 4 = 16<br>• SIR15 Cyber Security. Risk score 5 x 4 = 20<br>• SER6 Workforce Recruitment. Risk score 3 x 3 = 9 |
| **Other Standard Reference** | Care Quality Commission Standards. |
| **Financial implications** | No financial implications as a consequence of this report. |
| **Other Resource Implications** | No other resource implications as a result of this report. |
| **Legal Implications including Equality, Diversity and Inclusion Assessment** | No legal implications. |

| | |
|---|---|
| **Appendices:** | None |

## 1. Purpose

To provide a highlight of the key assurances, any escalations to the Board and identification of any new risks from the People & Digital Committee meeting held on 18 December 2019.

## 2. Background

The People & Digital Committee is a sub-committee of the Trust Board. It meets bi-monthly and reports to the Board after each meeting. The Committee was established to provide strategic direction and board assurance in relation to all workforce and IM&T issues.

## 3. Key Assurances & matters for the attention of Trust Board

3.1 The Committee discussed its terms of reference and agreed a set of questions to be circulated to the Committee to facilitate a self-review. A key item for consideration was whether the Committee meeting frequency should change from bi-monthly to quarterly. This will be explored via the questionnaire, discussed at the February Committee meeting and a recommendation made to February Trust Board.

3.2 The Committee received the quarterly Guardian of Safe Junior Doctor Working report; however it was not discussed in detail as it had been reviewed by the full Trust Board in November 2019.

3.3 An annual update from the Joint Consultative and Negotiation Committee (JCNC) was received. There were no items of concern raised via this report; however it was noted that work is underway to refresh the JCNC meetings to ensure a focus on strategic discussions.

3.4 The Workforce and IM&T risk registers were reviewed. There were no significant items of concern brought to the Committee's attention. The Committee took the decision to maintain an entry on the risk register relating to the BNSSG Agency Spend Reduction programme. It was felt that the programme is delivering; however there is an ongoing financial risk.

3.5 Workforce and IM&T risks on the Board Assurance Framework were also reviewed. The Committee agreed two changes:

- SER6 relating to recruitment risks have its score increased from 2x3=6 to 3x3=9 due to the limited availability of certain key staff groups; and
- SIR10 relating to capital investment be reworded to clarify that the risk is around capital prioritisation rather than a lack of capital investment. Wording changed from:
  *Lack of investment in appropriate technologies and infrastructure in a timely manner impacts the ability of the Trust to deliver operational, financial performance and quality improvement.*
  To:

*The Trust has limited capital funding and many competing priories for investment. Lack of investment in appropriate technologies and infrastructure in a timely manner impacts the ability of the Trust to deliver operational, financial performance and quality improvement.*

3.6 The Committee received and discussed the quarterly upward report from the Health & Safety Committee. This report highlighted increasing levels of violence and aggression against staff, as well as increases in sharps injuries. The Committee requested a deep-dive into these issues and actions being taken to address the concerns. This is scheduled for the April 2020 Committee meeting.

3.7 An update was received on the national NHS pension issue. The Committee was appraised of the national offering allowing senior clinicians to reduce tax liability via NHS pension "scheme pays" arrangements and a future balancing payment from Treasury. It was agreed that this would remain under review alongside the Trust's arrangements, with a further update to be provided at the end of the financial year.

3.8 Updates were received on the Electronic Patient Record project and other IM&T projects, with no areas of concern identified.

3.9 A deep-dive was undertaken into sickness absence data. This confirmed that in line with national experience, the Trust suffered from a spike in short-term sickness absence over winter, despite its award-winning health & wellbeing programmes. A further review of long-term sick levels was agreed for the April or June 2020 Committee meeting.

3.10 The Committee reviewed the emerging People Strategy, and Committee members provided feedback to the Director of People & Transformation.

## 4. Escalations to the Board

4.1 The Committee seeks Board ratification of the proposed updates to the Board Assurance Framework, as outlined in paragraph 3.5 above.

## 5. Recommendations

5.1 The Trust Board is recommended to receive the report for assurance approve the proposed changes to the BAF.