North Bristol NHS Trust Annual Report 2021/22 "Providing Care in a Challenging Year"

Contents

Chief Executive's Statement

Referencing the 2020/21 financial year at last year's Annual General Meeting, we described it as an extraordinary year, reflecting the impact the Covid-19 pandemic had on our staff, our patients and the communities we serve.

Little did we know then that 2021/22 would be similarly extraordinary with many of the pressures persisting and some becoming even more intense.

The perfect storm of the Covid-19 pandemic together with increased pressures around urgent care and an overwhelming desire to cut our waiting list backlogs placed huge pressure on our staff. We also recognise that these challenges affected our patients, with many waiting for unacceptably long periods of time for treatment and procedures, often in pain and discomfort.

I am pleased that we managed to deliver a significant reduction in the number of patients waiting over 104 weeks for their procedure, bringing the number down to fewer than 100 patients by the end of March 2022. While that is still 100 patients too many, it is a sign that we are making good progress in this area.

Getting our elective activity back on track – our planned treatments and procedures outside urgent care – has taken a monumental effort as we have continued to battle Covid-19 at the same time. Stringent Infection Prevention and Control measures have slowed down our elective activities as we've tried to minimise transmission within the hospital.

Spring and early Summer 2021 offered us grounds for optimism – the nation was opening back up and the vaccination programme was making a real difference. In typical North Bristol NHS Trust style, we mobilised quickly and delivered a very large number of vaccinations in an incredibly short period of time. It's worth paying tribute to all the staff involved in this Herculean effort, both within NBT and in other parts of the system. Their efforts really made Bristol and surrounding areas a safer place.

Optimism quickly turned to worry and concern later in the year with the emergence of the Omicron variant – a much more contagious variant of Covid-19 which we knew very little about. Thankfully, the NHS mobilised rapidly once more, delivering millions of booster jabs very quickly, protecting young and old against serious harm. With our system partners, NBT staff played a key role in that endeavour.

During the Autumn and Winter, we planned for the worst and hoped for the best. Record high community infection rates and rapidly increasing numbers of patients with Covid-19 in the hospital were of huge concern. In line with that, we worked with NHS England and the South West region to build a Nightingale "surge hub" in the grounds of our Southmead Hospital at NBT. Thankfully, it wasn't needed but it was a necessary contingency measure which, unavoidably, took a huge amount of energy and time to deliver.

Alongside Covid-19 and our elective recovery programme, we experienced unprecedented levels of demand in our emergency department. Long waits and delayed ambulance

handovers were a big concern for us, and we did what we could to encourage some patients to seek advice and support via more appropriate routes, including 111, minor injury units, pharmacies, and their GPs. But the pressures remained, and our responses were hampered by challenges around discharging patients back into the community as well as a range of other issues, including staff shortages and staff absence due to Covid-19. At the end of this financial year, these challenges remain, and we continue to work with system partners to try and address them.

As well as dealing with the immediate priorities, we also invested a lot of time in 2021/22 in planning for the future. We are focused on continuing the solid progress we have been making but recognise there are many things we need to do differently or better.

Our three strategic priorities for the coming year are to:

(i) Provide high quality patient care
(ii) Develop healthcare for the future and
(iii) Be an anchor in our community.

To deliver this, we are going to be more ambitious in the way we collaborate and work with partners.

Our Acute Provider Collaborative with University Hospitals Bristol & Weston (UHBW) is one such example, with the programme being set up to deliver sustainable and long-term benefits for patients across the Bristol, North Somerset, and South Gloucestershire (BNSSG) system. Increasingly, we're worrying less about institutional boundaries and focusing more on how we can work together as acute Trusts within the same system to tackle health inequalities and improve outcomes for patients. I look forward to seeing this Acute Provider Collaborative flourish and deliver tangible improvements for our patients in the next 12 months. Our commitment to working on a joined-up approach to continuous improvement (called "Patient First") will help underpin our collaboration.

The outcome of the Stroke Review consultation undertaken by the CCG is also an example of how, working together as a system, we can deliver better patient outcomes in an efficient manner. Stroke is the fourth biggest killer in the UK and a leading cause of disability. One in 50 of our residents live with the long-term consequences of the condition. We will move on to the implementation phase now, which will see Southmead Hospital hosting a 'Hyper Acute Stroke Unit' providing 24/7 emergency treatment for everyone in the area. Southmead Hospital will also host the 'Acute Stroke Unit' where more people will receive their ongoing care in a dedicated unit, where staff are specialists in stroke care. The unit will be located next to the 'Hyper-Acute Stroke Unit', significantly reducing transfers of care (where people are transferred from one ward or hospital setting to another) and improving patient experience.

In closing, I'd like to thank the many organisations and bodies that work with us and enable us to do what we do best – deliver high quality health care for our local population. From local authorities to partners in the healthcare system, voluntary and community groups, carers, advocates, and most importantly, our patients, whose feedback helps us get better and better, we thank you for your support.

I'd also like to thank the Board members at NBT for their expert input and hard work this year. But most importantly of all, I'd like to thank all the people who work at NBT and those who volunteer - over the last 12 months I have seen at first hand your commitment, dedication and expertise and I am ever so proud to be Chief Executive of this organisation.

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Maria Kane Chief Executive

Organisation's Purpose and Aims

NBT is a centre of excellence for health care in the South West in a number of fields with an annual turnover of circa £791 million. Of this, approximately 89% comes from commissioning through Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG) and specialist services through NHS England for direct patient care. Further income is also received from other NHS commissioner organisations and for purposes other than direct patient care (such as training and research activities).

We provide high quality clinical services to our patients from both the local area and across the region. These clinical services include:

- Urgent care – we provide expert care and treatment 24 hours a day, 365 days a year for patients when they need us most, in emergencies
- Local acute care – we provide elective and urgent hospital services for a population of more than 500,000 people, primarily in South Gloucestershire and North Bristol
- 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 across a wide network

Our core purpose will always be to provide patients with the standard of clinical care we would expect to receive ourselves. Our Trust Board remains committed to creating a strong, vibrant organisation that is at the forefront of healthcare delivery in the West of England as outlined in our Trust Strategy 2019-2024.

PART 1 - Performance Report

Our Performance and Progress

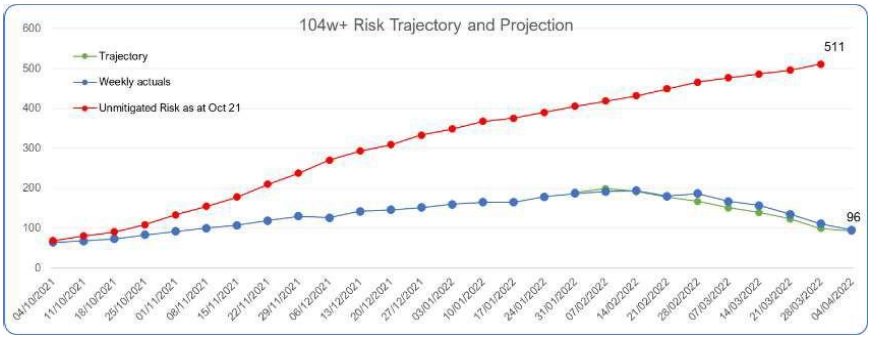
Performance Summary

NBT's services are delivered via our five clinical divisions:

- Anaesthesia, Surgery, Critical Care & Renal
- Core Clinical Services
- Medicine
- Neurological & Musculoskeletal Sciences
- Women & Children's Health

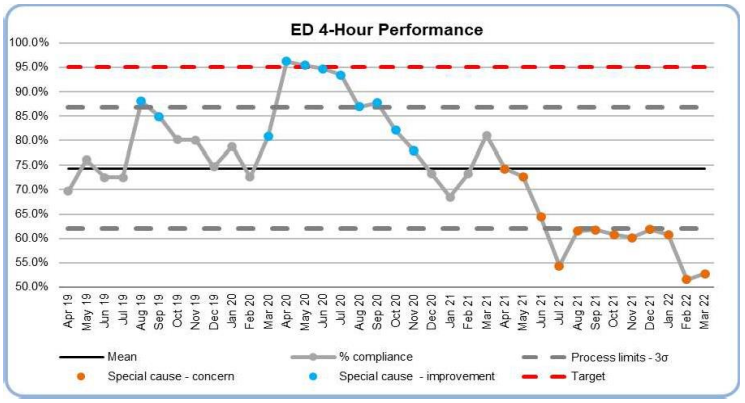
The clinical divisions are supported by our corporate directorates, aligned with Executive Directors' portfolios; namely, Finance, Informatics, Nursing & Quality, Operations, People & Transformation, and Research & Strategy. Further detail on the Trust's organisational and management structure is available on its website: http://www.nbt.nhs.uk/about-us.

The Trust's overall 2021/22 performance against key constitutional and regulatory standards is set out below. In some instances, we have included information showing the trust performance as a trend over the year.[1] Where we have not included that information, it is because we consider the final year end position to be most relevant, or because the trend data does not provide any additional insight into the Trust's overall performance. Detailed monthly performance is set out in Trust Board papers published on our website.

Standard/Measure	Performance
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Across the NHS patient waiting lists have increased substantially due to the impacts of the Covid-19 pandemic. National recovery trajectories have been set. The Trust delivered the year-end target of having no more than 99 patients waiting longer than 104-weeks for their treatment. Of the 96 patients waiting >104-weeks at year-end c.50% of these were due to patients choosing to wait longer for their treatment. The success in delivery of this target can largely be attributed to access to an additional Elective ward during Quarter 4 of 2021/22.  The overall RTT waiting list growth remained within the year-end trajectory at 39101 in March; this compares favourably with combined national provider growth.
ED: maximum waiting time of four hours from arrival to admission/transfer/ discharge	Four-hour performance has been challenged throughout the year. However, there was a marginal improvement in March with performance of 52.7%, with the Trust ranking first out of ten reporting peer providers, moving the Trust from the fourth to the third quartile.

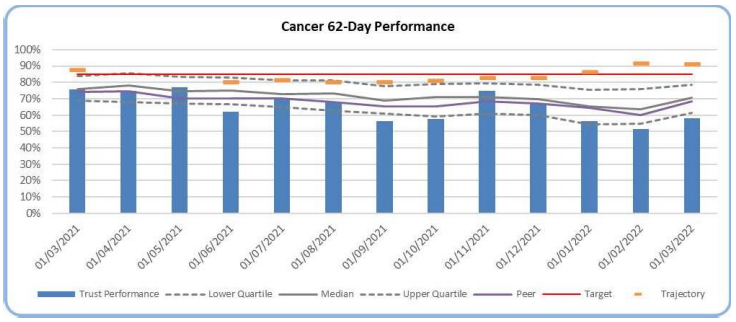
[1] SPC Chart Guidance – Statistical Process Control (SPC) is an analytical technique widely used in the NHS to understand whether change results in improvement, and in industry for quality control that plots data over time. It helps indicate special cause variation; either variation of particular concern and requiring action, or variation where improvement is taking place. In the SPC charts in this section:

- Orange dots signify a statistical cause for concern and reflects underperformance or a deteriorating trend.
- Blue dots signify a statistical improvement and reflects good performance or an improving trend.
- Grey data indicates no significant change (common cause variation).



There have been several 12-hour trolley breaches reported in the majority of months in 2021/22, with the highest volumes reported during Quarter 4. This is reflective of the operational pressures, including high levels of bed occupancy and a high volume of inpatients who do not meet the criteria to reside experienced throughout the winter period as well as the impact of Covid-19.

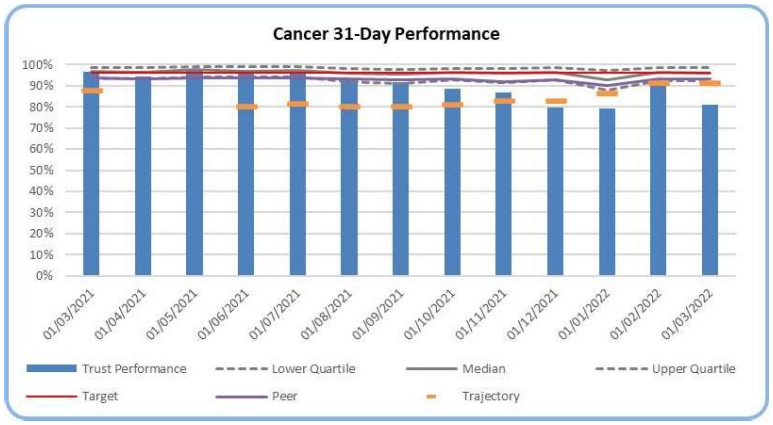
All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer	The Trust achieved the 62-day Patient Tracking List reduction trajectory of 475 by the end of March 2022; however, Trust 62-Day performance has been below the national 85% target throughout the year (although the Trust median is higher than the peer median for each month). Monthly performance has dropped below 65.0% in every quarter of 2021/22. Most recently there was an improvement in March to 58.66% from February's performance of 51.17%.



In Q3 the Trust took on responsibility for the Urology service at Weston, and it should be noted that the majority of the breaches in March were from Weston patients already breaching when transferred.

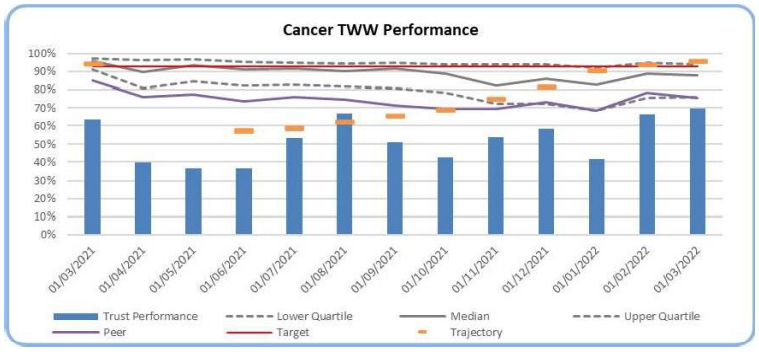
A series of Task Force meetings have been established to manage the Cancer pathways and ensure plans for improvement are in place. 62-Day patient tracking list reduction against the trajectory of 475 by the end of March 2022 was achieved.

All cancers: 31-day wait from diagnosis to first treatment	Trust 31-Day performance has deteriorated during the second half of 2021/22, with performance in all months below 90.0%. In the first half of the year all months were above 90.0%. The Trust's peer group followed the same general trend. April 2021 was the only month in the year where the Trust hit the national 95% target.



In March the Trust performance deteriorated, reporting 80.99% compared to 89.91% in February. The Trust continues to see improvements in the front end of the pathway and increased surgical activity including Waiting List Initiative activity.

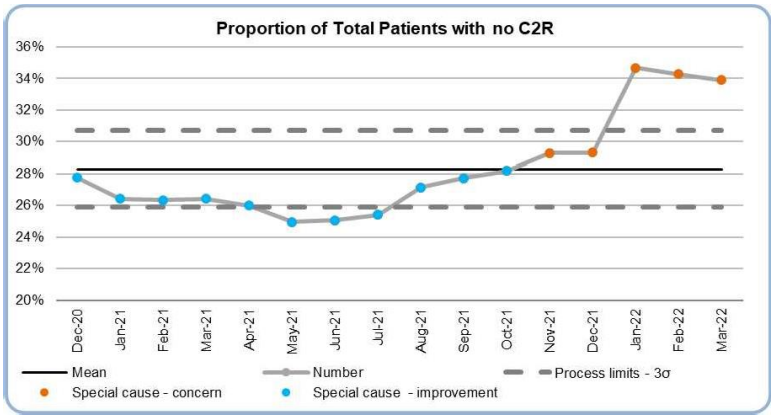
Cancer: two-week wait from referral to date first seen for all urgent referrals	Trust two-week wait (TWW) performance has been below the national 93% target throughout the year, although Trust median was higher than the peer median until November where Trust and peer performance aligned.



The Trust has achieved over 50.0% in 6 months of the year and over 60.0% in only 2 months. Underperformance has been due to increases in referral volumes as well as workforce and capacity challenges.

Covid-19 (Coronavirus)	The Trust also saw a spike in patients testing positive in August-September 2021 and from November 2021 Covid-19 inpatient levels increased significantly. In March 2022 the Trust had a daily average of 60 Covid-19 inpatients, an increase from 45 in February 2022, but a reduction from 71 in January 2022.
C. difficile: meeting the C. Difficile target of a maximum of 43 cases	There a total of 67 cases across the year and as a result, the Trust did not achieve its target trajectory of 43. The Trust was below trajectory until October 2021. NBT continues to progress improvement work to reduce the number of cases, which are linked to a variety of factors, including increased use of antibiotics as part of the response to Covid-19 pandemic.

MRSA: meeting the objective of none	There were no cases of MRSA bacteraemia reported in the period 1 April 2021 – 31 March 2022.
Mortality ratios	NBT remains nationally in the lowest quartile for the Summary Hospital Mortality Indicator (SHMI) indicating a lower mortality rate than most other Trusts, with no current Mortality Outlier alerts. High completion rates of mortality reviews continue, with Medical Examiner reviews and referrals into Trust governance processes operating effectively to address family concerns and integrate with coronial procedures, including inquests.
Unscheduled Care - No Criteria to Reside (No C2R)	The proportion of total patients who do not meet the nationally set "criteria to reside" in the hospital (i.e., do not require acute hospital care) increased each month from 25.0% in May 2021 to a year high of 34.7% in January 2022. However, since January 2022 the proportion of total patients with no C2R has marginally reduced to 33.0% in March 2022.

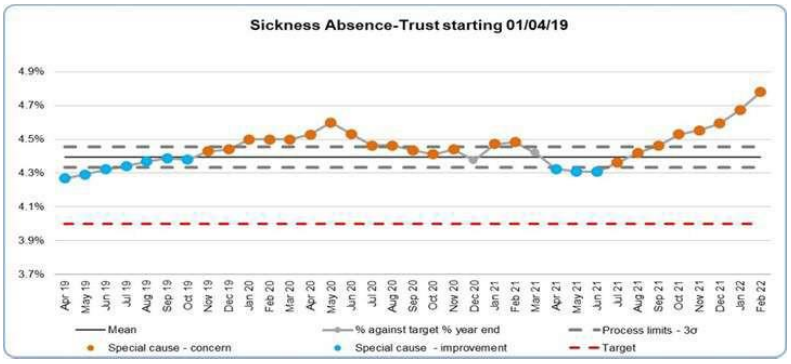
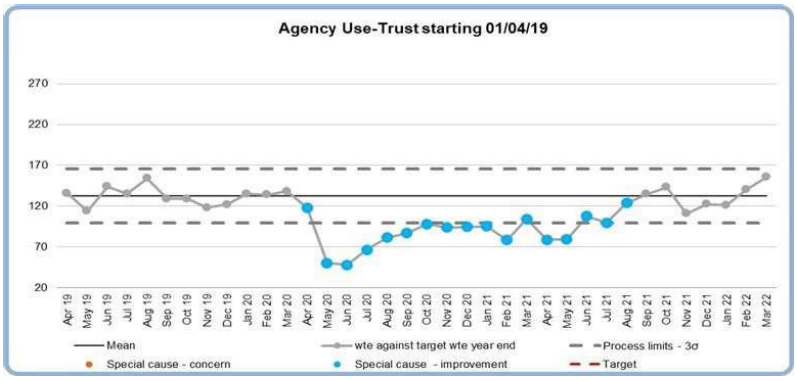


On 31 March, 261 patients in NBT beds had no C2R; 232 were waiting other external discharge pathway start dates. 29 patients with no C2R were waiting for internal reasons (i.e., reasons withing the Trust's direct control); 18 were waiting the completion of a single referral form (SRF).

In March 2022 the total delayed bed days associated with patients recorded as having no C2R and awaiting community discharge pathways rose to 6,711 compared to 6,639 in February. The total delay bed days associated with community discharge pathways steadily increased from December 2021 to March 2022.

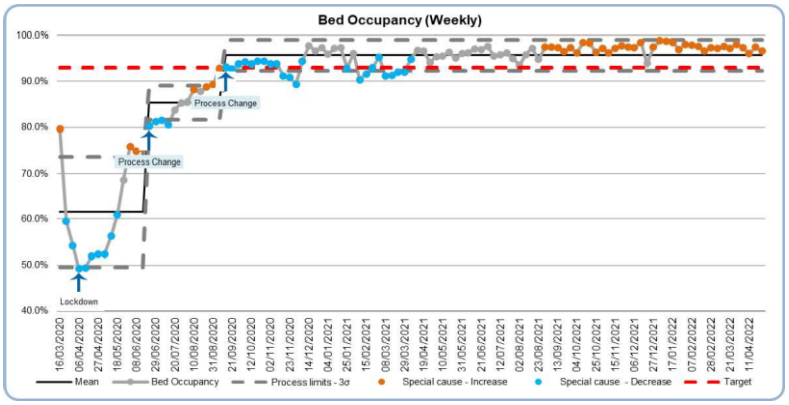
Discharges remain impacted by insufficient staff capacity for Local Authority (LA) funded domiciliary care and Community Provider care worker capacity.

At the end of March, the overall month average of total patients with no C2R and ready for discharge was 33.0% (34.3% in February). It has been above 28.0% since October 2021 and above 24.0% throughout 2021/22.

	These high numbers of patients with no C2R mean that the Trust is not able to flow patients efficiently out of the Emergency Department into speciality beds and also limits the beds available to support the elective care programme.
Sickness absence	In 2021/22 the rolling 12-month sickness absence rate increased from 4.4% in March 2021 to 4.7% in February 2022 (including COVID related absence). The initial view of the March position shows a 3.0% increase in days lost to absence (adjusted for February being a shorter month than March), this was predominantly driven by an increase in absence due to COVID Sickness.  However, the greatest driver of staff sickness absence in 2021/22 was stress/anxiety/depression/other psychiatric illness which has increased throughout the course of the pandemic and is the greatest reason for days lost to absence for both clinical and non-clinical staff. The Trust has invested permanently in its psychological support for staff, recognising this important aspect of supporting our staff's health and wellbeing and our award-winning programme will continue in 2022/23.
Agency usage	Throughout 2021/22 the demand for temporary staffing increased, with the second half of the year seeing 15% more demand that the first half. This drove an increase in agency use with the 2nd half of 2021/22 seeing an average of 125 WTE per month, compared with 94 WTE per month on average in the 1st half of the year.  Increases have been driven by ongoing recovery but predominantly by seasonal and operational pressures exacerbated by COVID related absence and an increase in demand for

	registered mental health nurses (33% rise in demand in the second half of the year compared to the first). Unavailability and fatigue from the pandemic response also affected agency staff, with our neutral vendor for nursing only able to fill 34% of requests, compared with 61% in the previous year. This meant despite worked agency hours increasing in 2021/22 it was not at the rate required to meet the increase in demand. This also manifested in higher agency costs with tier one agency use being replaced by higher cost tier three and non-framework use (tier one agency staff filled 95% of shifts in April 2021 compared to 72% in March 2022). There are a number of key actions initiated in 2021/22 and will be ongoing into 2022/23 that are targeted at reducing agency demand and use and moving back to a higher rate of fill from lower cost tier one agencies: • Work to change our nursing agency neutral vendor is complete and the anticipated impact is an improved ability to fill shifts with tier one agency staff • Harmonising tier 1 agency rates with surrounding regions to further drive a greater fill of shifts from tier 1 agency staff • Ongoing continuing work to put in place substantive staffing solutions that will mitigate registered mental health nurse agency use • Improve medical locum access – piloting software for a collaborative locum bank aimed at reducing medical agency use • Working with system partners on a set of staff-bank pay rates and incentives to avoid internal competition, drive up bank use and reduce agency use
Cancelled Operations	National reporting of same-day Cancelled Operations was suspended by regulators in March 2020 in response to the Covid-19 pandemic. Since the start of Q3 2021/22 the reporting of same day Cancelled Operations was resumed. Across Q3 and Q4 of 2021/22 0.9% of elective admissions (85 patients) were cancelled.

Bed Occupancy	Bed occupancy rates were below the 93% target rate in April 2021. In all other months, rates were above 95.0% and in six months the rate was above 97.0%, peaking in January 2022 at 98.2%. High No C2R numbers as outlined above have resulted in a failure to meet target bed occupancy in 11 months of the year.



Performance Analysis

Overall, performance against key constitutional and regulatory standards has been challenged throughout 2021/22, driven largely by the direct and indirect impacts of the Covid-19 pandemic. As outlined above, key drivers/risks have included high numbers of patients with no criteria to reside and associated high bed occupancy impacting patient flow through the hospital and capacity to undertake elective care, alongside staff shortages. Further information on these risks is set out in our Accountability Report.

However, in Q4 the Trust was able to successfully ring-fence a second ward for elective activity, allowing it to achieve the national recovery trajectories for patient's waiting over 104 weeks. And we continue to work internally and with our system partners both in our Acute Provider Collaborative and across the Integrated Care System (ICS) as a whole, to manage demand and capacity in a manner that will be of most benefit to our patients.

In terms of overall assurance on performance throughout the year, the Trust Board receives a monthly Integrated Performance Report (IPR) which provides overview and detail of the key measures of performance and supporting indicators to ensure that a balanced performance position is understood. It sets out over 100 measures and is posted to the Trust's website to allow public scrutiny. This information is provided for the previous month, trending over time, and, where available and relevant, against a benchmark. These key measures are then monitored through the Performance Assurance Framework and the Accountability Framework in both static and operational reports provided through the Trust's Business Intelligence Unit (BIU). These are monitored through a series of daily, weekly, and monthly performance reviews that provide a view of the current and past position as well as a forecast.

Other details of quality and performance measures are provided by the BIU and considered by the Executives at weekly meetings. The Quality, Finance & Performance and People Committees and other specialist groups also review their specific appropriate elements from the IPR. These sub-committees provide the Board with assurance that it is receiving correct data and that the right processes are in place to ensure patient safety and performance

standards are not only being maintained, but also improved. The BIU, in conjunction with the Operations Team, also monitors and acts to improve data quality and assurance reporting throughout the year through comparative measures and audits

Trust Objectives for 2021/22

In addition to the measures above the Trust set key strategic objectives for 2021/22. Delivery against those objectives was made despite the challenges faced and is set out below:

Objective:	**Performance**
Provider of high-quality patient care	
○ **Accelerate restoration of planned care, addressing clinical prioritisation and health inequalities across our system**	In 2021/22 the Trust achieved 90% of 2019/20 elective day case activity and 78% of elective inpatient work. 101% of pre-pandemic outpatient activity was undertaken in 2021/22 despite the high levels of inpatients with Covid-19. This activity has been delivered despite continued requirements for infection prevention and control measures, periods of high Covid-19 related staff absences and, at varying times, high levels of patients who chose not to attend pre-booked hospital appointments. The Trust also delivered the year-end target of having no more than 99 patients waiting longer than 104-weeks for their treatment. Of the 96 patients waiting >104-weeks at year-end c.50% of these were due to patients choosing to wait longer. The success in delivery of this target can largely be attributed to access to an additional Elective ward during Quarter 4 of 2021/22. The number of patients exceeding 52-week waits in March was 2,242 with the majority of breaches (847; 37.78%) being in Trauma and Orthopaedics. The overall proportion of the wait list that is waiting longer than 52-weeks is 5.73% which is marginally down compared to the previous month. The Trust is focussing on the treatment of patients who are waiting over 104-weeks or are at risk of waiting that long for their treatment; this is whilst maintaining timely access to treatment for those with the greatest clinical need.
○ **Transform non-elective care through continuous improvement**	Provision of non-elective care continues to be challenged with a continued high number of patients in acute beds who are ready to be discharged and cared for in the community. As a result, four-hour performance and ambulance handover times continue to be impacted by high bed occupancy at an average of 97.43% for the month of March. Our final annual IPR clearly shows the impact of the pressure on beds across the year. When occupancy is at its lowest, four-hour performance is at its best.

	Moving into 2022/23 the Trust has a clear improvement plan for Urgent & Emergency Care and is working with system partners to tackle system-wide challenges, where the solution sits outside our direct control.
Develop healthcare for the future	
○ **Create a BNSSG provider collaborative to improve patient experience and pathways**	In August 2020 NBT and UHBW created a "committee in common" called the Acute Services Review Programme Board, to provide oversight for a BNSSG acute services review. Subsequently, the government white paper on ICSs published in February 2021 required all acute providers to be part of one or more provider collaboratives by April 2022. In light of this, in summer 2021 the Acute Services Review Programme Board was re-constituted as the Acute Provider Collaboration Board, a committee in common with membership including the Chairs and Chief Executives of NBT and UHBW. This Board now oversee both clinical and corporate collaboration activities, providing a forum for agreeing and driving forward shared strategic objectives and priorities for the benefit of our patients.
○ **Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review**	Our response to the Ockenden review has been robust, with excellent engagement from all staff groups and proactive reporting to and engagement with Trust Board and Quality Committee. Maternity recruitment initiatives are resulting in a successful pipeline which, by September, will see the Women's and Children's health division over-recruited for the first time in several years.
○ **Recover and grow our research portfolio**	This year NBT opened 113 new studies to recruitment, in addition to the previously suspended studies which were able to restart. Despite the resurgence of Covid-19 in late 2021 and continuing to support Covid-19 research, NBT recruited over 4700 participants to non-Covid-19 studies including 2652 to new non-Covid-19 studies open within the year. More detail on research and innovation activity is set out later in this report.
Employer of choice	
○ **Support the recovery and wellbeing of our workforce**	The Trust's rolling turnover rate in March 2022 was 15.9%, higher than the 12.4% reported in March 2021. We recognise that the pressure experienced throughout the pandemic and ongoing operational pressure has meant some of our staff have left the organisation. We have enhanced our focus on retention and have investigated both quantitative and qualitative data to shape our understanding of the root causes of turnover. We have focussed on key themes:

	• Relationship with manager/peers • Morale: Fatigue and resilience • Lack of promotion opportunities • Flexible working/work-life balance The Trust has a substantial wellbeing support offering available to staff, which is set out in detail in the "Our People" section of this report.
○ **Embed new agile ways of working that allow our staff to thrive**	The Trust undertook a number of pilot schemes around agile working, drawing from the experience of changing work practices driven by the pandemic. We have developed guidance and tools to support staff and will continue to focus on this topic during the coming year.
○ **Promote a diverse, fair and inclusive culture**	We remain committed to increasing inclusion throughout NBT. During 2021 our primary focus was on our workforce, but we also collaborated on wider work around Equality Delivery Schemes and Health Inequalities. Further detail is set out in detail in the "Our People" section of this report.
Working with partners to:	
Support population health management and address inequalities	NBT has an Executive level lead for addressing health inequalities and work continues to ensure that Board performance reports include data which breakdown wait list by ethnicity, deprivation, and disability to enable Board oversight. Being an Anchor in the Community is one of the priority areas set out in NBT's five-year strategy – in 2022/23 contributing to public health initiatives and sustainability will be a priority for NBT. Significant work has already been undertaken to ensure anonymised data can be shared by partners to allow for cross referencing of ethnicity data, postcode and wait list. Across BNSSG, our business intelligence teams have carried out an initial analysis of elective activity and non-elective activity broken down by Index of Multiple Deprivation quintiles from April 2019 to December 2020. The results reflected the England level analysis that those in the most deprived quintile form the smallest proportion of total elective activity. We will use that data to provide specialty level reports on wait lists and will continue and to engage with our community to assess how well we are doing. With partners we are pursuing funding to pilot the C2AI tool, which considers the real impact of social determinants of health by assessing individuals' needs and prioritises them accordingly, which in turn can lead to more optimal ways of

scheduling patients including strategies for those at higher and lower risk of complication.

Cancer

We have both an ICS and a Cancer Alliance inequalities group on which the Cancer Manager and Lead Nurse for the Trust sit. These groups aim to identify and reduce inequalities. This work is a new area for cancer services and is still developing. Patients considered at risk of unequal access e.g., those with barriers to access such as homelessness, limited English, intellectual disabilities, are identified and given additional tracking and accommodations made to help them for example involving GPs or key workers, greater tolerance of patients who do not attend their appointment (DNAs). In line with national guidance, patients are seen and treated based on their clinical urgency, Priority Level 1 being urgent and emergency, and Priority Level 4 being surgery that can be delayed for more than 3 months. Priority Level 4 activity will be undertaken by both Trusts, but only where there is no potential to adversely impact the outcomes for Priority Level 2 and Priority Level 3 patients.

The following workstreams are also vital to tackling inequalities:

- Validation of wait lists and clinical prioritisation
- Ensuring patients are 'Waiting well' and pre-habilitation - to improve outcomes

Actions to address socio-economic/financial inequalities

- For a number of years NBT has run a successful Traineeship Programme. This programme is aimed at unemployed people (typically aged 19-24) from the local community and provides them with skills and work experience that will help them find employment. 88% of the participants in our Traineeship Programmes have been successful in securing permanent roles with NBT
- For over 10 years NBT has run a successful Apprenticeship Centre which has enabled us to offer people from the local community a career route into care. NBT elects to pay our Apprentices above the Annex 21 rate agreed so they all receive either the National Minimum Wage or National Living Wage
- In partnership with a local charity, the Womens Work Lab, we have been able to offer work placements to a small number of unemployed Mum's from the local community. This unpaid work experience has provided these individuals with an invaluable opportunity to regain personal confidence and has resulted in participants being

able to gain paid employment with NBT (either through NBTeXtra or a permanent contract)
- This year, in partnership with the Southmead Charity, the Trust has been able to sponsor 15 existing NBT Apprentices to complete their Nurse Degree Apprenticeships. Many of these individuals have caring responsibilities and are the main wage earner for their families so being able to step into full-time education to complete their Nursing Degree was never a viable economic option. This sponsorship has made this possible and will open up a whole world of career growth opportunities for these individuals.

Actions to understand and combat digital exclusion

To mitigate against digital exclusion, the BNSSG system has recruited a digital inclusion team to coordinate existing activity across partner organisation. Plans set out last summer included:

- Engaging with specific groups of people at risk of digital exclusion and working with existing public and voluntary groups to create a wider network focused on tackling digital exclusion across the BNSSG system
- Defining and agreeing national and local metrics to measure the impact of online consultation and other health care services on digital and social inclusion
- Identifying data and reporting requirements
- Mapping existing available services, activities and resources and generate a coordinated response and deploy a coordinated programme of user-centred design activity to address the barriers to accessing digital health and care services.
- Establishing subject specific task and finish groups (via key channels such as the “Stepping Up” and “Change for Good” initiatives to build a community of interest) focussed on removing accessibility, connectivity and skills and confidence barriers

Financial Performance

Due to the pandemic response the NHS suspended normal commissioner contracting processes. Instead, the financial framework for 2021/22 required the Trust to deliver core operations within an agreed financial envelope and manage costs incurred in dealing with the Covid-19 pandemic in line with Covid-19 funding provided.

The Trust has achieved a performance-adjusted surplus for 2021/22 of £2.2m (0.3% of turnover), against a required breakeven performance by NHS England and Improvement.

The reconciliation of this to the surplus from continuing operations is shown below:

	2021/22 (£m)
Surplus for the year from continuing operations	**1.1**
Add back impairments/ (reversals)	1.2
Add capital donations / grants and Income & Expenditure impact	0.3
Add net impact of DHSC centrally procured inventories	0.3
Remove gain on sales of assets and absorptions from service transfers	(0.7)
Adjust financial performance surpluses for the purposes of system achievement	**2.2**

The Trust delivered recurrent savings of £3.6m which was reinvested into clinically prioritised service developments to improve the quality of patient care.

The financial framework under which the Trust will work for the medium term will be as part of an ICS as laid out in the Health and Care Bill 2022 which is expected to be approved through Parliament in Spring 2022. The basis for income will not be based on levels of activity delivered (Payment by Results/PbR, or 'tariff'), but will move to block funding based on 2019/20 levels of activity, adjusted for inflation and efficiencies. There will be variable elements around the delivery of Elective activity. Through this, the BNSSG system has received funding to cover an element of the Trust's Private Finance Initiative (PFI) hospital and therefore, in part, mitigate the Trust's previous underlying deficit position. Whilst other drivers of the underlying deficit remain, including local prices agreed with commissioners in some areas, the impact of inflation is one of the key drivers of the position moving into 2022/23. Under ICS ways of working the BNSSG system will collectively work towards reducing the system underlying deficit through closer working between all partners to increase to planned levels of productivity.

Financial Duties and Financial Health

The Trust has three key financial duties:

- To break-even on income and expenditure taking one year with another
- Not to overspend its capital resource limit (a limit on capital expenditure set to an agreed plan with the Department of Health & Social Care)
- Not to overshoot its external financing limit (a cash limit set by the Department of Health & Social Care).

The table below sets out the Trust's performance against these targets in 2021/22 and the previous five years of the Trust.

£'m	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Breakeven Duty - Annual	(42.9)	(12.1)	(7.4)	7.5	10.8	12.7
Breakeven Duty - cumulative	(110.1)	(122.2)	(129.6)	(122.1)	(111.3)	(98.7)
External Financing Limit	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved
Capital Resource Limit	Achieved	Achieved	Achieved	Achieved	Achieved	Achieved

Despite recording surpluses in the last three years, the Trust remains cumulatively in deficit over the five-year period ending 31 March 2022. As a result, in accordance with their statutory responsibility, the Trust's external auditors have made a referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. This approach is consistent with previous years. Under the financial regime for 2020/21 and 2021/22, Trusts are being managed against a break-even requirement in-year and so it is unlikely that the Trust will be able to meet this statutory requirement until a financial regime that allows significant Trust surpluses to be generated exists.

The movement from 2018/19 to 2019/20 mainly consists of additional Provider Sustainability Fund (PSF) of £9m in addition to underlying improvements. For 2020/21 the Trust was not operating under the PbR regime due to the impact of the pandemic response and so received payments to cover the underlying deficit as part of the block funding arrangements.

Capital expenditure for 2021/22 was £33.5m. This figure comprised internally generated funds of £21.3m, together with funding from the receipt of a land sale of £3.4m and capital PDC draw down of £8.2m. There was a permitted overspend of £0.7m, which is allowable due to underspends elsewhere in BNSSG.

The Trust has a capital plan of £20.75m for 2022/23 and an opening cash position of £116.1m. The capital plan will be affordable from internally generated funds; thus, the Trust will have sufficient cash in 2022/23 that cash support from the Department of Health & Social Care will not be required.

After considering the above and making appropriate enquiries the directors of the Trust have a reasonable expectation that North Bristol NHS Trust has adequate resources to continue in operational existence for the foreseeable future. The annual report and accounts for 2021/22 have, therefore, been prepared on a going concern basis.

Our Patients

It is worth noting that while the performance against targets and trajectories provides us with a crucial view of how well our services are working, hearing from our patients about their experiences of those services is invaluable. This section of our report focuses on what they told us in 2020/21.

Friends and Family Test

The Friends and Family Test (FFT) is an important feedback tool that enables people using our services at North Bristol NHS Trust to give real-time feedback of their experiences.

The questions we ask are:

"Overall, how was your experience of our service?" and, "Please tell us why you gave your answer".

Between 1st April 2021 to 31st March 2022 79,177 responses were received. This is an increase of 14% on the previous year and equates to a 15% response rate for the Trust.

Complaints

In 2021/22, 666 formal complaints were received by the organisation. This is an increase of 36% from the previous year where 490 complaints were received. Whilst this is a significant increase, the Covid-19 pandemic led to the fall in complaints in 2020/21 and this year's activity is in line with previous reporting years showing a return to pre-pandemic levels.

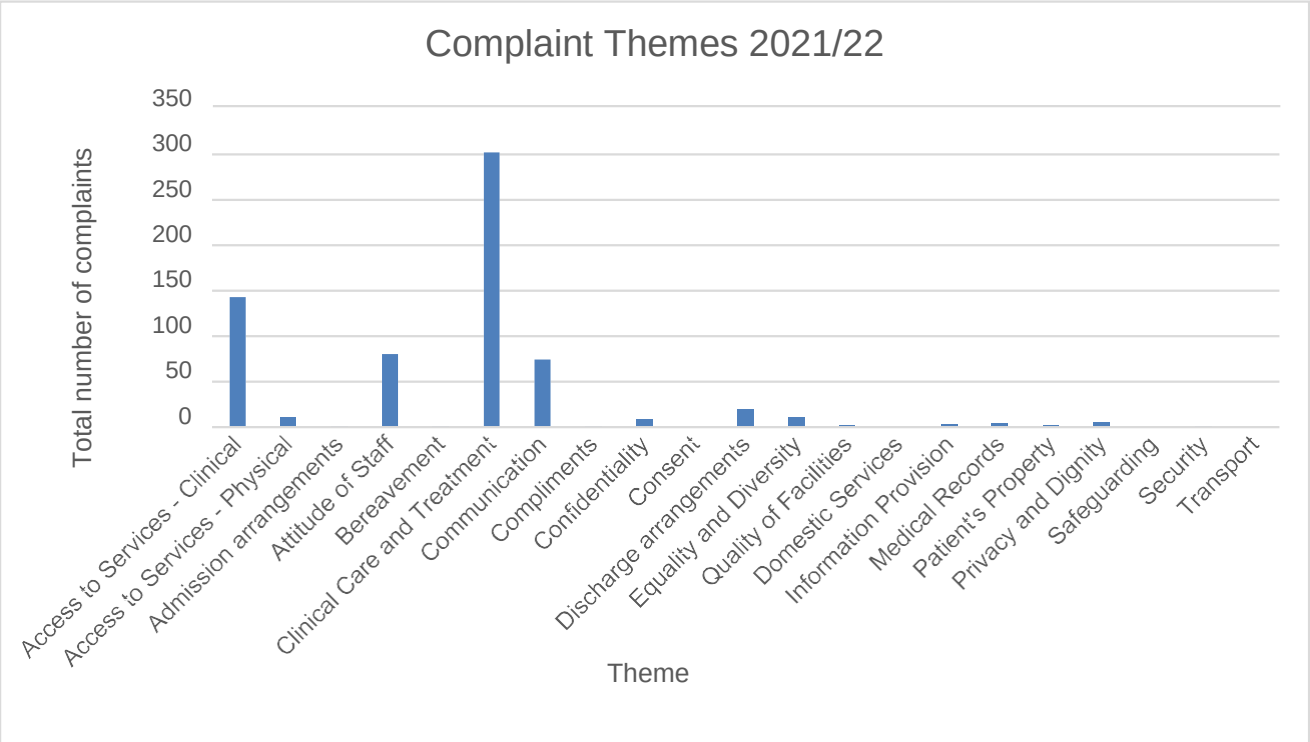
Of the 666 complaints received, 25 were re-opened or returned. This is 4% of all complaint cases and is an improvement on last year where 6% were re-opened. This reflects work undertaken to increase the provision of training for staff involved in complaints investigations and responses and, a further quality check introduced in the complaint sign off process.

In 21/22 we have seen a decrease in complaint response time compliance from 93% to 77%. This reflects the challenges experienced across the Trust with increased operational pressures for frontline staff and vacancies within the Divisional Patient Experience Teams. We have targeted recovery plans in place with the two largest divisions which are now fully resourced. We expect to see compliance improve over the next year back in line with our internal target of 90%.

The number of recorded compliments received has increased slightly since 2020/21; however, this is unlikely to be an accurate representation of all compliments and positive feedback received by teams as often these are not formally recorded.

Type	2018/19	2019/20	2020/21	2021/22
Complaints	723	626	490	666
Concerns	744	1,087	776	1,283
Compliments	7,704	8,072	3,689	4,672
Enquiries	280	188	659	911
Response Time (within timescale)	59%	80%	93%	77%

In 2021/22, the most common complaint theme was 'Clinical Care and Treatment', which is consistent with the previous reporting year. This was followed by 'Access to Services-Clinical' which has replaced 'Communication' as the second most common theme. This reflects the national picture across the NHS of increased waiting times as a result of the pandemic.



Additional information on complaints and compliments can be found in the Trust's Quality Account and Complaints Annual Report, which will be published in Summer 2022 in line with the national deadline.

Complaints Lay Review Panel

Throughout 2021/22 the Complaints Lay Review Panel has continued to convene virtually. Meeting quarterly, the panel reviews a randomised selection of complaints against the Policy and national best practice standards. They review how the case has been handled and provide a score, note areas of good practice and opportunities for improvement in complaints handling. We are extremely grateful to our skilled panellists for their commitment and valuable feedback. We were invited to speak at the NHS Complaints Summit and have been able to share the model for the panel and our approach to relaunching and sustaining this virtually through the pandemic with colleagues across health and social care.

Accessibility of the Complaints Process

We collect equality monitoring data about those that access the complaints service through a non-mandatory form.

Data in 2021/22 shows that most complainants are female. There is a good range of ages with complainants from 16 to 95 years of age and 28% of complainants stated they had a disability. This reflects some of the work undertaken to improve the format and accessibility of information on our website and printed leaflets.

The data also shows that there is still some work to be done as only 14% of complainants were not White-British and only 9% were not heterosexual. This highlights the importance of

us reaching out and engaging with our local community to ensure that all groups feel comfortable and confident approaching us to raise a complaint.

Due to the limitations of Covid-19 we have still not been able to raise awareness of the service by outreach to groups across the community, attending ward huddles or holding engagement events. We continue to hold onto this ambition and hope to be able to push forwards with this in 2022/23 to ensure accessibility of our complaints process for everyone.

We continue to seek feedback about the PALS and complaints processes from service users through a questionnaire. Results are shared with the PALS and Complaints teams and any actions or learning are taken forwards to improve service users' experience.

Patient and Carer Participation Group

One of our main focuses for 2021/22 has been to increase the number of Patient and Carer Partners in our Patient and Carer Participation Group and, aligned with our commitment to meet the goals of the Equality Delivery System (EDS2, 2013), for the diversity of our Partners to be more representative of our local community. To do this, we have worked collaboratively with our existing Partners to create a new role. This is a short-term consultancy type role that we hope will be more accessible and offer flexibility to those with childcare commitments, work commitments or other responsibilities that means it's difficult to offer lots of time to the role. We have also redesigned our website information and co-designed recruitment posters which will be distributed to key contacts across the community. We have also designed specific posters asking those from a Black, Asian or Minority Ethnic (BAME) background, disabled people, and LGBTQ+ groups to join us in our pursuit of improving outcomes and performance for those with characteristics protected by the Equality Act 2010. This year we have maintained close links with the Bristol Care Forum, Bristol Deaf Health Partnership and Bristol Sight Loss Council. We are proud to have been able to work with the Bristol Sight Loss Council to offer our staff Visual Impairment Training and, with Sign Solutions to provide Deaf Awareness Training. Feedback from these training sessions is positive and ensures greater staff awareness and understanding of the experience of those with a hearing or visual impairment. We look forward to continuing on the delivery of these sessions next year.

We continue to proactively capture patient stories which are shared at Trust Board, Patient and Carer Experience Committee, Patient Experience Group and Divisional Patient Experience Group to celebrate good practice and identify areas for improvement. These have included sharing stories about the experience of a blind patient to highlight the challenges for those with disabilities and ensure we work towards improving their experience through our Accessible Information Standards programme, awareness training and new Electronic Patient Record.

Healthwatch for Bristol, South Gloucestershire and North Somerset are key members of the Patient Experience Group, and we continue to benefit from feedback received through quarterly Healthwatch Feedback Reports. We continue to share the reports at our Patient Experience Group, reflect on the feedback provided and respond to this.

We continue to closely monitor the quality and delivery of contracted translation and interpreting services. The Trust also regularly engages with groups such as the Bristol Deaf

Health Partnership and Bristol Sight Loss Council to receive feedback from service users on the quality of these services.

Equality of Service Delivery

Unfortunately, we are currently unable to break down our customer satisfaction scores (e.g., FFT) by protected characteristics. We are currently seeking to improve these arrangements and hope to be able to provide this information in the future. However, during 2021/22 we have worked hard to expand the diversity of our Patient Participation Group and improved the way we engage with our populations who have diverse needs and/or protected characteristics. As examples, we have:

- Created hospital passports for patients who have particular needs, helping us to understand and cater to their needs as they move across the organisation
- Provided “Calm Bags” with different sensory items, which can assist some patients to adjust to hospital environments
- Put in place an oxygen therapy pathway standard operating procedure to help patients with Learning Difficulties and/or Autism who cannot tolerate oxygen provision in the usual way

We will continue with this work moving into 2022/23.

The Trust’s investment decision-making processes require that all business cases have an Equality Impact Assessment (EIA) completed, ensuring that the possible impact on different groups are considered and taken into account. Similarly, the development of new policies, strategies, or initiatives require the completion of an EIA.

Our People

In September 2020 the Chief People Officer launched our five-year People Strategy. Our strategy underpins the NHS People Plan and also charts our journey, ambition and passions to provide high quality compassionate patient care.

During 2020/21, despite the Covid-19 Pandemic, we made strong progress on the three key themes at the heart of our People Strategy and its aim to continue to build an empowered, inclusive and motivated workforce which is fit for the future and can adapt to the changing healthcare landscape both locally and nationally:

- Great Place to Work
- Growing and Developing our Workforce
- Better People Support

During 2021/22 whilst continuing to tackle the challenges of the pandemic and associated recovery, we have built on this early progress with a particular focus on supporting our workforce, delivering our commitments to be an inclusive employer, and building on our anchor organisation commitment to the population we serve. We’ve approached this by working collaboratively with our partners across BNSSG and further afield.

Equality, Diversity & Inclusion (EDI)

We remain committed to increasing inclusion throughout NBT and recognise our legal duties under the Equality Act 2010 and the need to take action under the public sector equality duty. During 2021 we had a primary focus on workforce, but also collaborated on wider work around Equality Delivery Schemes and Health Inequalities. While we recognise there is still progress to be made on this vital agenda our commitment has been reflected through our Workforce Races Equality Standard (WRES) staff attitude survey results showing better results than average in almost all areas and Workforce Disability Equality Standard (WDES) data showing around average results

We have made progress with BNSSG colleagues on developing an Inclusive Recruitment Action Plan. Internally we have relaunched our Harassment & Bullying Helpline and Advisors and embedded EDI into Freedom to Speak Up and Restorative Just Culture, holding our first Bystander to Upstander week in September 2021.

We support three Staff Equality Networks with protected time: LGBTQ+ Staff, Disabled and Neurodiverse Staff and Black, Asian and Minority Ethnic Staff and have enjoyed celebrating together History Months (Black, Disability Equality, LGBTQ+), International Women's Day, Pride, Mental Health Awareness Week and other relevant EDI and faith/cultural related occasions.

We have introduced EDI Consciously Inclusive Leadership training to the Senior Management Leadership Team and commissioned a Manager's EDI Toolkit, including focus groups with staff from equalities groups and separately with line managers, human resources and trade unions. The entire Executive Team has been part of the reciprocal mentoring scheme, which will now be rolled out across all senior leaders within the Trust.

We continue to support Departmental and Divisional EDI working Groups, e.g. the Medicine Division established an EDI Group in January 2021 and started its own EDI projects like Aspiring Matron & Aspiring Manager positive action development programme for BAME staff. In March the Trust Board agreed to establish a specific ED&I Committee, feeding directly into Board level to assure the profile of this work remains a core priority.

Race Equality: We have implemented a Reciprocal Mentoring Programme between six Executive Team members (including the Chief Executive) and six BAME Staff with a second planned.

We now have 12 Cultural Ambassadors (trained by the Royal College of Nursing) who support the Trust in employee processes, including disciplinaries and grievances, involving BAME staff to ensure that bias and potential for discrimination is eliminated and have plans to extend into a Cultural & Inclusion Ambassador scheme to support a wider range of staff from equalities groups.

We have re-launched our Red Card to Racism and Abuse programme, which includes the recording of racist and other discriminatory abuse on our patient safety recording system and improved support for staff targeted.

We are leading the delivery of the BNSSG Race Equality Talent Development (Positive Action) Believe Programme and Make it Right (B.A.ME Anti-Racist Activist) Leadership Programme for 8 -10 local public sector organisations

Disability Equality: We continue to ensure we meet the standards to continue as a Disability Confident Employer and Mindful Employer, promote and encourage staff to use NBT Disability Reasonable Adjustment Passport and promote the NBT Neurodiversity Toolkit and Buddies for neurodiverse staff.

Restorative Just Culture

NBT's commitment to developing a restorative Just Culture progressed throughout the year, working in partnership with our Trade Union colleagues. The focus remained on early resolution of issues in the workplace, reducing the need for formal investigations and promoting learning from mistakes or 'incidents.

We have introduced a clear, consistent process for managing investigations, training more investigators and we have made good progress with the majority of disciplinary cases being resolved informally through our early resolution approach. Timescale for formal employment cases have decreased to help the wellbeing of those involved with the average length of time reducing for disciplinary cases from six to three-and-a-half months, grievances cases three-and-a-half to two months and bullying and harassment from seven to one-and-a-half months.

We have updated our related policies and guidance to reflect a Just Culture approach, promoting the Early Resolution and Just Culture frameworks and recruited more Bullying & Harassment Advisors and Cultural Ambassadors to further strengthen our approach and provide support to those involved.

Health and Wellbeing

The health and wellbeing of our staff has remained critical given the additional pressured placed on our workforce by COVID-19. In response we have further enhanced our existing internal programme of support. By taking a strategic approach in line with British Psychological Society best practice we have focused on prevention as well as treatment, emphasised support to teams and managers and delivered a holistic approach to supporting our colleagues through mental health, physical health and lifestyle.

We have instigated and nurtured several staff networks to share, feedback and encourage wellbeing conversations across the trust:

- Wellbeing Champions – 88 staff across every work area and location
- Mental Health First Aid Network – 50 practitioners trained to support colleagues
- TRiM network – 40 staff trained in Traumatic Response Incident Management
- Junior Doctors wellbeing network via four lead Junior Doctors

Our in-house staff psychologist team shifted during the pandemic to doing predominantly bespoke work with teams within their workplace; building self-care, peer support and ongoing

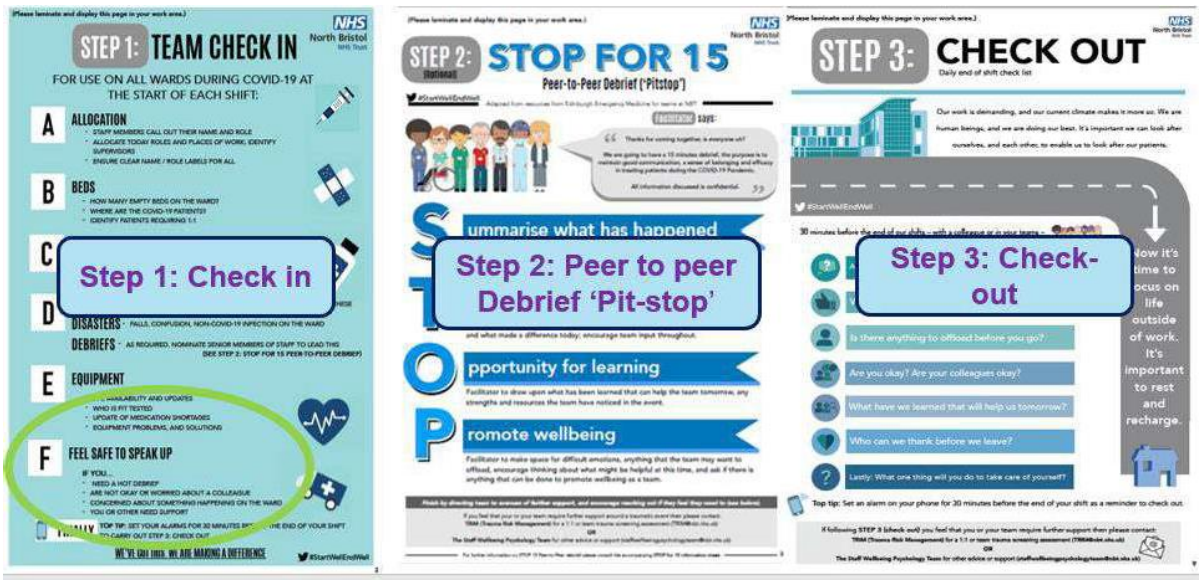
resilience by building wellbeing into their workplace routines - moving from “what’s the matter” to “what matters”.

We also increased communications across the trust to ensure we were reaching staff directly:

- Monthly wellbeing roadshows in staff canteen areas
- Talking with every new starter at induction about our wellbeing commitment
- A new wellbeing twitter account @nbtwellbeing with ~1000 followers
- Wellbeing leaflets and posters distributed with “healthy treats” out to all rest areas, at times of peak pressure, thanking staff and encouraging them to take a break
- A NBT Festival last Summer to showcase the diverse well-being offer, including a range of outdoor events from nature walks to outdoor gym sessions

Our strategy of a tiered pathway of support focussing predominantly on enabling teams and managers to support each other as part of their day-to-day work instead of wellbeing as a bolt-on; and preventing staff from becoming ill rather than focussing just on those who already were ill. We developed three key new supportive interventions: ACT with Mindfulness, Start Well>End Well, Me and My Team, and 20 Minute Care Space.

- ACT is a three-session course, based on behavioural science (Acceptance and Commitment Training) to enable staff to develop practical skills to support their own wellbeing and the culture in their teams. Over the Covid-19 period 160 staff completed this programme, and we saw “clinical” levels of psychological distress (“Caseness”) fall from 68% before the course to 14% afterwards.
- Start Well > End Well was developed in the context of a massive shift of our workforce from normal duties to mobilise to deal with the pandemic. It is a simple three step daily process of checking in; pit-stop debriefs; and checking out: run by managers but with a psychologically informed structure to enhance wellbeing and reduce the likelihood of traumatic responses. This structure has since been adopted by NHS England / Improvement as a best practice template, being adopted across the country.



- Me and My Team is based on the principle that “The most important influence on psychological safety is the nearest boss” (Amy Edmonson, 2008). We cannot reach every one of our staff individually, but we can support them through managers who have built confidence and skills to have psychologically informed conversations with their team. This is a coaching style session with a manager or group of managers tailored to their individual context, run by a psychologist. Over the Covid-19 period to date, we have run 134 of these and other bespoke team sessions.

Finally, the individual support which has been provided to 235 members of staff has impacted not only on their own wellbeing, but reduced sickness absence and reduced the number of days these staff reported coming in to work despite feeling unwell.

We were delighted when the impact of our efforts was reflected when we were shortlisted for Best Health and Wellbeing Strategy in the **HR Excellence Awards 2021**

Staff attitude survey

Our Trust-wide response rate for 2021 was 48%, with 4,490 staff responses. Whilst this presented a good representation of our workforce, this was slightly lower than last year (51%), but higher than the average for acute trusts of 46%. In recent years NBT has improved its position in the league table compared to other acute trusts and our above average position has been maintained in this year’s results.

However, overall, most results for NBT have deteriorated since last year, reflecting a worsened staff experience in 2021 compared to 2020. Given the pandemic this was not unexpected. It mirrors the national average position and reflects the extraordinary challenges facing the NHS and all colleagues working in health and care.

Staff engagement for this year is 6.9/10, just above the national average of 6.8/10 and overall, staff experience at NBT in 2021 compared favourably to the national average. Our areas of strengths remain the same as last year: high quality patient care, NBT as an employer and relationships at work.

Our priorities for the coming year will remain:

- Inclusion
- Management Development
- Staff Voice
- Workload and resources

Growing and developing our workforce

This year, as part of our strategic priority to be an anchor organisation we have focussed on maximising access to careers and pathways of development in health and care. We are extremely proud of our ongoing delivery on this commitment, which we have achieved through a number of routes:

Apprenticeships: Throughout the pandemic we have recognised the importance of continuing to support the progress of our apprenticeship programme and the development of our colleagues enrolled on apprenticeship pathways.

We had a full Ofsted inspection on healthcare apprenticeships (Level 2 Healthcare Support Worker & Level 3 Senior HCSW), with the visit taking place from 22 to 25 March. The outcome of the inspections was positive. Some of the positive comments made by the inspectors were:

"It is fantastic to see an apprenticeship learning culture that is embedded throughout the organisation"

"Every apprentice that we spoke to understands the value of their apprenticeship and wants to achieve"

"The Traineeship programme is exemplary in providing opportunities to individuals where employment previously was an unachievable option"

We have utilised 71% of our available levy pot in 2021 and have worked closely with other BNSSG organisations to transfer levy funds to 14 providers (Primary, Social & Community Care) to support our local health economy partners and ensure effective utilisation of the levy.

We have maintained ongoing success of the Level 3, Team Leader/Supervisor Apprenticeship with 24 completions resulting in 17 promotions and were delighted to launch our first cohort of Registered Nurse Degree Apprentices, leading to a clear progression pathway from Band 2 Healthcare Support Worker right through to Registered Nurse status.

Other new apprenticeship provision we have introduced includes:

- Pathology – Degree Healthcare Scientists in partnership with Staffordshire University (developing existing employees)
- Facilities – Production Chef
- Theatres – Operating Department Practitioner in partnership with The University of Gloucestershire (extending the current career pathway for unregistered employees)
- Physiotherapy – Physiotherapy Degree in partnership with UWE
- Physiology – Healthcare Scientist Practitioner (rotation with Cardiology), entry level positions to attract new talent.
- • Corporates – Human Resources, Finance, and Communications

Widening access: In addition to our highly successful apprenticeship programme, we have a number of other programmes to support access to experience and employment with NBT.

In partnership with Women's Work Lab, we have offered workplace experience to a further cohort of unemployed mothers from the local community, who went on to secure paid employment. We have also continued to provide Traineeships, which sees 83% of participants stay with NBT in paid employment.

We have also continued to work in partnership with BrisDoc, Sirona and CCG to host a collaborative NHS General Management Training Scheme experience (5 Trainees joined the collective scheme in September 2021)

We have extended the range and number of Schools (particularly Secondary) we are connected to ensure schools with more diverse student population so ensure widening participation and pipeline into placements, apprenticeships and traineeships.

We have also undertaken a critical strategic step by launching our first 1:3:5 workforce plan focussing not only on our immediate needs but growing a composite, agile workforce fit for future healthcare needs.

Leadership and Management Development

We recognise all we have achieved in 2021/22 would not be possible without effective leaders and managers.

To enable us to continue to support and develop this core group of colleagues we have reconfigured the Leadership Development Team which has allowed us to strengthen the services we are providing to the Divisional Teams. We have ensured a blend of learning on offer and given the pandemic this has required a very agile approach (examples include ILM Award in Team Leadership, ILM award in Coaching, Management Modules; continuation of the Matron Leadership Programme) and approved a new Specialty Leads Development programme

We have organised Senior Leadership Development events (Appreciative Inquiry, Thinking Environment and Valuing Difference; consciously inclusive leadership) and worked in close partnership with EDI colleagues to make improvements to how we cover important inclusion topics (e.g., reviewing our Schools Experience offering, promotional content for Leadership Apprenticeships to better demonstrate diversity).

Core to our priorities this year has been a focus on leadership training for our Clinical Leaders at both specialty and divisional level, which will complement our Board level development programme to support our aim to have compassionate leadership at all levels of our Trust.

Better people support

Throughout 2021 we have continued to review and improve our people service. We are delighted the progress we have made was reflected when we were shortlisted for HR Team of the Year HR Excellence Awards 2021. Key achievements in this area include:

Appraisal: Focussed work has been undertaken over the last year, aimed at reviewing and improving the quantitative and qualitative aspects of appraisal at NBT. Staff engagement and research was undertaken by the People Team and there was a clear message from staff and, from talking to high performing organisations, that appraisal works best when people really value it and have a stake in the process and its outcomes.

This led to the development of an approach known as ‘My Appraisal’:

- A shorter, more focused appraisal window linked to the publication of annual Trust strategic objectives allowing clear line of sight for staff in terms of knowing how their work contributes to Trust-wide priorities
- Removal of performance ratings
- Streamlined appraisal forms
- Updated learning resources & E-learning modules
- Links to quarterly 1:1s (as a minimum) and new materials for encouraging high quality, 1-1 conversations
- Information and support for staff on getting the most out of their appraisal

The appraisal policy was updated in line with the proposed new process and is now 'live', with links to relevant guidance, paperwork, and additional resources.

Workforce transformation: We have continued with delivering our digital based approach to transformation, delivering roll out of e-rostering and e-job planning to the majority of clinical colleagues and launching with BI colleagues a QLIK dashboard of key workforce information, that is accessible in real time to managers.

Freedom to speak up

Freedom to Speak Up (FTSU) is an arrangement arising from the recommendations in the Francis report (the Mid Staffordshire NHS Foundation Trust public enquiry). Effective speaking up arrangements help to protect patients and improve the experience of NHS workers.

In 2021/22 the Trust launched a refreshed FTSU Vision and Strategy, aligned with the organisations Restorative and Just Culture approach:

FTSU Vision: Trusted, Safe, Supported

Our Vision:

North Bristol NHS Trust is a safe and fair place where everyone's voice is encouraged, valued, and listened to, helping us to continually learn and improve.

Freedom to Speak Up at NBT will be **ambitious and proactive** and will aim to:

- Protect patients and staff with a safe and effective FTSU service
- Place patient safety and staff care at the centre of its purpose
- Empower staff to have a clear, confident, and valued voice
- Encourage leaders and managers to listen when people speak up
- Enable our staff and teams to be the best they can be each day
- Play a part in creating a fair, psychologically safe, no blame, Just Culture
- Provide clear speaking up routes, training and communicate learning

During 2021/22 we introduced the Trust's first group of FTSU Champions, who support the FTSU Guardians in raising awareness of FTSU and being a local present in teams across the organisation.

There has been a consistent quarter-on-quarter increase in the number of concerns being raised at NBT, although the numbers are still less than the national comparator average. This is being viewed as positive overall and appears to be due to raised awareness through proactive work by the Lead FTSU Guardian.

More information on FTSU will be available in the Trust's Quality Account published in Summer 2022 in line with national publication requirements.

Fundraising – Southmead Hospital Charity

Our official charity, Southmead Hospital Charity, continues to secure donations to support the Trust, funding cutting-edge equipment, supporting world-leading research, enhancing the hospital surroundings, and supporting staff wellbeing. Every penny ultimately benefitting patients at NBT.

Research & Innovation

The focus for 2021/22 has been the re-introduction of non-Covid-19 research across all areas of NBT. This year NBT opened 113 new studies to recruitment, in addition to the previously suspended studies which were able to restart. Despite the resurgence of Covid-19 in late 2021 and continuing to support Covid-19 research, NBT recruited over 4,700 participants to non-Covid-19 studies including 2,652 to new non-Covid-19 studies open within the year. Research is again underway across the Trust with research being offered across all divisions.

In addition to this success, over 6,000 people were recruited into studies understanding, treating, and preventing serious illness from Covid-19, helping society live alongside Covid-19 in the future.

Our refocus on non-Covid-19 is also reflected in our grants success this year. The Research & Innovation (R&I) team supported the submission of 82 grants with NBT as either lead, partner, site, or co-applicant (incl. 3 Covid-19 grants based in the Women & Children's Health Division). Of these 82, NBT was the lead on 41 grants. All the newly awarded grants led by NBT focus on non-Covid-19 health outcomes.

The success rate for NBT-led grants from the National Institute for Health Research (NIHR) remains outstanding at 75%. This continued success means NBT now leads 60 research grants and is a partner on a further 59, with a total value of £27.9 million.

This year NBT also implemented the STAR (Support and Treatment After joint Replacement) care pathway, within 6 months of submitting the final research report to the NIHR. Implementing the outcomes of a research trial within months of the end of the trial is a testament to the research and clinical teams' collaboration and acts as a model for the future.

The STAR Programme grant was led by NBT and Professor Rachel Gooberman-Hill (University of Bristol). The trial found patients who had STAR had half the hospital admissions and shorter inpatient stays with a total net cost savings c£725 per patient. The trial data demonstrated the benefits of treatment per patient over 12-months showing fewer admissions and shorter length of stays (5.6 days instead of 11.4).

This year our patient and public involvement (PPI) groups have developed, as they continue to adjust to the virtual and mixed model meeting approach. In 2021/22 the R&I team has supported 49 meetings to help shape our work. Feedback from our PPI partners has helped shape the future management of our PPI groups with many people preferring to continue virtual meetings for personal and environmental reasons. A mixed model approach which facilitates and supports engagement has therefore been adopted

NBT continues to work closely with other Trusts and health organisations in the region leading and supporting the quality improvement programme of work initiated by the West of England Clinical Research Network (CRN). This programme gained its genesis during the height of the Covid-19 pandemic when National Rail supported the region, and Trusts within the region, to undertake reflective lessons learned exercises. These have been converted into work packages aimed at ensuring the West of England CRN takes forwards the beneficial changes to our ways of working.

In common with the rest of the NHS, 2021/22 saw a spotlight shine brightly on equality, diversity, and inclusivity (EDI) within our service. Working with our regional partners and Trust EDI leads we are seeking ways to highlight research as a career pathway, a care pathway, and a right for everyone. This will be a long-term project as we seek to redress the inequalities and build trust and confidence across research and the wider NHS.

The priority for 2022/23 is to continue to rebuild research engagement opportunities for our patients and communities and establish a process for ensuring the research findings from our NIHR grants are embedded into care pathways in efficient ways. This year we are also renewing our Research Strategy and the R&I team are engaging widely to ensure our aims, objectives and aspirations reflect the clinical and service provision needs of our patients, NBT and the ICS.

Sustainability

Leadership in Sustainable Development

Our 2019-24 Trust Strategy commits us to being an Anchor in the Community with associated responsibilities for sustainable development, local product sourcing, improving population health and preventing illness. As part of this we are seeking to urgently reduce our 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 and the natural environment, for now and generations to come.

Our sustainability work is co-ordinated by the Sustainable Development Unit (SDU), supported by Glyn Howells, Chief Finance Officer and the Trust Chair, Michele Romaine and monitored by the Sustainable Development Steering Group.

In 2021/22 NBT led the development of the Healthier Together Green Plan alongside our system partners which outlines our system-wide commitments to achieve net zero. In 2022 we will publish our Green Plan 2022-25 which will lay out our strategic aims, objectives, and targets for decarbonising our activities and services over the next three years.

Being an Anchor in the Community

Working with Local Partners

In 2021/22, the Trust expanded our network of local partners thanks to the community outreach work of our Nature Recovery Rangers and Interns, our membership on the One City Environment Board, our core member role in developing the first Healthier Together ICS Green Plan and our involvement in WECA's Future Transport Zone programme

Using Building and Spaces to Support Communities

The Trust recognises the utilisation of our estate is key to embedding ourselves as an anchor organisation. Throughout 2021/22 we have invited staff, patients, visitors and the local community to engage with our green and blue spaces as a tool to improve health and wellbeing.

Engagement

Despite the pandemic impacting engagement, we were still able to host a wide range of events in our outdoor spaces for staff, patients, and the local community to engage with our estate and learn more about NBT's Net Zero Carbon 2030 goal.

2021/22 Sustainability Events	
Allotment Lunchtime Club	One NBT Festival – SDU stall
Virtual Sustainability Lunch & Learn	Nature Connection Activities
Hay gathering workshop	COP26 at NBT
Pumpkin carving and seed saving party	Festive Wreath Making
Winter Warmer Walks	Nature Wellness course

Electric Bike Trial	Tree and bulb planting
Allotment Food Cooking Demo	Wellbeing in Nature
Carbon Sink Walk	Butterfly Walks
No Mow May	Clean Up the World Campaign Litter Pick
Allotment design competition	Forest School
Nature-based Giveaways	Berry Picking Ramble

In 2021/2022, through Lunch and Learns we trained 150 NBT staff members and provided 86 hours of virtual engagement. Through our outdoor nature events, training and bike loan service we have engaged with approximately 16% of NBT staff, surpassing our goal of 10%.

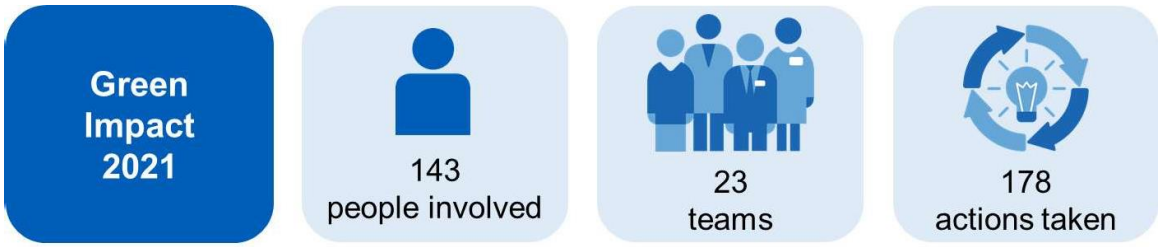
Use of Green Spaces

We recognise the huge importance of the provision, protection and enhancement of green spaces for staff and patient health and wellbeing and wildlife conservation. In 2021 NBT was granted the opportunity to host a Nature Recovery Ranger and two interns to support the Trust in responding to the Ecological Emergency. Our rangers have made significant progress against our Biodiversity Management Plan and are working towards applying for the Green Flag Award.

The NHS as an Employer

We recognise that staff are vital to our sustainability work and have a comprehensive offering for engaging, educating, and supporting staff to embed sustainability at NBT.

In 2021, we launched and completed an in-house staff engagement scheme, Green Impact Plus, which encouraged simple and effective actions to achieve our sustainability objectives and net zero goal.



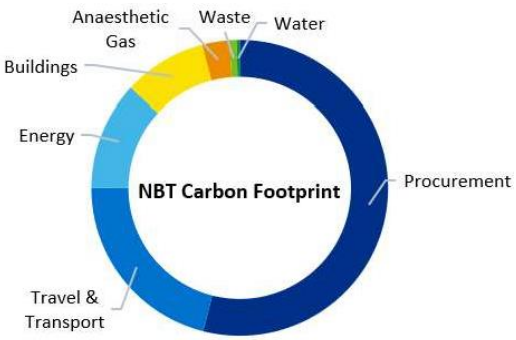
Sustainability Advocate Programme

During 2021/22, we launched the Sustainability Advocates Programme to further engage with all divisions/directorates in our net zero goal and Green Plan objectives. In 2021/22 we managed to recruit 12 Sustainability Advocates across 7 divisions/directorates.

Developing Sustainably

Net Zero Carbon 2030

NBT has a goal to achieve net zero carbon by 2030 across all emission scopes. In 2021/22 we developed a 'Carbon Route Map to Net Zero by 2030' to map out how we will achieve this goal. The Route Map models our future carbon emission trajectories, identifies the challenges for each key emission sector and prioritises interventions that will deliver the most effective carbon reduction. Achieving net zero carbon by 2030 will require commitment from every department across the Trust.



Energy/Water/Waste

Through our Warp-It portal our staff have saved £20,514 of waste and procurement costs, 1,663kg of waste and 9,918kg of CO2 equivalent in 2021/22.

NBT successfully completed the first phase of the Health Care Without Harm (HCWH) Europe project 'Towards plastic-free healthcare in Europe' which involved a review of plastic waste. NBT and UHBW have started work on phase 2 of the HCWH project which shall hopefully yield more results. NBT has continued to align itself with the NHS Plastic Pledge, which focuses on removing single-use plastics from staff-facing catering facilities.

NBT's Carbon and Energy Manager has made significant progress improving the energy efficiency of our buildings, most notably securing £4.3 million of grant funding for energy efficiency projects such as LED lighting upgrades, insulation improvements and replacing our inefficient heating systems with a net zero carbon compatible system. He was also able to secure a grant for consultants to develop heat decarbonisation plans for all our buildings.

The effects of the pandemic on our waste generation have been significant with an anticipated increase in infectious waste and a reduction in offensive and recycled waste. The table below shows the estimated trend in utility figures (pending receipt of final bills) compared to 2020/2021. Full statistics on our consumption and associated carbon emissions will be reported in the Trust's Green Plan 2022-25.

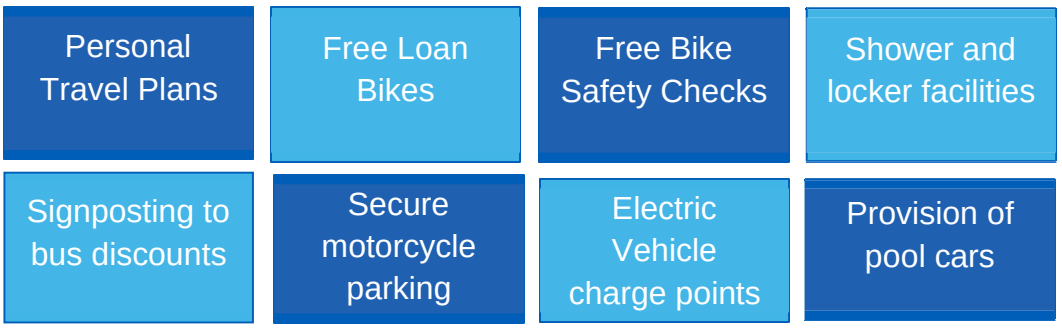
Resource	Trend
Electricity consumption	
Onsite renewable energy generation	↑
Gas consumption	
Water consumption	↓
Waste generation	

Travel and Transport

During 2021/22 the Trust has made good progress on the Travel Plan Action Plan with the completion of the Fleet and Business Travel Scoping Study Report identifying several recommendations to support the reduction of air pollution and mileage associated with transport in line with the NHS Long Term Plan and the NBT Net Zero Carbon goal.

Progress is monitored by the Travel Strategy Group and the implementation of various focus groups will further support our journey of phasing out petrol and diesel vehicles from our fleet and encouraging sustainable travel choices for our staff, patients and visitors.

NBT continues to offer a wide variety of incentives to encourage staff to try more sustainable travel choices whenever possible and monitor progress through an annual travel to work survey. Covid-19 has continued to have an impact on travel choices; both increases in cycling and decreased use of public transport and car sharing.



NBT promotes sustainable travel choices to patients travelling to site through our website and site maps, the public transport hub outside our main entrance and access to electric vehicle charging points. Outpatient travel modes are monitored via the check in kiosks in the Brunel Atrium. The results have shown that most patients travel by privately owned vehicles (84%), with bus (7%), taxi (4%) and walking (3%) being the next highest proportions.

Sustainable Models of Care

Through the Green Impact scheme and Quality Improvement Projects we have identified existing and potential examples of sustainable care models. This year NBT has identified 16 Sustainable Models of Care and Sustainable Quality Improvement Projects, most notably IM&T projects digitalising clinical systems.

Purchasing more locally and for social benefit

Procurement remains the largest element of our carbon footprint (54%). We have produced a pan-consortium Sustainable Procurement Strategy which outlines the joint vision and commitments of BWPC, NBT and UHBW, to support the delivery of exceptional healthcare services in a sustainable manner. The strategy addresses the ethical, social and environmental impacts arising from procurement.

This year the SDU and BWPC have worked in collaboration to incorporate sustainability into tender specifications. Through the Business Case Review process, NBT staff submitted 81 Sustainability Impact Assessments associated with their business cases which ensured alignment to the Trust's net zero goal.

Signed……

Maria Kane, Chief Executive Date: 27th June 2022

PART 2 - Accountability report

Corporate governance report

NHS bodies are required under statute to prepare their annual report and accounts in compliance with the determination and directions given by the Secretary of State for Health. This section takes account of the Department of Health guidance for NHS trusts in the manual for accounts

Directors' Report

The Trust Board

The Trust Board is a unitary board accountable for setting the Trust's strategic direction, vision, and values, monitoring performance against strategic and operational objectives, ensuring high standards of corporate governance, and helping to promote links between the Trust and the local community, including the local ICS, Healthier Together.

The Trust Board is made up of the Chair, Chief Executive, four Executive Directors and six Non-Executive Directors all with voting rights. Two additional Executive Directors attend the board in a non-voting capacity alongside two non-voting Associate Non-Executive Directors. The Associate Non-Executive Director posts are intended to bring diverse skills and perspectives that are otherwise under-represented at board-level, and to serve as a talent development and succession planning pipeline for NHS Non-Executive Directors.

As of 31 March 2022, there were no executive or non-executive vacancies on the Trust Board. The details of individual Director appointments and board members' declarations of interest are detailed within the Annual Governance Statement below.

In normal circumstances the Trust Board meets regularly in public and invites questions from members of the public on any items covered during the meeting. Due to the impact of the Covid-19 pandemic and the requirements of social distancing and infection prevention control, throughout 2021/22 the Trust Board met virtually via secure videoconferencing or via a combination of face-to face (with social distancing) and virtually. Public Board papers were published on the Trust's website ahead of each meeting, and questions from the public were invited. A video recording of each public Trust Board meetings is published on the Trust's website following the meeting.

The Trust undertook its Annual General Meeting (AGM) on 30 September 2021 to present the 2020/21 annual report and accounts. Members of the Trust Board met via a combination of in person (with social distancing) and virtually, and the AGM was broadcast via video livestream.

The Board plays a key role in shaping the strategy, vision, and purpose of the Trust. It is responsible for holding the organisation to account for the delivery of the strategy, quality and safety of healthcare services, and value for money. Day-to-day responsibility for implementing the Trust's strategy and delivering operational requirements is delegated through the Chief Executive to the Executive Directors and their directorates. Key duties are set out in the Trust's standing orders and standing financial instructions which are available on the Trust's website (https://www.nbt.nhs.uk/about-us/trust-board/standing-orders).

Trust Board and Committees

The Trust Board has established several committees to assist it to carry out its functions. Throughout most of 2021/22 the Board committees comprised of an Audit Committee, Finance & Performance Committee, People & Digital Committee, Quality & Risk Management Committee (QRMC), Patient & Carer Experience Committee, and a Nominations & Remuneration Committee. Terms of reference for these committees are reviewed on an annual basis, and they report to the Board following each meeting.

In July 2021 the Board approved changes to its committee arrangements as follows:

- Responsibility for oversight of the system of risk management in the Trust was transferred to the Audit Committee. The Audit Committee was renamed to the Audit & Risk Committee and the Quality & Risk Management Committee was renamed to the Quality Committee,
- The meeting frequency of the Quality Committee and the Finance & Performance Committee were increased from bi-monthly to 10-times per annum, to ensure sufficient meeting time to cover key business.

Further detail on the composition and business of the board's committees are set out in the Annual Governance Statement below.

Impact of Covid-19 on Committees

Throughout 2021/22 every effort was made to ensure that Trust Board and Committee meetings progressed as usual; however, at the height of Covid-19 pressures in January 2022, the decision was taken to stand down some Committee meetings to allow staff to focus on the operational response.

Items from the stood down Committees' work plans were added to Trust Board agenda or carried forward to future meetings as required. The following Committee meetings were stood down:

Committee:	**Meeting date:**
Acute Provider Collaborative Board	10 January 2022
Finance & Performance Committee	21 January 2022
Patient & Carer Experience Committee	19 January 2022

Audit & Risk Committee

Members of the Trust's Audit & Risk Committee in 2021/22 have been:

- Richard Gaunt, Non-Executive Director (Chair)
- Tim Gregory, Non-Executive Director
- John Everitt, Non-Executive Director (1 April 2021 – 30 November 2021)
- Kelvin Blake, Non-Executive Director (1 December 2021 – 31 March 2022)

External Auditors' Remuneration

The Trust's auditors are Grant Thornton. During the financial year there was expenditure of £154k (including VAT) for statutory audit services to the Group (£134k for the Trust).

Public Sector Payment Policy – Better Payments Practice Code

In accordance with the Better Payments Practice Code and government accounting rules, the Trust's payment policy is to pay creditors within 30 days of the receipt of the goods or a valid invoice (whichever is the later) unless other terms have been agreed.

In 2021/22 the Trust paid 84.1% of non-NHS invoices within 30 days compared with 87% in the previous year. Further details of compliance with the Code are contained in note 37 to the Annual Accounts

Fraud, Bribery and Corruption

The Trust's Counter Fraud & Corruption Policy sets out the arrangements that the Trust maintains to deter, prevent, detect, and investigate instances of fraud, corruption and bribery carried out against the Trust and the wider NHS.

The Trust maintains a qualified Local Counter Fraud Specialist (contracted from KPMG LLP) who ensures that the annual plan of proactive work minimises the risk of fraud within the Trust and is fully compliant with NHS Counter Fraud Authority counter fraud standards for providers. Proactive reviews were carried out in the following areas during 2021/22:

- Private Ambulance Providers Review (carried forward from 2020)
- Patient Expenses
- Procurement & Contract Management
- Managing Conflicts of Interest

Counter fraud reports are presented to the Audit & Risk Committee at each meeting.

Modern Slavery

The Modern Slavery Act 2015 became statutory law from October 2015. The Trust has reviewed the controls it has in place to comply with the law and is assured that these are adequate. The controls in place include:

- Employment checks of individuals and of agencies which supply temporary staff; and
- Use of NHS General Terms and Conditions of Contract for Goods and Services which cover all suppliers to the Trust including medicines.
- Due diligence within our procurement and tendering processes to test that selected suppliers and third parties are complaint with the Modern Slavery Act (2015).

The Trust is a member of the Bristol and Weston NHS Purchasing Consortium (BWPC) and is fully committed to BWPC's aim to ensure that Ethical Procurement is at the forefront when having discussions with suppliers. We believe in treating individuals with respect and dignity, and do not condone the use of products or services which infringe the basic human rights of others. We expect our suppliers and business partners to adhere to these high standards and to take all reasonable steps to combat slavery and human trafficking.

BWPC is working with the supply chain to set out a clear Code of Conduct for suppliers. This Code will support the principles in the United Nations Global Compact, the UN Universal Declaration of Human Rights and the 1998 International Labour Organisation Declaration on Fundamental Principles and Rights at Work, in accordance with national law and practice. BWPC is also working with the Trust to develop a Modern Slavery Statement, in accordance with section 52 of the Modern Slavery Act 2015 (which is likely to be extended to apply to public sector organisations)

Signed……

Maria Kane, Chief Executive Date: 27th June 2022

Annual Governance Statement

Maria Kane, Chief Executive

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of North Bristol NHS Trust,
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and
- Manage them efficiently, effectively, and economically.

The system of internal control has been in place in North Bristol NHS Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Governance framework

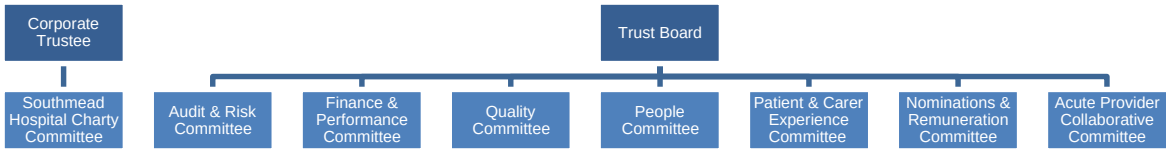
The role of the Trust Board is to govern the organisation effectively and in doing so, to build public and stakeholder confidence in the organisation and the services that it provides. The Board maintains overall accountability for the effectiveness of the Trust's system of internal control. In 2021/22 it primarily discharged this responsibility through the receipt and review of:

- Quarterly reports on the Board Assurance Framework and Trust Levels Risks ensuring key risks were identified and controls or assurance gaps were being addressed,
- Regular upward reports from the Committees, including assurance that the Committees were reviewing relevant strategic and operational risks and associated controls and actions at each meeting,
- An Integrated Performance Report providing internal assurances at monthly intervals on quality, finance, activity and workforce measures and other quarterly and six-monthly measures on quality and safety, clinical governance and safe staffing, and
- External assurance sources, including the External Auditors review of financial year-end accounts and value-for-money (VFM) commentary, the formal and informal visits/inspections from the CQC and other external regulators as relevant.

Authority was delegated by the Board to various Committees and the role and terms of reference of these Committees were reviewed as part of the Board's commitment to improving and maintaining its governance processes.

Approved terms of reference for each of the Board's Committees and the Chief Executive's Trust Management Team are available on the Trust's website (https://www.nbt.nhs.uk/about-us/trust-board/committee-terms-reference).

The formal Committee structure on 31 March 2022, and information on each Committee is set out below:



Audit and Risk Committee

The Audit & Risk Committee provides independent and objective scrutiny of Trust activities through its membership, which consists of three Non-Executive Directors. The Chief Finance Officer, senior managers, Internal and External auditors are also in attendance. This Committee:

- Provides the board with assurance that there are arrangements for the establishment and maintenance of an effective system of integrated governance, risk management and internal control,
- Ensures that there is an effective internal audit function put in place by management that meets mandatory NHS Internal Audit standards and provides appropriate independent assurance to the audit and risk committee, Chief Executive, and board,
- Considers the findings of internal and external audit work and the management response and acts as the auditor panel, making recommendations to the board on appointment and removal of external audit partners.

The Chair of the Audit & Risk Committee is a qualified accountant. The other Non-Executive Directors members of the Audit & Risk Committee in 2021/22 comprised the chairs of the People Committee and the Finance & Performance Committee.

Finance and Performance Committee

The Finance and Performance Committee (F&PC) is the assurance committee responsible for overseeing the management of the Trust's finance and performance and providing assurance to the board that the Trust's mechanisms for monitoring its financial and operational performance are robust and integrated. It also plays a key role in assessing significant business cases and making recommendations to Trust Board, and in overseeing key operational and finance strategic risks via the Board Assurance Framework.

In 2021/22, membership of this Committee comprised of three Non-Executive Directors (one as committee chair) and four Executive Directors. Several senior managers also attended regularly.

Quality Committee

The Quality Committee is responsible for ensuring that the Board is adequately assured in relation to all quality, clinical governance, and research matters. In 2021/22 its membership comprised of three Non-Executive Directors (one of them as chair) and three Executive Directors.

This Committee's work focuses on ensuring that effective quality governance, quality and clinical risk management and regulatory compliance systems are in place and that effective actions are taken to identify, and address deficiencies should they arise.

In 2021/22 the Committee focused particularly on the Trust's response to the Ockenden Report, and assurance on the progress of the Women & Children's Division Improvement Programme.

People Committee

This Committee is the assurance function responsible for overseeing the management of the Trust's workforce and ensuring the Trust's mechanisms for driving change in its workforce.

In 2021/22 the Committee membership comprised three Non-Executive Director (one as chair) and four Executive Directors.

Patient and Carer Experience Committee

The Patient and Carer Experience Committee's purpose is to raise the profile and visibility of patient experience at Trust Board level and to provide assurance to the Board on those matters. The Committee reviews patient survey results, complaints data, and patient experience risks and sets the strategic direction for patient and carer experience including the experience of patients with disabilities.

In 2021/22 the membership of the Committee was comprised of three Non-Executive Directors (one as chair of the Committee), one Executive Director and the Deputy Medical Director, as well as patient representatives.

Nominations and Remuneration Committee

The Trust Board maintains a Nominations and Remuneration Committee which meets to discuss and approve appointments and remuneration for Executive Directors and senior staff not on NHS Agenda for Change terms and conditions. The membership of this Committee is made up of the Non-Executive Directors, with the Chief Executive also forming part of the membership when exercising decisions on executive appointments or dismissals.

NHS Improvement, on behalf of the Secretary of State, appoints the Non-Executive Directors to the Trust.

Acute Provider Collaborative Board

In August 2020 NBT and UHBW created a “committee in common” called the Acute Services Review Programme Board, to provide oversight for a BNSSG acute services review. Subsequently, the government white paper on ICSs published in February 2021 required all acute providers to be part of one or more provider collaboratives by April 2022.

In light of this, in summer 2021 the Acute Services Review Programme Board was re-constituted as the Acute Provider Collaboration Board, a committee in common with membership including the Chairs and Chief Executives of NBT and UHBW, alongside other Executive and Non-Executive Directors of each organisation. This Board oversees both clinical and corporate collaborative activities, providing a forum for agreeing and driving forward shared strategic objectives and priorities.

Southmead Hospital Charity Committee

This Committee oversees the operation of the Southmead Hospital Charity, ensuring that it is managed and operated in accordance with its governing documents, and that it complies with relevant legislation and guidance from the Charity Commission, Fundraising Regulator, and the Information Commissioners Office. It reports to the Trust Board, operating as the Corporate Trustee.

Trust Management Team

Trust Management Team (TMT) operates as the Chief Executive’s senior executive management committee. In this capacity, it supports the Chief Executive in the exercise of her delegated powers from the Trust Board, overseeing the day-to-day management of the Trust, and an effective system of integrated governance across the whole organisation’s activities (both clinical and non-clinical).

Membership of TMT comprises all Executive Directors, (including the Chief Executive as Chair) together with the five Clinical Directors, five Divisional Operations Directors, five Divisional Directors of Nursing / Midwifery / Allied Health Professions, and other core functional leaders (including the Director of Research and Innovation).
For most of 2021/22, the Trust managed the operational response to the Covid-19 pandemic through a specific Emergency Preparedness, Resilience and Response (EPRR) command and control structure, which is outlined in more detail below. TMT continued to meet, focusing on non-Covid-19 related matters.

Trust Board members

Board membership for the year ending 31 March 2022 is set out below. Biographies of existing board members can be located on the Trust’s website.

Non-Executive Directors:

- Michele Romaine, Trust Chair
- Tim Gregory, Vice-Chair
- Professor John Iredale
- Kelvin Blake
- Kelly Macfarlane
- Richard Gaunt
- John Everitt (until 30 November 2021)
- Professor Sarah Purdy (joined from 1 December 2021)
- LaToyah McAllister-Jones (Associate Non-Executive Director, non-voting until 31 March 2022)
- Ade Williams (Associate Non-Executive Director, non-voting, until 31 December 2021)
- Sandra Harding (Associate Non-Executive Director, non-voting, joined from 3 January 2022)
- Ike Anya (Associate Non-Executive Director, non-voting, from 1 February 2022)

Executive Directors

- Maria Kane, Chief Executive (in post from 1 April 2021, and Accountable Officer from 1 May 2021)
- Evelyn Barker, substantive role as Chief Operating Officer & Deputy Chief Executive (Interim Chief Executive and Accountable Officer until 30 April 2021, then BNSSG System-wide Senior Responsible Officer focusing on Elective Recovery Accelerator Programme, retired from 30 September 2021)
- Karen Brown, Interim Chief Operating Officer (until 17 September 2021)
- Jon Scott, Interim Chief Operating Officer (from 26 August 2021 until 31 December 2021)
- Steve Curry, Chief Operating Officer (from 1 January 2022)
- Dr Chris Burton, Medical Director (until 30 July 2021)
- Tim Whittlestone, Interim Chief Medical Officer (from 12 July 2021), Chief Medical Officer (from 1 November 2021)
- Helen Blanchard, Director of Nursing & Quality (until 31 March 2022)
- Steve Hams, Chief Nursing Officer (from 1 March 2022)
- Glyn Howells, Chief Finance Officer
- Jacqui Marshall, Chief People Officer (non-voting)
- Neil Darvill, Chief Digital Information Officer (non-voting)
- Simon Wood, Director of Estates, Facilities & Capital Planning (non-voting, retired 31 December 2021)

Changes to the Trust Board

There were a number of personnel changes on the Board in 2021/22. The Deputy Chief Executive & Chief Operating Officer, Evelyn Barker, acted as Interim Chief Executive to allow an effective handover to the substantive Chief Executive, Maria Kane, who joined the Trust in April 2021. Maria formally took over as Accountable Officer from 1 May 2022.

Karen Brown was in post as Interim Chief Operating Officer until 17 September 2021. She was replaced by Jon Scott, who was in post as Interim Chief Operating Officer until the substantive post-holder joined the Trust from 1 January 2022.

The Trust's Medical Director, Dr Chris Burton, retired at the end of July 2021 and was replaced by Mr Tim Whittlestone, first in an interim role from 17 July 2021 and then substantively from 1 November 2021.

The Trust's Director of Nursing & Quality, Helen Blanchard, retired at the end of March 2022 and was replaced by Steven Hams, Chief Nursing Officer, who joined the Trust from 1 March 2022.

The Trust's Director of Estates, Facilities & Capital Planning, Simon Wood, retired at the end of December 2021. This post was not replaced, and the Estates, Facilities & Capital Planning portfolio is now the responsibility of the Chief Finance Officer.

The Trust welcomed a new Non-Executive Director in 2021/22. Professor Sarah Purdy joined the Board from 1 December 2021, replacing John Everitt as Non-Executive Director. The Trust also welcomed Sandra Harding as a new Associated Non-Executive Director from 1 January 2022, replacing Ade Williams, Associate Non-Executive Director, and Ike Anya, Associate Non-Executive, from 2 February 2022.

Board Committee membership (31 March 2021)

Board member	Trust Board	Audit & Risk	Finance & Performance	Quality	People	Rem & Nom	Charity	Patient and Carer	Acute Provider Collaborative
Michele Romaine	Chair	-	-	-	-	✓	✓	-	Co-Chair
John Iredale	✓	-	-	Chair	-	✓	-	-	✓
Tim Gregory	✓	✓	Chair	-	✓	Chair	-	-	-
Kelvin Blake	✓	✓	✓	-	Chair	✓	✓	Chair	-
Kelly MacFarlane	✓	-	✓	✓	-	✓	-	-	✓
Richard Gaunt	✓	Chair	-	-	-	✓	Chair	-	-
Sarah Purdy	✓	-	-	✓	✓	✓	-	-	-
Sandra Harding	✓	-	-	✓	-	-	-	✓	-
Ike Anya	✓	-	-	-	-	-	-	✓	-
Maria Kane	✓	-	-	-	-	✓	-	-	✓
Tim Whittlestone	✓	-	-	✓	✓	-	-	-	✓
Jacqui Marshall	✓	-	-	-	✓		✓	-	-

Board member	Trust Board	Audit & Risk	Finance & Performance	Quality	People	Rem & Nom	Charity	Patient and Carer	Acute Provider Collaborative
Neil Darvill	✓	-	✓	-	-	-	-	-	-
Glyn Howells	✓	✓	✓	-	✓	-	✓	-	✓
Steve Curry	✓	-	✓	✓	-	-	-	-	✓
Steve Hams	✓	-	-	✓	✓	-	✓	✓	-

Board effectiveness and development

Trust Board undertook a review of its effectiveness, focusing on Committee structures and responsibilities, in July 2021. This resulted in a series of changes, including the creation of an Audit & Risk Committee and an increase in frequency of meetings of the Quality Committee and the Finance & Performance Committee. Each Committee undertakes a self-assessment of their effectiveness and reports the results to Trust Board.

Moving into 2022/23 the need to commission a formal Board development programme has been identified as a priority. The timing is felt to be appropriate as there are no longer any interim post-holders on the Board, and no anticipated vacancies in 2022.

Well-Led Services

The most recent CQC inspection in September 2019 identified the trust as “Good” overall and “Outstanding” when assessed against the CQC’s well-led framework. The Trust has continued to maintain an internal well-led self-assessment document. The CQC identified that the leadership, governance and culture of the organization promote the delivery of high-person-centred care, and leaders were experienced and approachable with clear vision for the services they delivered.

Quality Governance

The Trust is fully compliant with the registration requirements of the CQC and maintains an active dialogue with the local inspection team to address any specific issues raised during the year and to facilitate in year ‘monitoring’ visits undertaken by the CQC. During 2021/22, the Trust has liaised closely with the CQC in ensuring correct registration and quality assurance of the Mass Varication Centre, and the provision of Urology Services at Weston General Hospital.

CQC on site monitoring and engagement core service visits were re-established during the year, with visits successfully facilitated for Maternity Services, Critical Care, and Outpatients.

Internally, the Trust reviews monthly publication of CQC Insight data which includes approximately 280 indicators aligned to the CQC’s Key Lines of Enquiry (KLOE). This is reviewed through the Trust Management Team and Quality Committee and discussed with the CQC at the monitoring visits where appropriate.

Amidst the continued challenges of the Covid-19 pandemic, NBT has progressed a range of quality improvement initiatives, aligned to the Quality Strategy approved in Summer 2020. A Quality Plan for the year was approved by the Board and tracked during the year, aligned to the quality themes:

- Exceptional Personalised Care
- Safe & Harm free Care
- Excellence in Clinical Outcomes

Focus on improvement projects that align to these themes also continued. These were set out within the Quality Plan for 2021/22, overseen through Executive Director-level committees and their sub-groups and formally reported to the Quality Committee during the year and then as part of the annual Quality Account.

Throughout the year Executive Director-led committees have continued to operate as follows:

- Clinical Effectiveness & Audit Committee
- Patient Safety Committee
- Safeguarding Committee
- Drugs and Therapeutics Committee, and
- Patient Experience Committee

The necessary focus on operational priorities during the different waves of the Covid-19 pandemic and winter pressures meant that standing committees were on occasions reduced in length and urgent business prioritised.

The first four committees listed above report into the Quality Committee and the final committee reports into the Patient & Carer Experience Committee, both also chaired by a Non-Executive Director. These committees seek assurance from Executive Directors and clinical teams and provide assurance to the Trust Board based upon the business conducted within those meetings.

The necessary focus on operational priorities during the different waves of the Covid-19 pandemic and winter pressures meant that some significant assurance activities were reported directly to Quality Committee, or received additional attention there, key examples being:

- Maternity Services – review of self-assessments against the recommendations of the national Ockenden report and delivery of related evidence and actions for this and also the CNST Maternity Incentive Scheme
- Women's & Children's Clinical Division Development Programme – reporting of delivery against programme goals and milestones.
- Approval and ongoing review of the Patient Safety Incident Response Plan for 2021/22
- Mass Vaccination Programme – ongoing oversight of NBT's role leading the system planning and response to each phase of the Covid-19 vaccine rollout.

- Review of NBT's self-assessment and improvement work in response to the national Paterson Inquiry, including programmes covering patient consent and shared decision-making and the effectiveness of non-cancer multi-disciplinary team (MDT) meetings.
- Control of infection in year review of the Infection prevention & Control (IPC) Board Assurance Framework and the IPC Annual Report.
- Review and actions from Covid-19 outbreaks and hospital acquired cases, including case reviews relating to patients that died following probable and/or definite hospital associated Covid.

Independent quality assurance is provided through the Trust's Internal Audit programme. The outcomes are reported through the usual route to the Audit & Risk Committee but also through Quality Committee and into the executive-led quality committees outlined above where appropriate. Examples in 2021/22, reported by the Internal Auditors, were Learning From incidents, Patient Property, Accessible Information Standards and Freedom to Speak Up.

Risk Management

As designated Accountable Officer, the Chief Executive has overall accountability for risk management in the Trust. The Chief Nursing Officer leads on risk management at Trust Board level with additional support from the Trust Secretary.

Capacity to handle risk

The Trust's risk management approach focuses on equipping staff to manage risk in a way that is simple and helpful, and appropriate to their authority and duties. Rather than an extensive "corporate risk register", the Trust ensures senior focus using:

- The descriptor of "Trust Level Risk" (TLR). This is used to describe any risk that meets the risk appetite threshold for its related risk type as set by the Trust Board. The Trust Risk Register is made up of all TLRs
- Executive Risk Sponsors (ERS) for all TLRs
- Accountable Committees: these are Board Committees, with all TLRs mapped to an appropriate Accountability Committee for oversight
- In 2021/20 the Executive Team also implemented a monthly "Executive Assurance Forum"; a meeting of all the Executive Directors where TLRs and the Board Assurance Framework are reviewed, scrutinised, and challenged.

Governance arrangements are strengthened using:

- Clear reporting mechanisms
- Standardised reporting templates
- Simplified risk module on Datix, and
- A clear and up-to-date risk management strategy and policy.

Local ownership, knowledge & skills are maintained by:

- Clinical Division and Corporate Directorate governance and leadership groups reviewing their risks in line with the Trust policy

- All TLRs being approved by the relevant Divisional/Directorate management team
- Upskilling key staff via risk workshops, underpinned by the revised risk management strategy and policy and providing practical guidance on the process to identify, assess, approve, manage and report risk
- Ongoing coaching on risk management through existing governance structures.

Accountable Committees

The overall responsibility for managing risk remains with the Chief Executive and assurance to the Board is provided through the Audit & Risk Committee, chaired by a Non-Executive Director. The Board maintains oversight of the risk management system and reviews the Board Assurance Framework alongside the TLRs on a quarterly basis.

Approved subject specific TLRs are also reported to other key Accountable Committees as appropriate, and when deemed necessary or important, these are highlighted to Trust Board via Committee reports.

During 2020/21 the Quality & Risk Management Committee, and then the Audit & Risk Committee (from November 2021), have received all TLRs and reviewed progress on them at each meeting.

Risk Appetite

Board members have participated in a risk seminar session to determine the Trust's appetite and tolerance for risk (2019/20). This workshop is being revisited in April 2022. Ongoing challenge and review of risk appetite/tolerance forms part of the discussion at Board and Committees when reviewing Trust Level Risks, and any recommendation on changing risk appetite/tolerance would be referred to Trust Board for ratification. The Board's tolerance for risk informs the threshold for a TLR. The Trust's risk approval process strengthens divisional ownership of risk and aligns with the responsibilities of the divisional governance leads.

The Patient Safety Team reviews the risk register to identify risks common across more than one division in order to aggregate the separate risks and assess as one.

The Risk and Control Framework

The Trust's risk strategy and objectives are in place to ensure a pro-active approach to risk management by engaging staff at all levels in efforts to resolve risk locally. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

There is an annual audit of risk management processes via the Trust's Internal Audit function which includes reference and comparison to best practice guidance and good practice in other organisations. Recommendations are acted upon by the Trust and this is overseen by the Audit & Risk Committee. The 2021/22 Internal Audit review of risk management concluded "significant assurance with minor improvement opportunities" (as it did in 2020/21 and 2019/20).

The Trust's approach to risk management as outlined in the Risk Management Strategy and Policy, and as implemented via Datix, encourages a strong focus on identifying controls, gaps and mitigations to ensure there is a proactive approach to managing risks.

This approach to risk management is integrated with other supporting and co-dependent mechanisms. For example, themes and learning from incidents, investigations and audits contribute to the organisation's understanding of risk exposure. Discussions of new and emerging risks form a key part of the Trust's committee framework. For example, the Patient Safety and Clinical Risk Committee receives monthly updates on all patient safety risks rated as ≥9 as well as receiving reports on all TLRs across the Trust. This approach can also be seen in the Trust's Patient Experience Committee.

Board Assurance Framework

The Board Assurance Framework (BAF) defines and assesses the principle strategic risks to the Trust's objectives and sets out the controls and assurances in place to mitigate these.

Each of the risks in the BAF have been aligned to the objectives within the Trust's strategy, have their unmitigated, mitigated and target risk scores reported, and information showing the anticipated changes in rating over time. Gaps or areas where controls can be improved are identified which are translated into actions.

The BAF is reviewed by Trust Board in an ongoing quarterly cycle alongside TLRs, with key risk changes highlighted, and updates provided on any ongoing actions to improve risk control and mitigation. Trust Board's Committees also review relevant risks from the BAF at each meeting.

The BAF is used to help inform the Internal Audit work programme, and audit outcomes are used to inform further actions, or are used by the Board as part of its assurance process that the risk is adequately controlled. The risks are also used to inform the work programmes of the Committees to ensure they are focusing on the key risks to the delivery of the Trust's strategy.

Strategic and Trust Level Risks

At various points during 2021/22 the following key strategic risks on the BAF have been scored 15 or above, and have been closely monitored by Trust Board and its Committees:

Strategic Risk (16 or above)	**Additional context and actions to reduce or mitigate risk**
Patient flow across the hospital is constrained by: - Low numbers of early ward discharges - inconsistent "internal professional standards" - strained community capacity, - high numbers of patients with no criteria to reside,	This risk has remained relatively high during 2021/22 due to increasing numbers of patients in the Trust who no longer fit the "criteria to reside". On 31 March 2022 was assessed as a 5x4=20 (Severe) risk. Mitigating actions have focused on implementing Internal Professional Standards to ensure timely internal support to the Emergency Department,

Strategic Risk (16 or above)	Additional context and actions to reduce or mitigate risk
This affects the performance of the hospital against key operational performance and quality targets, including ambulance handover times. In turn this: - affects patient experience - leads to potential patient harm, and - affects the reputation of the Trust and of the NHS.	implementing model ward rounds, accessing support from ALAMAC and ECIST and engaging with system partners to ensure benefits of system initiatives are achieved (such as increased discharge capacity in the community).
Due to the impact of social distancing, lockdowns, and other IPC controls during the past 12-18 months, it is probable that 2021/22 winter period will see an increase in infectious diseases within the hospitals (such as flu, norovirus and ongoing Covid-19 infections). This would likely impact across several areas including: - Capacity to provide effective and safe care to patients, including through the cancellation of planned care and increased waiting list size - Impact on bed numbers due to IPC controls and closed beds - Reduction in staff numbers due to staff sickness, self-isolation, and shielding, and - Increase in patients waiting packages of care - Public confidence in the hospital and the NHS.	During the winter period of 2021/22 and the Covid-19 surge associated with the Omicron variant, this remained a significant risk, scored at 4x5=20 (Severe) between October 2021 and February 2022. On 31 March 2022 this risk had reduced to a 3x4=12 (High) risk, reflecting the reduced acuity of Covid-19 patients and the changing Infection Prevention & Control guidance in hospitals.
National/system competition for workforce in key specialties/ professions (e.g. sonographers & histopathologists), together with increasing demands on remaining staff plus post-Covid-19 fatigue could result in skills/capacity shortages within the Trust and increased instability in the workforce. Consequences would include: - Increased reliance on expensive agency staff - Higher turnover, which could result in dramatic increase in recruitment activity and associated costs - Poor patient safety & experience due to staff shortages.	While staff turnover rates have remained stable during 2020/21, the Trust has seen increasing number of staff absence due to sickness and has experienced workforce shortages in key areas (such as obstetrics sonography) which has had significant impact on some services. On 31 March 2022 this risk was assessed as 5x4=20 (Severe). Mitigations have included an ongoing focus on well-being initiatives, improved flexible working offering, international recruitment campaigns and joint system working on workforce.
A significant cyber-attack takes out the Trust's IT systems leading to an inability to treat patients and the potential loss of critical data.	This risk has remained high during 2021/22, remaining at 3x5=15 throughout the year. It has remained under close scrutiny, in light of successful cyber-attacks against the Irish Health Services in May 2021 and the alerts issued following the conflict in eastern Europe in early 2022. Mitigations have included significant hardware and software upgrades, increased monitoring and system/national engagement to ensure best practice.

As 2021/22 draws to a close, the risks associated with direct Covid-19 infection rates and the limits imposed by Infection Prevention Control measures have begun to reduce, although they remain under constant review. The substantial backlog of planned care and pressures on community resources mean that risks around access to timely care, both in urgent care (such as ambulance handover waits, cancer diagnostics) and in planned care are now a key focus. There is likely to be a BAF risk relating to these issues added in early 2022/23, and these issues are reflected in the organisation's TLRs.

In 2021/22 the Trust monitored TLRs across the following themes:

- Patient safety, experience and operational performance risks linked to long patient waiting lists in planned care, delays in ambulance handover times at the Emergency Department, delays in cancer pathways and diagnostics, and poor patient flow.

  Mitigating these risks remains a major focus, with the Trust receive support from ALAMAC, ECIST and taking advantage of national funding opportunities to increase its capacity to deliver timely care.

- Staff shortages and workforce pressures (driven by Covid-19 as well as national workforce shortages in key areas), staff wellbeing and the experience of staff with protected characteristics. The Trust has continued to invest in its wellbeing programme, international recruitment campaigns and is leading a joint BNSSG system approach to workforce planning.

  In 2021/22 the Trust faced particular workforce shortages in its antenatal screening service resulting in a number of screening breaches. An "Appreciating Enquiry" report was undertaken in Q1 of 2021/22, and the oversight of the ongoing risk and improvement actions was managed through the Quality Committee.

- Financial risks relating to inflation and energy prices, high levels of non-recurrent funding associated with the pandemic response, and shortfalls in CIP delivery during the year. The Trust is engaging with BNSSG system partners to ensure a system approach to financial balance and is ensuring that investments for 2022/23 are only made once there is assurance on CIP plans and delivery. Longer-term procurement strategies are also being considered to help mitigate sudden increases in energy prices and supply chain inflation.

- Specific areas of cyber-security risk, data quality, and operational risks associated with significant IM&T infrastructure upgrades or old equipment. The Trust has an experienced, well-resourced IM&T function which has worked with estates, facilities, and clinical/operational teams throughout the year to mitigate these risks.

Risks to Data Security

Risks to data security are managed by the Informatics Division (IM&T). Internally, any risks to Trust data can be raised on the Trust's risk register, which is regularly monitored, with all TLRs reported to an Accountable Committee. Cyber Security is also a prevailing risk on the BAF, so Board visibility of Cyber Security risks and mitigation remains high. On a day-to-day basis,

monitoring is in place to ensure any unusual IT activity can be reported by staff to the IT Service Desk to investigate further, e.g., for virus risks, phishing attacks etc. IM&T also monitor network security boundaries to pick up and block any suspicious activity.

Externally, IM&T is an active member of the National Cyber Security Centre (NCSC) Cyber information sharing partnership (CiSP) which is a national forum for sharing security incidents and receiving advice and support. IM&T subscribes to the NHS Digital CareCERT initiative and receive regular security advice and guidance on how to update our IT systems and prevent unauthorised access to our data. We actively support NHS Digital, NHS England and other regulating bodies in their Cyber Security planning through supplying additional evidence and assurance sourced from the Trust's Data Security & Protection Toolkit which is also managed by the Informatics Division.

Continual improvement in data security is also addressed through regular external cyber security audits and technical vulnerability testing, a programme of decommissioning end-of-life IT infrastructure, and advisory recommendations from the Information Commissioner's Office (ICO).

As part of the overall IM&T cyber security provision and assurance, The Trust has commenced Cyber Essentials Plus accreditation in 2021/22 with the aim of securing accreditation in 2022/23.

Covid-19 Governance and Controls

The Trust's Covid-19 command and control (C&C) arrangements reported in its 2020/21 Annual Report remained in place during 2021/22, with meeting frequency determined by the level of Covid-19 cases within the hospital.

- **Gold Command**: Chaired by the Chief Operating Officer with the Chief Medical Officer and Chief Nursing Officer, Gold Command provides strategic direction and coordination and acts as a point of escalation for Silver Command. It is the key liaison with BNSSG Health and Care Silver Command and connects with regulators and other external bodies as appropriate. Gold Command is responsible for reporting to Trust Management Team and Trust Board on all Covid-19 related matters.

- **Silver Command:** overseeing the organisational response to Covid-19. Silver Command is supported by a series of Bronze-level cells focusing on specific areas including workforce, communications, facilities, out-patients, divisional management teams, personal protective equipment, and finance and logistics.

- **Clinical Reference Group**: Bringing together senior clinical leaders from across the Trust, this group provides advice to both Silver and Gold Commands and is responsible for determining clinical thresholds and guidelines.

As effects of the Covid-19 pandemic diminish and the Trust returns to "business as usual" in line with the Government's "Living with Covid" guidance, the need for frequent C&C meetings has diminished. In February 2022 the decision was taken to stand down regular Silver and

Gold Command meetings and to meet by exception only. The Trust has initiated a review of key decisions taken in the C&C structure, with a view to bringing these structures to a formal close in early 2022/23.

Nightingale Hospital Bristol

In late 2019/20, statistical modelling underpinning the government and NHS response to the Covid-19 pandemic identified a real risk that the UK would have insufficient critical care capacity to respond effectively at the peak of the crisis. As part of the national planning and preparation, several short-term "field hospitals" were created across the UK to provide additional critical care and step-down capacity for Covid-19 patients. On 30 March 2020 NBT was identified as the host organisation for the NHS Nightingale Hospital Bristol (NHB), accountable to NHS England for the setting up and operation of the new unit at pace to provide additional ICU bed capacity for the Severn Network area of the West of England.

Ultimately the NHB was not required to operate as a Covid-19 field hospital; however, it remained in "stand-by" mode throughout 2020/21, and decommissioning works commenced at the end of March 2021. Decommissioning was completed by 1 June 2021 and the site formally returned to the University of the West of England, Bristol.

Mass Vaccination Programme

In November 2020 the Trust agreed to undertake the role of Management and Coordination Organisation for the BNSSG Covid-19 Mass Vaccination Programme, working collaboratively with BNSSG system partners (including the CCG and Primary Care Networks) to ensure that the programme was accorded the correct governance, financial oversight, and workforce to deliver nationally set targets. It has remained in this role throughout 2021/22 and into 2022/23, but it is anticipated that this programme will transition to a "business as usual" model in the community or primary care at some point in 2022/23.

Principal Risks to compliance with the NHS Provider Licence condition 4

As an NHS trust, the Trust is exempt from the requirement to apply for and hold a Provider Licence; however, directions from the Secretary of State require the NHS Trust Development Authority (NHS Improvement) to ensure that NHS Trusts comply with conditions equivalent to the licence as it deems appropriate. The Trust's regulators therefore base their oversight of all NHS Trusts on the conditions of the NHS Provider Licence. Condition 4 relates to having in place effective governance to ensure compliance with the Licensee's duty to operate efficiently, economically, and effectively.

In March 2019 the Trust agreed a series of enforcement undertakings with NHS Improvement under section 106 of the Health and Social Care Act 2012 to address identified areas for improvement and to repair identified breaches of Condition 4 of its licence. These undertakings required improvements across the four-hour standard in the emergency department and a target for zero incomplete RTT pathways waiting over 52 weeks, together with the creation and delivery of a long-term financial model leading to financial sustainability.

On 12 January 2022 the Trust received a compliance certificate from NHS Improvement confirming that it had complied with the undertakings relating to financial strategy and planning. NHS Improvement also formally discontinued the undertakings relating to the four-hour standard in the emergency department and the RTT standard, noting the passage of time and the changes in the Trust's circumstances meant that they were no longer relevant.

Like most NHS organisations, NBT is not currently achieving the four-hour standard in the emergency department and is also working to improve the backlog of planned care activity built up during the Covid-19 pandemic; however, it is not an outlier when compared to other organisations.

These areas continue to represent a significant risk to NBT's compliance with its provider licence, and while the Trust has achieved national improvement trajectories for reducing long-waiting patients at the end of March 2022, further deterioration in the number of patients waiting in excess of national standards remains a possibility.

The Trust's Committee structure ensures that there is timely scrutiny of performance data (particularly via the monthly Finance & Performance Committee). The Trust Management Team and Trust Board have received "deep-dives" into both urgent and emergency care performance and planned care modelling in March 2022 and this remains on forward work-plans for 2022/23.

The Trust has been placed into Segment 3 of the System Oversight Framework, meaning that it can receive mandated support from NHS Improvement in relation to its performance. The Trust is taking advantage of this support to help shape its improvement and recovery plans for 2022/23.

Workforce Safeguards

The Board receives a regular report on Nursing and Midwifery staffing to provide assurance that the Trust has a clear validated process in place for monitoring and ensuring safe staffing in line with current national recommendations and is compliant with the *'Developing Workforce Safeguards'* recommendations and the requirements of the National Quality Board (NQB).

In October 2021 the People committee received the six-monthly review of safe nursing staffing at North Bristol NHS Trust undertaken in August and September 2021 using the Safer Nursing Care Tool (SNCT) (Shelford 2013) covering the period April to September 2021. This was subsequently reported to the public meeting of the Trust Board in November 2021.

Divisional Directors of Nursing & the Director of Midwifery reviewed the results and triangulated the findings with professional judgement in reaching conclusions and making recommendations. The Divisional Director of Nursing for ASCR has also completed a forward-facing review of all Critical Care units in the context of changing capacity and Guidelines for the Provision of Intensive Care Services (GPIC's).

The Director of Midwifery has reviewed Midwife to Birth ratios as recommended and found within the Birthrate Plus® tool and endorsed by the Royal College of Midwives. The ratios are reviewed monthly against the recommended mean national ratio of one whole time equivalent

(WTE) midwife per 29.5 births, Midwifery staffing continues to be reviewed alongside development of the continuity of carer model. The Women & Children's Health Division has also responded to the Ockenden report (Part One published on 10 December 2020) and responded to the 7 Local Immediate and Essential Actions, including a maternity workforce gap analysis.

The Trust's process for managing safe staffing on a daily basis is set out in a Safe Staffing Standard Operating Procedure to ensure consistency in the process of managing safe staffing and a clear process for the escalation of shifts. This articulates the triangulated approach to safe staffing that NQB require and ensures robust decision making for all staff around the safe care of our patients.

Daily safe staffing meetings occur between Divisions, overseen by a Divisional Director of Nursing for the week, where real time data of actual staffing levels and patient acuity can be viewed, and staff redeployed as required. The staffing meetings assess this level of risk and move staff between clinical areas to balance the risk across the organisation.

In line with the junior doctor contract the Trust's Guardian of Safe Working (GOSW) is responsible for ensuring that Postgraduate Doctors in Training have systems in place to exception report should there be any breach of safe hours limits, or if there are any other immediate safety concerns. This is reported through the Allocate Exception Reporting system which both Postgraduate Doctors in Training and Trust appointed Clinical Fellows have access to in order to raise any concerns.

The GOSW produces monthly reports for Divisional Management Teams allowing them to review and address any persistent breaches as well as a report presented to the Trust Board three times a year (as well as to the People Committee).

The Trust continues to roll out eRostering and eJob Planning for all medical staff providing transparent divisional and corporate oversight of medical staff deployment across the Trust. Monitoring of medical staff deployment is through the Medical Professionals Committee which in turn reports through to the People Committee.

In January 2021 the People Committee also received a review of compliance against NHS England Winter 2021 preparedness: Nursing and midwifery safer staffing Version 1 released November 2021. The trust was largely compliant with most areas and declared partial compliance against standards 2.4 & 2.5 with further work being completed to ensure appropriate patient handover SOPs within the CareFlow Connect system.

Alongside the Trust's own People Strategy (launched in September 2020), workforce forms part of the annual business planning cycle. The Trust is also involved in driving forward the BNSSG 1, 3, and 5-Year People Plan. In 2022/23 this will:

- Capitalise on and bring together existing work being progressed corporately or by professional groups or divisions,
- Cover all professional groups and staff groups,
- Align 1, 3 and 5-year planning with current operational planning and recovery,
- Provide a clear view of additional or enhanced workforce projects required.

The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust Board has overarching responsibility for ensuring that the organisation has appropriate arrangements in place to exercise its functions effectively, efficiently and economically, and in accordance with the Trust's principles of good governance.

The Chief Finance Officer has delegated responsibility to determine arrangements to ensure a sound system of financial control. The Trust produces an annual operating plan that is underpinned by plans produced by each division. The Plan details how the Trust will utilise its resources throughout the year, identifies the principal risks to the delivery of the Plan and any mitigation, and is supported by financial forecasting. The Chief Finance Officer and his team work closely with divisional and corporate managers throughout the year to ensure that a robust annual budget is prepared and delivered.

Throughout the year Trust Board, via its Finance & Performance Committee, have received regular reports about the economy, efficiency, and effectiveness of the use of resources. The reports provide detail on the financial and operational performance of the Trust and the delivery of CIP and highlight any areas where there are concerns.

The Trust's Transformation Office provides oversight and assurance of delivery of annual cost improvement plans delivered across the organisation, reporting progress to the Trust Management Team and the Finance & Performance Committee. Transformation Analyst support was also provided to Clinical Divisions in considering benchmarking data from Model Hospital, GIRFT and other national databases in considering efficient use of resources. In 2021/22 the Trust delivered £3.6m of savings across several schemes including non-pay, pay and non-commissioner income.

Internal audit has reviewed various systems and processes in place during the year and has published reports setting out any required actions to ensure economy, efficiency, effectiveness and use of resources (including a review of theatres stock management, financial systems, and implementation of Theatre Blue Spear system). The outcomes of these reports are graded as to the level of assurance and are reviewed by the appropriate Trust Board committee.

Annual Quality Account

The Trust's Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Quality Account is produced to a structured timetable that commences in January and supports the engagement in its production from clinical staff, internal and external stakeholders and Board review and final approval for the required deadline of 30 June 2022 for external publication. This includes review and scrutiny of the overall contents, selection of quality priorities and overall contents at the Trust's Patient Safety Committee, Patient Partnership Group, Patient & Carer Experience Committee and Quality Committee before review at Trust Board. Any unusual trends in data are investigated and considered in light of the narrative provided and in light of the wider knowledge of clinical services applied through the senior clinical and managerial leads included in those reviews.

Preparations for the Quality Account for 2021/22 are in hand, including the agreement of quality priorities for 2022/23, approved by the Trust Management Team and then the Quality Committee under delegated authority from the Trust Board. External stakeholder consultation on the contents will be undertaken in line with requirements and this will include presentations and Q&A sessions with Local Authority Health Scrutiny Committees for BNSSG. NHS England has stipulated that the external audit of the Quality Account is no longer mandated for any future years, but it is at local discretion to do so, if required. The Trust has elected not to undertake an external audit for 2021/22.

Information governance

The Trust has self-reported 14 data security breaches in the last 12 months through the Data Security and Protection Toolkit (DSPT). The incidents related to disclosure of personal identifiable information in error. Only a single breach required further investigation by Information Commissioner's Office (ICO). The ICO took no action against the Trust for that single data security breach.

Data quality and governance

Work has continued throughout the year to identify and address data quality issues. Issues are identified through a data quality monitoring which highlights where review and remedial action is required. Issues can also be reported by system users across the Trust. The Trust has Data Quality Marshalls who work within the hospital to holistically review data pathways from input stage to reporting, to identify and correct issues. They also ensure that capability in the workforce is increased through the provision of on-going engagement and consultancy across the organisation. Data Quality is subject to internal audit and has maintained and built

upon recommendations contained within an overall status of ‘Significant Assurance with Minor Improvements’ in 2021/22.

To provide data quality assurance the Trust utilise monitoring tools both internally and externally:

Internally the Data Quality Tracker is updated daily and made available to all staff. The Data Quality Tracker is one of the leading quality management products used by the Data Quality Marshalls within IM&T. The Tracker includes approximately 50 Key Performance Indicators covering all elements of the Referral to Treatment (RTT) patient pathway. The data is reviewed on a regular basis by all specialities and any data quality issues are validated and amended to ensure accuracy. Training issues are also identified by using the Tracker to ensure that staff are adhering to the SOPs that are in place.

There are various reports on the Data Quality Tracker relating specifically to waiting lists. This is validated by specialities to ensure that all patients are added to the correct waiting list. In addition, there are monthly validation processes in place to ensure the quality of the Trust’s national RTT submissions, which are signed off by the Associate Director of Performance prior to submission. The Trust has fully implemented the RTT suite of reports, as recommended by the NHS Improvement Intensive Support Team, and continues to monitor RTT performance daily.

In 2021/22, tailored Data Quality Plans were agreed and issued to all Divisions, focussing on approximately 30 metrics that are of highest importance to patient safety, and effective operational activity as a Trust. Significant progress has been made within each Division, with progress regularly reported at every level of Trust governance.

Externally, Data Quality Marshalls work with Commissioners and the Commissioning Support Unit to understand measurable quality improvements from contractually mandated submissions. The outputs are circulated to Finance and Operations Teams, and are used to structure data quality improvement plans, both externally mandated by commissioners and internally within the Trust.

In terms of governance, all data quality queries are logged, assigned, tracked, and ultimately resolved, engaging wider resources as required. There is a monthly Data Quality Meeting, focusing on all internal and external quality issues. The outcome from this meeting is then visible internally to higher level quality forums and to the IM&T Divisional Board, and externally to our commissioners via a Data Quality & Improvement Plan Meeting.

Historically, performance has been reported to the Commissioner-led Finance Information Group meetings and upwardly reported to Trust governance and assurance groups including Finance & Performance Committee, Audit & Risk Committee, and an Integrated Care Quality & Performance Management Group. Since 2018/19, this governance structure has continued to report Data Quality as Green and an area of increasing assurance. The success of the data quality agenda has seen no mandated quality improvement plans for the past 2 years. Ad hoc data quality queries are actively tracked and monitored and are reported on monthly to the monthly internal governance structure described above. Nationally mandated Data Quality Improvement Plans are expected in 2022/23 covering Maternity Services and Learning

Disability data sets, and the Trust expects to be well-placed to respond to these new national requirements.

Each year since 2019/20, a Data Quality Position Statement is produced for the Finance & Performance Committee, and we have maintained a position of Good in the first two years of reporting, which has risen to Excellent in 2021/22.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board and its Committees, particularly the Audit & Risk Management Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review of the effectiveness of the Trust's system of internal control has particularly been informed by the following:

- Executive Directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control (including but not limited to the Chief Operating Officer, the Chief Finance Officer, the Chief Nursing Officer and the Director of Corporate Governance) who provide me with assurance,
- The Board Assurance Framework and TLR reports and their regular review via Trust Board's committees and the Board itself, as well as the Executive Assurance Forum, provides me with evidence of the effectiveness of controls that manage the risks to the organisation achieving its strategic and operational objectives,
- Internal Audit provides me with an opinion about the effectiveness of the Board Assurance Framework and the internal controls reviewed as part of the Internal Audit plan,
- Work undertaken by Internal Audit is reviewed by the Board's committees and management responses/action via the Executive Assurance Forum,
- The Board has set a risk appetite for the organisation and is revisiting this in April 2022. TLRs are reviewed regularly by the Board's committees and by the Board on a quarterly basis. This provides me and the Trust Board with evidence of the effectiveness of controls in place to manage risks to achieving the Trust's principal priorities.

The Head of Internal Audit provides me with an opinion (HIAO) for the period of 1 April 2021 to 31 March 2022 of 'significant assurance with minor improvement opportunities' on the

overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

In 2020/21 the Head of Internal Audit advised me that they provided only partial assurance in respect of their 2020/21 review of the Trust's core financial controls. I am pleased that following delivery of key high priority recommendations during 2021/22, the repeat audit of Financial Systems reported in January 2022 provided an assurance opinion of 'significant assurance with minor improvement opportunities.'

The Head of Internal Audit has provided me with additional assurance that the Board Assurance Framework reflects the Trust's key objectives and risks and is reviewed by the Executives prior to review at the Board on a quarterly basis.

Internal Audit issued four 'partial' assurance reports, seven 'significant assurance with minor improvement opportunities' reports, one 'significant assurance' report and zero 'no' assurance opinions in respect of their 2021/22 assignments. The partial assurance reports related to Theatres Stock Management, Health & Safety Compliance, Patient Property, and Accessible Information Standards.

This did not prevent Internal Audit from issuing "significant assurance with minor improvements required" as an overall opinion as the organisation has made progress to address the issues identified by the recommendations raised through the Internal Audit work. All of these reports are "risk based", and known areas of challenge for the Trust, and are a fundamentally important management tool for testing areas of potential weakness and identifying improvement opportunities.

My review is also informed by External Audit opinion, the 2019 Trust-wide inspection carried out by the CQC which commented positively on the Trust's governance structures and controls, and other external inspections and reviews.

I have also been notified that a "key service" auditor report relating to Shared Business Services (SBS), completed by PwC has reported a qualified opinion in 2021/22 relating to one control objective. I am aware that the control related to performing the annual inspection of fire alert and detection systems, and for one instance the test of the generator did not operate effectively. I reassured that SBS have reviewed their testing schedules and controls and have mitigations in place and deem the incident to represent a very low risk to client data and systems.

In addition to the above, the processes outlined below are well established and ensure the effectiveness of the systems of internal control and data quality through:

- Board Committees' review of the Trust Level Risks, and divisional/directorate review of their own specific risk registers
- Review of serious incidents and learning by the Executive Incident Review Meetings and the Clinical Risk Operational Group
- Clinical Audits
- National Patient and Staff Surveys
- Internal audits of effectiveness of systems of internal control

- The Trust's ongoing engagement with the CQC.

In 2021/22 the Trust has made a performance adjusted surplus of £2.2m (0.3% of turnover). Under the financial regime in place during 2021/22, the Trust has recovered its agreed cost base while delivering an agreed level of activity, and the Payment by Results (PbR) payment mechanism has remained suspended. As such, there is no concept of an "underlying deficit" although one would exist in a PbR environment. In light of this the Trust is not reporting its financial position as a significant internal control issue. This is in line with our approach in 2020/21.

Considering the guidance provided by NHS Improvement on determining significant internal control issues, I do not consider there to have been any significant internal control issues in 2021/22.

Conclusion

My overall opinion is that, taking into account the items referred to above and the various mitigations put in place, there is an adequate system of internal control in place, which is designed to manage the key organisational objectives and minimise the Trust's exposure to risk, and that there have been no significant internal control issues. The Board of directors is committed to continuous improvement and enhancement of the system of internal control.

Signed 

Maria Kane, Chief Executive Date: 27th June 2022

PART 3 - Remuneration Report

Salary and Pensions entitlements of senior managers 2021/22

Remuneration of senior managers (audited)

Name and title	2021/22						2020/21					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits, (bands of £2,500)	(f) Total (a to e) (bands of £5,000)	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) Total (a to e) (bands of £5,000)
Non-Executive Directors												
Michele Romaine - Chair	50-55	3,700	0	0	-	50-55	40 - 45	2,300	-	-	-	40 - 45
John Everitt - Non Executive Director, left November 21	5-10	0	0	0	-	5-10	10 - 15	100	-	-	-	10 - 15
Kelvin Blake - Non Executive Director	10-15	0	0	0	-	10-15	10 - 15	0	-	-	-	10 - 15
John Iredale- Non Executive Director	10-15	0	0	0	-	10-15	10 - 15	0	-	-	-	10 - 15
Tim Gregory - Non Executive Director	10-15	0	0	0	-	10-15	10 - 15	0	-	-	-	10 - 15
Kelly Macfarlane - Non Executive Director	10-15	0	0	0	-	10-15	10 - 15	0	-	-	-	10 - 15
Sarah Purdy - Non Executive Director, joined December 21	0-5	0	0	0	-	0-5						
Dr Ike Anya - Non Executive Director, joined February 22	0-5	0	0	0	-	0-5						
Richard Gaunt- Non-Executive Director	10-15	0	0	0	-	10-15	10 - 15	0	-	-	-	10 - 15
Ade Williams- Associate Non-Executive Director, left December 21	5-10	0	0	0	-	5-10	5 - 10	0	-	-	-	5 - 10
Sandra Harding - Assocuate Non-Executive, joined January 2022	0-5	0	0	0	-	0-5						
LaToyah McAllister-Jones- Associate Non-Executive Director, left March 22	5-10	0	0	0	-	5-10	0 - 5	0	-	-	-	0 - 5
Jaki Davis - Non Executive Director- left 30/09/2020							5 - 10	0	-	-	-	5 - 10

Executive Directors												
Maria Kane- Chief Executive, joined April 21	225-230	21,800	5-10	0	67.5-70	325-330						
Tim Whittlestone - Chief Medical Officer from July 21	160-165	0	0	0	117-120	275-280						
Chris Burton - Medical Director until August 21	75-80	0	0	0	0	75-80	195 - 200	-	-	-	105 - 107.5	300 - 305
Evelyn Barker - Deputy Chief Executive, retired September 21	85-90	9,000	0	0	0	95-100	180 - 185	18,000	-	-	0 - 0	195 - 200
Steve Curry- Chief Operating Officer, joined Jan 22	35-40	4,500	0-5	0	87.5-90	135-140						
John Scott - Director of Operation between August and February 22	140-145	0	0	0	0	140-145						
Helen Blanchard - Director of Nursing and Quality, left March 22	145-150	28,300	0	0	0	175-180	140 - 145		-	-	85 - 87.5	230 - 235
Steve Hams- Chief Nursing Officer, joined March 22	10-15	0	0-5	0	52.5-55	65-70						
Karen Brown - Interim Chief Operating Officer, Left September 21	65-70	0	0	0	0	65-70	55 - 60					55 - 60
Glyn Howells-Chief Finance Officer	145-150	8,000	0	0	45-47.5	200-205	10 - 15	700	-	-	35 - 37.5	45 - 50
Andrea Young - Chief Executive - end 11/12/2020							95 - 100	-	-	-	0 - 0	95 - 100
Catherine Phillips - Director of Finance-left 28/02/2021							145 - 150	0	-	-	112.5 - 115	255 - 260
Sue Jones - Director of Nursing and Quality, left 30/11/2020							75 - 80	-	-	-		75 - 80
Corporate Directors												
Neil Darvill – Chief Digital Information Officer	140-145	0	0-5	0	27.5-30	165-170	135 - 140	-	-	-	107.5 - 110.0	**245 - 250**
Simon Wood - Director of Estates, Facilities & Capital Planning retired December 21	85-90	100	0-5	0	5-7.5	90-95	120 - 125	100	-	-	75 - 77.5	**200 - 205**
Jacqueline Marshall - Chief People Officer	155-160	0	20-25*	0	0	180-185*	155 - 160	-	15 - 20	-	35 - 37.5	**205 - 210**

*This includes £4k related to performance bonuses related to 20/21 but paid in 21/22

Jacqui Marshall, Jon Scott, Karen Brown, Evelyn Barker chose not to be covered by the pension arrangements during the reporting year

Salary

The following Director's salaries are based upon the commencement dates shown below:

Maria Kane commenced as Chief Executive Officer from 1 April 2021

Tim Whittlestone commenced as Interim Chief Medical Officer from 12 July 2021, and substantive Chief Medical Officer from 1 November 2021

John Scott commenced as Chief Operating Officer from 26 August 2021

Steve Curry commenced as Chief Operating Officer from 1st January 2022

Steve Hams commenced as Chief Nursing Officer from 1 March 2022

Dr Ike Anya joined as a non-Executive Director from 1 February 2022

Sandra Harding joined as an Associate Non-Executive Director from 3 January 2022

Sarah Purdy joined as a Non-Executive Director from 1 December 2021

Expense Payments

Expense payments within the Trust largely relate to taxable mileage expenses, some telephone rental expenses and, where applicable, relocation expenses.

The Trust Chair, Michele Romaine (2021/22: £3,700), Chief Executive Officer Maria Kane (2021/22: £21,800), Deputy Chief Executive Officer Evelyn Barker (2021/22: £9,000), Chief Operating Officer Steve Curry (2021/22: £4,500), Director of Nursing and Quality Helen Blanchard (2021/22: £28,300) and Chief Financial Officer Glyn Howells (2021/22: £8,000) received in-year living allowance payments. This reflects where posts are difficult to fill requiring additional expenses associated with living away from home during the week.

In 2020/21 The Trust's Chair, Michele Romaine (2020/21: £2,268), Interim Chief Executive, Evelyn Barker (2020/21: £18,000) and Chief Finance Officer, Glyn Howells (2020/21: £700) received in-year living allowance payments.

Performance Pay and Bonuses

In 2021/22 Chief Executive Officer Maria Kane (2021/22: £7,500), Chief Operating Officer Steve Curry (2021/22: £4,375), Chief Nursing Officer Steve Hams (2021/22: £708), Chief People Officer Jacqueline Marshall (2021/22: £21,874 of which £4,374 related to 2020/21) received performance related bonus contributions, recognising the complexities of the roles and the deliverables strongly associated with the success of the Trust.

The Directors were set individual 'SMART' objectives under the following key Trust level strategic drivers:

- Financial Sustainability
- Transformation and Improvement
- Strategy

- Organisation /Operations
- System
- Personal Development and Values

Attainment and performance was reviewed by the Chief Executive Officer at Year end and reported to Remuneration Committee for Assurance

In 2020/21, the Director of People and Transformation (Jacqueline Marshall) received a performance-related bonus contribution of £17,499.

The performance related bonuses were agreed by NHS England & Improvement (NHSE/I) and the Trust's Remuneration and Nominations Committee.

All Pension Related Benefits

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It isa calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Remuneration Policy

The Trust's approach to Remuneration Policy for Directors is in line with guidance issued by NHSE/me in order that directors' pay remains both competitive and provides value for money.

The Trust has a Remuneration and Nominations Committee that agrees the remuneration packages for executive directors.

Percentage change in remuneration of highest paid director (audited)

For salary and allowances the percentage change in the highest paid director from 20/21 to 21/22 was an increase of 40.5%. The average percentage increase for all other staff was 5.3%.

In both 20/21 and 21/22 the highest paid director did not receive any performance related bonuses. The average percentage increase in performance related bonuses for all other staff was 90%, this was driven by additional board members receiving performance bonuses.

For all taxable benefits the percentage change from 20/21 to 21/22 for the highest paid director was 40.5%. The average percentage increase for all other staff was 7.1%.

The percentage change in the highest paid director is driven by an interim Director of Operations being paid at a higher rate due to the short and fixed term nature of the role.

Pay Multiples (audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The annualised banded remuneration of the highest paid director in the organisation in the financial year 2021/22 was £275k-£280k (2020/21: £195k-£200k). The relationship to the

remuneration of the organisation's workforce is disclosed in the table below:

2021/22	25th percentile	Median	75th percentile
Total remuneration (£)	25,563	37,016	46,328
Salary component of total remuneration (£)	21,777	31,534	39,467
Pay ratio information	10.9:1	7.5:1	6:1
2020/21	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	24,423	31,671	43,770
Salary component of total remuneration (£)	21,142	27,416	37,890
Pay ratio information	8.1:1	6.2:1	4.5:1

In 2021/22 two employees (2020/21 five employees) received remuneration in excess of the highest-paid director. Remuneration ranged from £18,546 to £287,715 (2019/20: £18,005 to £219,170).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. This has been audited.

It should be noted that the change in ratio has been affected by an appointment of an interim Director of Operations, the short-term nature of which resulted in a premium being paid. The impact of which is outlined in the preceding section "Percentage change in remuneration of highest paid director".

Pension Entitlements of senior managers (audited)

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2022	Lump sum at pension age related to accrued pension at 31 March 2022	Cash Equivalent Transfer Value at 1 April 2021	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
	£000	£000	£000	£000	£000	£000	£000	£000
Executive Directors								
Maria Kane - Chief Executive	2.5-5	0-2.5	55-60	100-105	1,019	65	1,244	0
Glyn Howells – Chief Finance Officer	2.5-5	0-2.5	20-25	0-5	238	32	292	0
Chris Burton - Medical Director	0	0	70-75	205-210	1,763	0	1,728	0
Tim Whittlestone – Chief Medical Officer started 1/7/21	5-7.5	5-7.5	65-70	155-160	1,204	100	1,343	0
Helen Blanchard - Director of Nursing and Quality Finished 31/5/21	0-2.5	0-2.5	50-55	160-165	1,309	2	1,346	0
Steve Hams – Chief Nursing Officer	0-2.5	0	45-50	95-100	719	2	770	0
Steve Curry – Chief Operating Officer	0-2.5	0-2.5	65-70	160-165	1,364	27	1,482	0
Corporate Directors								
Neil Darvill – Chief Digital Information Officer	0-2.5	0	55-60	135-140	1,176	42	1,244	0
Simon Wood - Director of Estates, Facilities & Capital Planning	0-2.5	0-2.5	60-65	190-195	0	0	0	0

Note: *There are no Cash Equivalent Transfer Value (CETV) figures as at 31 March 2021 for Director of Estates, Facilities & Capital Planning as they are over the normal retirement age and therefore the CETV calculation is not applicable.*

Jacqui Marshall, Jon Scott, Karen Brown, Evelyn Barker chose not to be covered by the pension arrangements during the reporting year

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2021	Lump sum at pension age related to accrued pension at 31 March 2021	Cash Equivalent Transfer Value at 1 April 2020	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2021	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
	£000	£000	£000	£000	£000	£000	£000	£000
Executive Directors								
Andrea Young - Chief Executive	0	0 - 2.5	70 - 75	230 - 235	0	0	0	0
Catherine Phillips - Director of Finance	5.0 - 7.5	7.5 - 10.0	65 - 70	145 - 150	1,076	121	1,227	0
Glyn Howells – Chief Finance Officer	0 – 2.5	0	15 - 20	0	193	2	238	0
Chris Burton - Medical Director	5.0 - 7.5	15.0 - 17.5	70 - 75	215 - 220	1,560	149	1,763	0
Helen Blanchard - Director of Nursing and Quality	2.5 - 5.0	12.5 - 15.0	50 - 55	160 - 165	1,148	120	1,309	0
Corporate Directors								
Neil Darvill – Chief Digital Information Officer	5.0 - 7.5	0	50 - 55	135 - 140	1,045	94	1,176	0
Simon Wood - Director of Estates, Facilities & Capital Planning	2.5 - 5.0	10.0 - 12.5	60 - 65	185 - 190	1,431	0	0	0
Jacqueline Marshall, Chief People Officer	2.5 - 5.0	0	5 - 10	0	41	23	86	0

Note: *There are no Cash Equivalent Transfer Value (CETV) figures as at 31 March 2021 for the Chief Executive or Director of Estates, Facilities & Capital Planning as they are over the normal retirement age and therefore theCETV calculation is not applicable.*

Past and present employees of the Trust are covered by the NHS Pension Scheme,details of this scheme are provided within the full accounts.

The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2021/22 NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in the accounts.

The tables of salary and pension entitlements of senior managers, including supporting notes, and the narrative notes relating to pay multiples have been audited.

As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The pension benefits and related CETVs above do not include any potential future adjustments for eligible employees arising from the McCloud judgement. The McCloud judgement is a legal case concerning age discrimination over the manner in which UK public services pension schemes introduced an average earnings based benefits scheme from 2015 for all but the oldest members, who retained a final salary benefit design.

Real Increase CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by theemployee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of theperiod.

Staff Report

The Staff Report is subject to audit.

Staff Numbers (audited)

The Trust staff numbers are listed below. Senior Managers are listed as per theRemuneration Report.

	2021/22			2020/21
Average Staff Numbers	**Permanent**	**Other**	**Total**	**Total**
	Number	**Number**	**Number**	**Number**
Medical and dental	1021	61	1082	1081
Administration and estates	1936	173	2110	1958
Healthcare assistants and other support staff	1470	256	1727	1654
Nursing, midwifery and health visiting staff	2372	262	2634	2582
Scientific, therapeutic and technical staff	900	6	907	886
Healthcare Science Staff	655	21	676	652
Total	**8,354**	**781**	**9,135**	**8,813**
Of Which				
Staff engaged on capital projects	77	0	77	42

Staff Composition

	2021/22			2020/21		
	Male	Female	**Total**	Male	Female	**Total**
Board members	10	9	19	11	10	21
Other staff	2,194	6,130	8,323	2,282	6,510	8,792
Total	**2,204**	**6,130**	**8,843**	**2,293**	**6,520**	**8,813**
Total %	**26%**	**74%**		**26%**	**74%**	

Staff Costs (audited)

The table below shows staff costs:

	2021/22			2021/22
Staff Costs	**Permanent**	**Other**	**Total**	**Total**
	£000s	**£000s**	**£000s**	**£000s**
Salaries and wages	358,036	3,415	361,451	345,428
Social security costs	36,298	0	36,298	33,142
Apprenticeship levy	1,759	0	1,759	1,624
Pension cost - Employer's contributions to NHS pension scheme	43,173	0	43,173	57,708
Termination benefits	68	0	68	479
Temporary staff - agency/contract staff		15,599	15,599	9,907
Total gross staff costs	**458,149**	**19,014**	**477,163**	**448,288**
Of which				
Costs capitalised as part of assets	**3,687**	**792**	**4,479**	**4,479**

Exit Packages (audited)

Reporting of compensation schemes – exit packages 2021/22 (audited)

The Exit packages agreed by the Trust are as follows:

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE ONLY	£s	WHOLE ONLY	£s	WHOLE ONLY	£s	WHOLE ONLY	£s
Less than £10,000	0	0	23	67,625	23	67,625	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	0	0	**23**	**67,625**	**23**	**67,625**	**0**	**0**

Note: *the expense associated with these departures may have been recognised in part or in full in a previous period*

Reporting of compensation schemes – exit packages 2020/21 (audited)

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	3	19,622	16	47,875	19	67,497	0	0
£10,000 - £25,000	4	68,736	1	11,604	5	80,340	0	0
£25,001 - £50,000	4	136,875	0	0	4	136,875	0	0
£50,001 - £100,000	3	194,659	0	0	3	194,659	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	14	419,892	17	59,479	31	479,371	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the relevant contractual obligations and NHS Pensions scheme. Exit costs in this note are the full costs of departures agreed in the year. Where North Bristol NHS Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages in the year.

Note: *the expense associated with these departures may have been recognised in part or in full in a previous period.*

Exit Packages: Other (non-compulsory) departure payments (audited)

	2021/22		2020/21	
	Agreements	**Total value of agreements**	**Agreements**	**Total value of agreements**
	Number	**£000s**	**Number**	**£000s**
Voluntary redundancies including early retirement contractual costs				
Mutually agreed resignations (MARS) contractual costs				
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice	23	68	17	59
Exit payments following Employment Tribunals or court orders				
Non-contractual payments requiring HMT approval				
Total	23	68	17	59
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

As a single exit package can be made up of several components each of which will be counted separately in this note, the total number above will not necessarily matchthe total numbers in the Exit Packages tables above, which will be the number of individuals.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

Sickness Absence Data and Pension Liabilities

	2021/22	2020/21
Total Days Lost	90,657	81,726
Total FTE Staff Years	8,277	8,070
Average working days lost per staff year	11	10

***Note**: Figures presented are per financial year. Pension liabilities are detailed within the accounts under Note 9. The policy note for pensions is presented under note 1.9 detailing how pension liabilities are treated in the accounts.Salary and pension entitlements of senior managers has been provided within the Remuneration Report.*

Trade Union Facility Time as at 1 April 2022

The Trade Union (Facility Time Publication Requirements) Regulations 2017 cameinto force on 1 April 2017.

Under the Regulations, North Bristol NHS Trust is required to publish the following information relating to trades union officials and facility time.

Trades Unions and numbers of representatives	
Staff who are Union representatives	34
Staff who are Union representatives (H&S only)	10
Staff who are Union representatives with regular paid facility time	9
Unions (covering the above) BDA (British Dietetic Association) BMA (British Medical Association) CSP (Chartered Society of Physiotherapists) FCS (Federation of Clinical Scientists) GMB RCM (Royal College of Midwives) RCN (Royal College of Nurses) SOR (Society of Radiographers) UNISON Unite	

Relevant Union Officials	
What was the total number of your employees who were relevant union officials during the relevant period?	
Number of employees who were relevant union officials employed during the relevant period	Number of employees (WTE) in the organisation
53	9135

Percentage of time spent on facility time for each relevant union official	
How many of your employees who were relevant union officials employed during the relevant period spent a) 0 - 50%, b) 51 – 99%, c) 100% of their time on facility time?	
Percentage of time	Number of employees
0 – 50%	50
51 – 99%	0
100%	3

Percentage of pay bill spent on facility time
*What is the percentage of pay bill spent on facility time?**
0.038%

*calculation based on central pay budget allocated for facility time

Paid Trade Union activities
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials?
100%

Staff Policies applied during the year

The Trust has a range of Human Resources policies that support staff, which are available on the Intranet.

In respect of disability, the Trust's Recruitment and Selection Policy and Guidelinessets out its commitment to ensuring that all staff, including those who are disabled, are treated fairly and equitably in relation to the appointment processes.

The Trust is now a Disability Confident employer guaranteeing an interview for disabled applicants who meet the person specification and to ensure reasonable adjustments are made.

The Trust monitors its employment and policies to ensure actions are taken to avoid unlawful discrimination whether direct or indirect.

Expenditure on consultancy

Expenditure on consultancy services was £1,388,077 (2020/21 £2,223,000) during the year.

Off Payroll Arrangements

As part of the 'Review of Tax Arrangements of Public Sector Appointees' the Trust is required to disclose the number of non-payroll arrangements which existed at 31March 2021 and what action has been taken in regard to their tax status since that date.

As per IR35 legislation, the responsibility for applying these rules rests with the employer. As a result of this all off-payroll arrangements, irrespective of value, have been assessed using the HMRC on-line tool and steps taken to ensure that tax and national insurance is deducted correctly in line with the results of the tool.

Existing off-payroll engagements as of 31 March 2022, for more than £245 per day

	2021/22 Number
Number of existing engagements as of 31 March 2022	17
Of which, the number that have existed	
for less than one year at the time of reporting	12
for between one and two years at the time of reporting	2
for between 2 and 3 years at the time of reporting	2
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	1

For any off-payroll engagements of board members, and / or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022

	2021/22 Number
Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	22
Of which	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	22
Number subject to off-payroll legislation and determined as out of scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which, number of engagements that saw a change to IR35 status following review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022:

	2021/22 Number
Number of off-payroll engagements of Board members, and / or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "Board members, and/or, senior officials with significant financial responsibility", during the financial year.	25

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the trust
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust' s auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information. To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed. .....Chief Executive

Date.....27th June 2022

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

27th June 2022 .....Date. .....Chief Executive

27th June 2022 .....Date. .....Finance Director

North Bristol NHS Trust

Annual accounts for the year ended 31 March 2022

Contents

Statement of the chief executive's responsibilities as the accountable officer of the trust

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- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Chief Executive

Date..27th June 2022....

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- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

27th June 2022 .....Date ..... Chief Executive

27th June 2022 .....Date.....Finance Director

Independent auditor's report to the Directors of North Bristol NHS Trust

Report on the Audit of the Financial Statements

Qualified Opinion on financial statements

We have audited the financial statements of North Bristol NHS Trust (the 'Trust') and its subsidiary (the 'group') for the year ended 31 March 2022, which comprise the Consolidated Statement of Comprehensive Income, the Statements of Financial Position, the Consolidated Statement of Changes in Equity, Statement of Changes in Equity the Statements of Cash Flows and notes to the accounts, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022.

In our opinion, except for the possible effects on the corresponding figures of the matter described in the Basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2022 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for qualified opinion

Due to the national lockdown arising from the Covid-19 pandemic in March 2020, the Trust did not count all its physical inventories at 31 March 2020 and we were unable to satisfy ourselves by alternative means concerning the inventory quantities held at that date, which had a carrying amount in the Statement of Financial Position of £13.070 million. Consequently, we were unable to determine whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021. Our audit opinion on the financial statements for the year ended 31 March 2021 was modified accordingly. Our opinion on the current year's financial statements is also modified because of the possible effect of this matter on the comparability of the current year's drug costs figures and the corresponding prior year figures.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group accounting manual 2021 to 2022 that the group and Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and Trust and the group and Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Directors with respect to going concern are described in the 'Responsibilities of the Directors and Those Charged with Governance for the financial statements' section of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

As described in the basis for qualified opinion section of our report, we were unable to satisfy ourselves concerning the inventory quantities of £13.070 million held as at 31 March 2020, and whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021. Accordingly, we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS England, or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 31 May 2022 we referred a matter to the Secretary of State under section 30 (b) of the Local Audit and Accountability Act 2014 in relation to North Bristol NHS Trust's ongoing breach of its culumulative break-even duty for the five year period ending 31 March 2022.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained in the Statement of directors' responsibilities in respect of the accounts set out on page 83, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the services to another public sector entity.

The Audit and Risk Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the group and Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group accounting manual 2021 to 2022).
- We enquired of management and the Audit and Risk Committee, concerning the group and Trust's policies and procedures relating to:
    - the identification, evaluation and compliance with laws and regulations;
    - the detection and response to the risks of fraud; and
    - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the group and Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and revenue and expenditure recognition. We determined that the principal risks were in relation to the following transactions of the Trust:
    - journal entries posted by senior officers, journals not authorised, large value manual journals towards and after year end and journals posted by super users; and
    - the significant accounting estimates in the financial statements, including those related to the valuation of property, plant and equipment and the year-end accruals.

Our audit procedures involved:

- evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
- journal entry testing, with a focus on large and unusual journals;

- challenging assumptions and judgements made by management in its significant accounting estimates in respect of property, plant and equipment valuations and significant accruals;
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, included the ongoing breach of the Trust's breakeven duty, potential for fraud in revenue and expenditure recognition, and the significant accounting estimates related to property, plant and equipment valuations and accruals.
- Our assessment of the appropriateness of the collective competence and capabilities of the group and Trust's engagement team included consideration of the engagement team's;
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the group and Trust operates
  - understanding of the legal and regulatory requirements specific to the group and Trust including:
  - the provisions of the applicable legislation
  - NHS England's rules and related guidance
  - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The group and Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation processes, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The group and Trust's control environment, including the policies and procedures implemented by the group and Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust set out on page 82, the Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in December 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of North Bristol NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors as a body, for our audit work, for this report, or for the opinions we have formed.

Peter Barber

Peter Barber, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

28 June 2022

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2021/22	2020/21	2021/22	2020/21
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	701,860	623,186	701,860	623,186
Other operating income	4	90,201	151,723	89,536	150,098
Operating expenses	6, 8	(754,252)	(734,310)	(751,692)	(732,576)
Operating surplus/(deficit) from continuing operations		**37,809**	**40,599**	**39,704**	**40,708**
Finance income	11	287	208	59	5
Finance expenses	12	(35,117)	(35,068)	(35,117)	(35,068)
PDC dividends payable		(4,289)	(3,171)	(4,289)	(3,171)
Net finance costs		**(39,119)**	**(38,031)**	**(39,347)**	**(38,234)**
Other gains / (losses)	13	1,011	1,905	607	531
Gains / (losses) arising from transfers by absorption		101	-	101	-
Surplus / (deficit) for the year		**(198)**	**4,473**	**1,065**	**3,005**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Revaluations	17	27,753	14,096	27,753	14,096
Total comprehensive income for the period		**27,555**	**18,569**	**28,818**	**17,101**

Statements of Financial Position

	Note	Group 31 March 2022 £000	Group 31 March 2021 £000	Trust 31 March 2022 £000	Trust 31 March 2021 £000
Non-current assets					
Intangible assets	14	13,736	14,749	13,736	14,749
Property, plant and equipment	15	604,994	579,293	604,994	579,293
Other investments / financial assets	18	10,347	10,198		
Receivables	21	1,488	1,728	1,488	1,728
Total non-current assets		**630,565**	**605,968**	**620,218**	**595,770**
Current assets					
Inventories	20	9,145	8,538	9,145	8,538
Receivables	21	39,419	36,504	39,509	36,460
Cash and cash equivalents	22	117,224	123,467	116,153	121,458
Total current assets		**165,788**	**168,509**	**164,807**	**166,456**
Current liabilities					
Trade and other payables	23	(110,281)	(117,630)	(109,795)	(117,484)
Borrowings	25	(17,331)	(15,079)	(17,331)	(15,079)
Provisions	27.1	(3,418)	(8,157)	(3,418)	(8,157)
Other liabilities	24	(16,419)	(8,467)	(16,419)	(8,467)
Total current liabilities		**(147,449)**	**(149,333)**	**(146,963)**	**(149,187)**
Total assets less current liabilities		**648,904**	**625,144**	**638,062**	**613,039**
Non-current liabilities					
Borrowings	25	(361,308)	(372,573)	(361,308)	(372,573)
Provisions	27.1	(1,872)	(2,222)	(1,872)	(2,222)
Other liabilities	24	(5,208)	(5,611)	(5,208)	(5,611)
Total non-current liabilities		**(368,388)**	**(380,406)**	**(368,388)**	**(380,406)**
Total assets employed		**280,516**	**244,738**	**269,674**	**232,633**
Financed by					
Public dividend capital		456,945	**448,722**	456,945	448,722
Revaluation reserve		184,070	162,022	184,070	162,022
Income and expenditure reserve		(371,341)	(378,111)	(371,341)	(378,111)
Charitable fund reserves	19	10,842	12,105		
Total taxpayers' equity		**280,516**	**244,738**	**269,674**	**232,633**

The notes on pages 8 to 50 form part of these accounts.

Name 

Position **Chief Executive**

Date **27th June 2022**

Consolidated Statement of Changes in Equity for the year ended 31 March 2022

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**448,722**	**162,022**	**(378,111)**	**12,105**	**244,738**
Surplus/(deficit) for the year	-	-	(5)	(193)	**(198)**
Other transfers between reserves	-	(2,302)	2,302	-	**-**
Revaluations	-	27,753	-	-	**27,753**
Transfer to retained earnings on disposal of assets	-	(3,403)	3,403	-	**-**
Public dividend capital received	8,223	-	-	-	**8,223**
Other reserve movements	-	-	1,070	(1,070)	**-**
Taxpayers' and others' equity at 31 March 2022	**456,945**	**184,070**	**(371,341)**	**10,842**	**280,516**

Consolidated Statement of Changes in Equity for the year ended 31 March 2021

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**248,513**	**149,139**	**(382,329)**	**10,637**	**25,960**
Surplus/(deficit) for the year	-	-	1,947	2,526	**4,473**
Other transfers between reserves	-	(1,213)	1,213	-	**-**
Revaluations	-	14,096	-	-	**14,096**
Public dividend capital received	200,209	-	-	-	**200,209**
Other reserve movements	-	-	1,058	(1,058)	**-**
Taxpayers' and others' equity at 31 March 2021	**448,722**	**162,022**	**(378,111)**	**12,105**	**244,738**

Statement of Changes in Equity for the year ended 31 March 2022

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**448,722**	**162,022**	**(378,111)**	**232,633**
Surplus/(deficit) for the year	-	-	1,065	**1,065**
Other transfers between reserves	-	(2,302)	2,302	**-**
Revaluations	-	27,753	-	**27,753**
Transfer to retained earnings on disposal of assets	-	(3,403)	3,403	**-**
Public dividend capital received	8,223	-	-	**8,223**
Taxpayers' and others' equity at 31 March 2022	**456,945**	**184,070**	**(371,341)**	**269,674**

Statement of Changes in Equity for the year ended 31 March 2021

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**248,513**	**149,139**	**(382,329)**	**15,323**
Surplus/(deficit) for the year	-	-	3,005	**3,005**
Transfers between reserves	-	(1,213)	1,213	**-**
Revaluations	-	14,096	-	**14,096**
Public dividend capital received	200,209	-	-	**200,209**
Taxpayers' and others' equity at 31 March 2021	**448,722**	**162,022**	**(378,111)**	**232,633**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable funds reserve
This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 19.

Statements of Cash Flows

		Group		Trust	
		2021/22	2020/21	2021/22	2020/21
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus		37,809	40,599	39,704	40,708
Non-cash income and expense:					
Depreciation and amortisation	6.1	30,523	29,437	30,523	29,437
Net impairments	7	2,753	3,100	2,753	3,100
Income recognised in respect of capital donations	4	(43)	(1,565)	(373)	(2,050)
Amortisation of PFI deferred credit		(77)	(77)	(77)	(77)
(Increase) / decrease in receivables and other assets		(6,453)	34,532	(6,622)	34,469
(Increase) / decrease in inventories		(589)	4,532	(589)	4,532
Increase in payables and other liabilities		200	56,980	200	56,980
Increase / (decrease) in provisions		(5,105)	5,301	(5,105)	5,301
Movements in charitable fund working capital		293	48	-	-
Other movements in operating cash flows		12	-	-	-
Net cash flows from / (used in) operating activities		**59,323**	**172,887**	**60,414**	**172,400**
Cash flows from investing activities					
Interest received		59	5	59	5
Purchase of intangible assets		(4,400)	(8,504)	(4,400)	(8,504)
Purchase of PPE and investment property		(29,546)	(26,331)	(29,546)	(26,331)
Sales of PPE and investment property		7,375	4,130	7,375	4,130
Receipt of cash donations to purchase assets		43	15	373	500
Net cash flows from charitable fund investing activities		255	(732)	-	-
Net cash flows from / (used in) investing activities		**(26,214)**	**(31,417)**	**(26,139)**	**(30,200)**
Cash flows from financing activities					
Public dividend capital received		8,223	200,209	8,223	200,209
Movement on loans from DHSC		-	(178,461)		(178,461)
Capital element of finance lease rental payments		(2,623)	(2,720)	(2,623)	(2,720)
Capital element of PFI		(8,301)	(9,059)	(8,301)	(9,059)
Interest on loans		-	(568)	-	(568)
Interest paid on finance lease liabilities		(208)	(261)	(208)	(261)
Interest paid on PFI		(31,977)	(37,603)	(31,977)	(37,603)
PDC dividend (paid)		(4,694)	(3,025)	(4,694)	(3,025)
Net cash flows from charitable fund financing activities		228	203	-	-
Net cash flows from / (used in) financing activities		**(39,352)**	**(31,285)**	**(39,580)**	**(31,488)**
Increase / (decrease) in cash and cash equivalents		**(6,243)**	**110,185**	**(5,305)**	**110,712**
Cash and cash equivalents at 1 April - brought forward		**123,467**	**13,282**	**121,458**	**10,746**
Cash and cash equivalents at 31 March	22.1	**117,224**	**123,467**	**116,153**	**121,458**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

An assessment of the Trust's Private Finance Initiative (PFI) scheme has been made and it has been determined that the PFI scheme in respect of the main hospital building should be accounted for as an on Statement of Financial Position asset under IFRIC 12. This is on the grounds that the Trust controls, or regulates through contract and key performance indicators, what services the PFI operator must provide with the property, to whom it must provide them and at what price. The Trust will control the residual interest in the building at the end of the contract term. The impact on the accounts is that the PFI buildings are included in the accounts as property, plant and equipment, and a financial liability is recognised relating to the remaining term of the PFI contract. This is referred to in note 1.11 of the accounting policy. The PFI assets are valued at £390,338k as at 31st March 2022, as per note 15.3.

The PFI assets have been valued net of VAT, as the VAT is recoverable. In the event of an instant rebuild requirement, the default position of the contract is that the PFI operator would reinstate the building, which would remain VAT recoverable. The PFI contract is in place until 30 September 2045 and therefore it is considered reasonable to assume VAT recovery for the foreseeable future. The impact of VAT if the decision had been made to value the assets gross of VAT would be an increase in the valuation of the asset by £78m. This is referred to in note 1.11 of the accounting policy.
The value of the PFI liability was £374,543k (2020/21 £380,936k), further details can be found in note 32

Modern equivalent asset valuation of property - as detailed in note 1.11 items of property are periodically revalued to ensure that their book values are not materially different from their fair values. During the year the District Valuation Service provided the Trust with a valuation of its land and building assets and an assessment of their remaining useful economic lives. Specialised assets are valued on a depreciated replacement cost basis using hypothetical modern equivalent assets (MEA). An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.
Future revaluations may result in further material changes to the carrying values of non-current assets. Many factors drive property values including BCIS (all price) Tender Price Index (TPI) and the BCIS Location Factor, as detailed in note 17. Based on sensitivity analysis for these factors, the value could vary to a range of £23m.

Note 1.4 Key Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:
The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Modern equivalent asset valuation of property - as detailed in note 1.11 items of property are periodically revalued to ensure that their book values are not materially different from their fair values. During the year the District Valuation Service provided the Trust with a valuation of its land and building assets and an assessment of their remaining useful economic lives. Specialised assets are valued on a depreciated replacement cost basis using hypothetical modern equivalent assets (MEA). An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.
Future revaluations may result in further material changes to the carrying values of non-current assets. Many factors drive property values including BCIS (all price) Tender Price Index (TPI) and the BCIS Location Factor, as detailed in note 17. The carrying value of assets valued using MEA as at 31st March 2022 was £387m (of which £28m Land and £359m Buildings excluding dwellings). Based on sensitivity analysis for these factors, the value could vary to a range of £23m.

Note 1.5 Consolidation
NHS Charitable Funds
The Trust is the corporate Trustee to North Bristol NHS Trust Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

• recognise and measure them in accordance with the Trust's accounting policies and

• eliminate intra-group transactions, balances, gains and losses.

The accounting policies of the Charity are consistent with the Trust, with no variations against material balances.
The Charity's registered office is Southmead Hospital, Southmead Road, Bristol, which is also the Charity's principal place of business.

Note 1.6 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Payment terms are standard reflecting cross government principles. Significant terms include payment within 30 days.

Revenue from NHS contracts
The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied.

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred, such as variable income from high cost drugs and other block contract adjustments. In 2020/21 and 2021/22, reimbursement and top-up income has been received as well to offset costs of specific projects such as Nightingale Hospital or Mass Vaccination Programme.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Revenue from education and training
A large proportion of education and training income is received from Health Education England to fund various undergraduate and postgraduate course, as well as continuous professional development and training and education opportunities. Where education contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For multi-year contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. If obligation are not met, the income would be deferred.

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For multi-year contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Legacy income

Legacy income in the Charity is accounted for once the receipt of the legacy becomes reasonably certain and it can be quantified. This will be once confirmation has been received from the representatives of the estate that payment of the legacy will be made or property transferred and once any conditions attached to the legacy have been fulfilled.

Note 1.7 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.8 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period and our records support.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Further details on the pension scheme are at Note 9.

National Employment Savings Trust

Where staff are not eligible for or opt out of the NHS Pension Scheme, they are entitled to join the National Employment Savings Trust (NEST), as part of the auto enrolment into workplace pension schemes. Employer's pension cost contributions are charged to operating expenses as and when they become due.

Note 1.9 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust s business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	5	7
Software licences	5	10
Licences & trademarks	5	7

Note 1.11 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
• where the collective value of items is significant, the group may be capitalised even where the individual value of some component items falls below £250.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

Valuations of PFI assets include VAT at 0% on the basis that all VAT has been recoverable.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.
Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.
This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI)

PFI and transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Where lifecycle replacement works have been capital in nature, they are included as additions to Property, Plant and Equipment.

Useful lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Buildings, excluding dwellings	2	96
Dwellings	10	47
Plant & machinery	5	15
Transport equipment	5	7
Information technology	2	15
Furniture & fittings	5	31

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. Please see Note 20 for inventories held.

The Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department and provided to the Trust.

Note 1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Note 1.14 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost or fair value through profit or loss.

Trade receivables that do not contain a significant financing component and are measured at the transaction price in accordance with IFRS 15 do not require to be initially measured at fair value.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets measured at fair value through income and expenditure are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

North Bristol Trust NHS Charitable Fund holds financial instruments measured at fair value through profit or loss.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are calculated and provided for based on different classes of financial asset. A detailed table of provision for debt losses is given in Note 21.4.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

The Trust has not provided for any debts against DHSC organisations, in line with GAM 4.271-274. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2022:

		Nominal rate
Short-term	Up to 5 years	0.47%
Medium-term	After 5 years up to 10 years	0.70%
Long-term	After 10 years up to 40 years	0.95%
	Exceeding 40 years	0.66%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2022:

	Inflation rate
Year 1	4.00%
Year 2	2.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 27.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.17 Contingent Assets and Contingent Liabilities

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care notably the Trust's average cash balance.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-Trusts-and-foundation-Trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 Corporation tax

As an NHS Trust, NBT has determined that it is has no corporation tax liability.

Note 1.20 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Transfers of functions from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain corresponding to the net assets transferred is recognised within income, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust s incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	18,570
Additional lease obligations recognised for existing operating leases	(18,570)
Changes to other statement of financial position line items	-
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(5,965)
Additional finance costs on lease liabilities	(196)
Lease rentals no longer charged to operating expenditure	6,167
Other impact on income / expenditure	-
Estimated impact on surplus / (deficit) in 2022/23	**6**
Estimated increase in capital additions for new leases commencing in 2022/23	**11,231**

Key judgements used in the IFRS 16 above impact assessment are:

-The Trust s schedule of existing leases (per note 10.1) has been used as the start point for the IFRS 16 calculations;
-A discount rate of 0.95% has been applied in order to take into account the time value of money;
- Assumption that renewal of the Trust s existing leases will occur on comparable terms, on the basis of the Trust s requirements for provision of continuing services;
-Forecast IFRS 16 addition in 2022/23 of £8,962k in relation to a Pathology managed service contract.

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust s PFI liabilities where future payments are linked to RPI. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Other standards, amendments and interpretations in issue but not yet in use

IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 2 Operating Segments

The Trust is managed by the Board of Directors, which is made up of executive and non-executive Directors. The non-executive Directors bring expertise to the Trust and provide advice and challenge to the executive Directors. The executive Directors have responsibility for the day to day running of the Trust. The Board is therefore considered to be the chief operating decision maker of the Trust.

The Board receives regular reports on the financial performance and financial position of the Trust. These include a Statement of Comprehensive Income and a Statement of Financial Position, which are provided on a 'whole Trust' basis. It is therefore considered that the Trust has just one reportable segment, a healthcare segment. There are no other segments that constitute 10% or more of the Trust's operations. The Trust receives income from a number of healthcare commissioners, which are under the common control of the Department of Health and Social Care. The bodies involved and the respective income levels are disclosed in note 36 to these accounts and the Trust's total income from patient care and other operating activities is disclosed in notes 3 and 4.

The Group also includes a subsidiary charity which undertakes a number of charitable activities which are healthcare related. The results and net assets of the Trust are separately reported throughout these accounts. For the Charity the transactions and balances included in the Group's results and Statement of Financial Position are summarised as follows:

	2021/22 £000s	2020/21 £000s
Income	665	1,625
Expenditure	2,560	1,734
Net assets	10,842	12,105

Note 3 Operating income from patient care activities (Trust and Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.6.

Note 3.1 Income from patient care activities (by nature)	2021/22 £000	2020/21 £000
Acute services		
Block contract / system envelope income*	627,354	566,740
High cost drugs income from commissioners (excluding pass-through costs)	14,563	6,245
Other NHS clinical income**	25,265	22,616
All services		
Private and overseas patient income	2,673	3,068
Elective recovery fund ***	8,881	-
Additional pension contribution central funding****	18,815	17,508
Other clinical income	4,309	7,009
Total income from activities	**701,860**	**623,186**

* As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the 2020/21, a revised financial framework was built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. One of the major changes was reduction of funding going through top-ups and reimbursements (as per Note 4) and increase in block contract. In 2021/22, the funding regime was set on similar principles as second half of 2020/21 continuing a trend of moving from top-up to block contracts.

** 2021/22 Other NHS Clinical Income (£25.265m) consists of two income streams – (1) Injury cost recovery scheme £2,126k and (2) Variable block income of £23,139k which represents all of the variable income adjustments (non-core block) transacted by BNSSG CCG and NHSE during 2021-22.

*** Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets in 2021/22 only. It is disclosed separate as per NHSE&I guidelines.

**** Fund The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	Trust and Group	
	2021/22	2020/21
Income from patient care activities received from:	**£000**	**£000**
NHS England	251,630	239,708
Clinical commissioning groups	441,122	373,490
Non-NHS: private patients	1,275	1,533
Non-NHS: overseas patients (chargeable to patient)	1,398	1,535
Injury cost recovery scheme	2,126	2,994
Non NHS: other	4,309	3,926
Total income from activities	**701,860**	**623,186**

All of the above related to continuing operations.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	Trust and Group	
	2021/22	2020/21
	£000	**£000**
Income recognised this year	1,398	1,535
Cash payments received in-year	211	407
Amounts added to provision for impairment of receivables	1,382	1,342
Amounts written off in-year	227	919

Note 4 Other operating income (Group)

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	**£000**	**£000**	**£000**
Research and development	10,360	8,575	10,360	8,575
Education and training	20,748	20,737	20,748	20,737
Non-patient care services to other bodies	9,483	7,654	9,483	7,654
Reimbursement and top up funding *	17,984	76,950	17,984	76,950
Income in respect of employee benefits accounted on a gross basis	6,738	5,693	6,738	5,693
Education and training - notional income from apprenticeship fund	1,266	1,047	1,266	1,047
Receipt of capital grants and donations**	43	1,565	373	2,050
Charitable and other contributions to expenditure***	1,646	11,168	2,386	11,741
Rental revenue from operating leases	2,141	3,119	2,141	3,119
Amortisation of PFI deferred income / credits	77	77	77	77
Charitable fund incoming resources	1,735	2,683	-	-
Car Parking income	1,355	734	1,355	734
Catering	1,374	1,084	1,374	1,084
Pharmacy sales	15	15	15	15
Staff accommodation rental	166	84	166	84
Other income	15,070	10,538	15,070	10,538
Total other operating income	**90,201**	**151,723**	**89,536**	**150,098**

All of the above related to continuing operations.

* As part of the coronavirus pandemic response, transaction flows were simplified in the NHS leading to introducing of reimbursements and top- up mechanisms in 20/21. Initially, there were setup as a broader mechanisms to support overall NHS Trust's financial performance and to fund non-recurrent initiatives, such as Nightingale Hospitals or Mass Vaccination Programme. In 21/22, the reimbursement mechanism was only used for specific projects, such Mass Vaccination Programme and Nightingale Surge Wards, while other financial support was recognised through block contracts (as per note 3.1).

** includes donated equipment from group bodies for COVID response

*** includes donated inventories and equipment below capitalisation threshold for COVID response

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	Trust and Group	
	2021/22	2020/21
	£000	**£000**
contract liabilities at the previous period end	293	291

Note 6.1 Operating expenses

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	509	-	509	-
Purchase of healthcare from non-NHS and non-DHSC bodies	4,995	830	4,995	830
Staff and executive directors costs	472,684	445,575	472,684	445,575
Remuneration of non-executive directors	159	138	159	138
Supplies and services - clinical (excluding drugs costs) *	81,057	74,609	81,057	74,609
Supplies and services - general **	10,722	24,199	10,722	24,199
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	56,351	48,981	56,351	48,981
Consultancy costs	1,388	2,223	1,388	2,223
Establishment	6,278	4,760	6,278	4,760
Premises	36,319	48,067	36,319	48,067
Transport (including patient travel)	1,536	2,066	1,536	2,066
Depreciation on property, plant and equipment	26,479	23,618	26,479	23,618
Amortisation on intangible assets	4,044	5,819	4,044	5,819
Net impairments	2,753	3,100	2,753	3,100
Movement in credit loss allowance: contract receivables / contract assets	2,484	2,164	2,484	2,164
Increase/(decrease) in other provisions	(386)	5,246	(386)	5,246
Change in provisions discount rate	(5)	(9)	(5)	(9)
Fees payable to the external auditor				
audit services- statutory audit ***	153	80	134	80
Internal audit costs	131	138	131	138
Clinical negligence	18,198	17,655	18,198	17,655
Legal fees	581	638	581	638
Insurance	164	505	164	505
Research and development	3,172	3,245	3,172	3,245
Education and training	4,148	2,786	4,148	2,786
Rentals under operating leases	7,180	8,093	7,180	8,093
Charges to operating expenditure for on-SoFP IFRIC 12 PFI schemes	6,379	6,332	6,379	6,332
Charges to operating expenditure for off-SoFP PFI schemes	165	165	165	165
Hospitality	-	10	-	10
Other NHS charitable fund resources expended	2,541	1,734	-	-
Other	4,073	1,543	4,073	1,543
Total	**754,252**	**734,310**	**751,692**	**732,576**

All of the above related to continuing operations.

* includes utilisation of donated consumables (personal protective equipment)

** includes the cost of donated equipment for COVID response below the capitalisation threshold (applies to 2020/21 only)

*** Audit fees for both Trust and Group are at gross of VAT value.

Note 6.2 Other auditor remuneration

There was no other auditor remuneration paid to the external auditor for 2020/21 or 2021/22.

Note 6.3 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £2 million (2020/21: £2 million).

Note 7 Impairment of assets

	Trust and Group	
	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	813	1,851
Over specification of assets	448	943
Abandonment of assets in course of construction	289	275
Other	1,203	31
Total net impairments	**2,753**	**3,100**

Note 8 Employee benefits

	Trust and Group	
	2021/22	2020/21
	Total	Total
	£000	£000
Salaries and wages	361,451	345,428
Social security costs	36,298	33,142
Apprenticeship levy	1,759	1,624
Employer's contributions to NHS pensions	61,988	57,708
Termination benefits	68	479
Temporary staff (including agency)	15,599	9,907
Total staff costs	**477,163**	**448,288**
Of which		
Costs capitalised as part of assets	4,479	2,713

Note 8.1 Retirements due to ill-health (Group)

During 2021/22 there were 3 early retirements from the Trust agreed on the grounds of ill-health (7 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £270k (£233k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that 'the period between formal valuations shall be four years, with approximate assessments in intervening years'. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Note 10 Operating leases

Note 10.1 North Bristol NHS Trust as a lessor

This note discloses income generated in operating lease agreements where North Bristol NHS Trust is the lessor.

	Trust and Group	
	2021/22	2020/21
	£000	£000
Operating lease revenue		
Minimum lease receipts	2,141	3,119
Total	**2,141**	**3,119**

	Trust and Group	
	31 March 2022	31 March 2021
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	1,803	2,191
- later than one year and not later than five years;	6,309	7,542
- later than five years.	20,454	21,348
Total	**28,566**	**31,081**

The Trust has acted as lessor to a number of different NHS and non-NHS organisations in respect of land, buildings and other assets associated with the provision of healthcare in the Bristol area.

Note 10.2 North Bristol NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where North Bristol NHS Trust is the lessee.

	Trust and Group	
	2021/22	2020/21
	£000	£000
Operating lease expense		
Minimum lease payments	7,180	8,093
Total	**7,180**	**8,093**

	Trust and Group	
	2022	2021
	£000	£000
Future minimum lease payments due on Land leases:		
- not later than one year;	5	5
- later than one year and not later than five years;	22	22
- later than five years.	525	531
Total	**552**	**558**

	Trust and Group	
	2022	2021
	£000	£000
Future minimum lease payments due on Buildings leases:		
- not later than one year;	1,310	1,330
- later than one year and not later than five years;	2,693	4,725
- later than five years.	3,626	6,409
Total	**7,629**	**12,464**

	Trust and Group	
	2022	2021
	£000	£000
Future minimum lease payments due on Other leases:		
- not later than one year;	4,856	2,660
- later than one year and not later than five years;	8,166	1,030
- later than five years.	-	2
Total	**13,022**	**3,692**

	Trust and Group	
	2022	2021
	£000	£000
Future minimum lease payments due on Total leases:		
- not later than one year;	6,171	3,995
- later than one year and not later than five years;	10,881	5,777
- later than five years.	4,151	6,942
Total	**21,203**	**16,714**

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Interest on bank accounts	59	5	59	5
NHS charitable fund investment income	228	203	-	-
Total finance income	**287**	**208**	**59**	**5**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	Trust and Group	
	2021/22	2020/21
	£000	£000
Interest expense:		
Finance leases	208	261
Main finance costs on PFI schemes obligations	23,473	24,013
Contingent finance costs on PFI scheme obligations	11,420	10,788
Total interest expense	**35,101**	**35,062**
Unwinding of discount on provisions	16	6
Total finance costs	**35,117**	**35,068**

Note 13 Other gains / (losses)

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Gains on disposal of assets	632	531	632	531
(Losses) on disposal of assets	(25)	-	(25)	-
Total gains / (losses) on disposal of assets	**607**	**531**	**607**	**531**
Fair value gains on charitable fund investments & investment properties	404	1,374	-	-
Total other gains	**1,011**	**1,905**	**607**	**531**

Note 14.1 Intangible assets - 2021/22

Trust and Group	Software licences	Licences & trademarks	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**26,534**	**114**	**2,625**	**6,451**	**35,724**
Additions	-	114	44	4,242	**4,400**
Impairments	(27)	-	-	(1,563)	**(1,590)**
Reclassifications	-	-	294	(88)	**206**
Valuation / gross cost at 31 March 2022	**26,507**	**228**	**2,963**	**9,042**	**38,740**
Amortisation at 1 April 2021 - brought forward	**20,468**	**44**	**463**	**-**	**20,975**
Provided during the year	3,410	21	613	-	**4,044**
Impairments	1	-	-	-	**1**
Reversals of impairments	(16)	-	-	-	**(16)**
Amortisation at 31 March 2022	**23,863**	**65**	**1,076**	**-**	**25,004**
Net book value at 31 March 2022	**2,644**	**163**	**1,887**	**9,042**	**13,736**
Net book value at 1 April 2021	**6,066**	**70**	**2,162**	**6,451**	**14,749**

Note 14.2 Intangible assets - 2020/21

Trust and Group	Software licences	Licences & trademarks	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - brought forward	**24,819**	**90**	**301**	**1,669**	**26,879**
Additions	1,462	-	580	6,462	**8,504**
Revaluations	253	-	-	-	**253**
Reclassifications	-	24	1,744	(1,680)	**88**
Valuation / gross cost at 31 March 2021	**26,534**	**114**	**2,625**	**6,451**	**35,724**
Amortisation at 1 April 2020 - brought forward	**14,781**	**23**	**99**	**-**	**14,903**
Provided during the year	5,434	21	364	-	**5,819**
Revaluations	253	-	-	-	**253**
Amortisation at 31 March 2021	**20,468**	**44**	**463**	**-**	**20,975**
Net book value at 31 March 2021	**6,066**	**70**	**2,162**	**6,451**	**14,749**
Net book value at 1 April 2020	**10,038**	**67**	**202**	**1,669**	**11,976**

Note 15.1 Property, plant and equipment - 2021/22

Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**33,727**	**481,163**	**165**	**7,417**	**83,274**	**507**	**25,804**	**7,699**	**639,756**
Transfers by absorption	-	-	-	-	369	-	-	-	**369**
Additions	-	8,879	-	12,235	7,313	-	665	36	**29,128**
Impairments	-	(3,097)	-	(429)	(2,071)	-	(818)	-	**(6,415)**
Reversals of impairments	-	3,335	-	-	-	-	-	-	**3,335**
Revaluations	2,065	13,635	-	-	-	-	-	-	**15,700**
Reclassifications	-	6,567	-	(7,216)	443	-	-	-	**(206)**
Disposals / derecognition	(3,400)	-	-	-	(2,838)	-	-	(12)	**(6,250)**
Valuation/gross cost at 31 March 2022	**32,392**	**510,482**	**165**	**12,007**	**86,490**	**507**	**25,651**	**7,723**	**675,417**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**-**	**-**	**-**	**45,990**	**308**	**9,241**	**4,924**	**60,463**
Transfers by absorption	-	-	-	-	286	-	-	-	**286**
Provided during the year	-	12,045	8	-	7,475	43	5,409	1,499	**26,479**
Reversals of impairments	-	-	-	-	(1,532)	-	(370)	-	**(1,902)**
Revaluations	-	(12,045)	(8)	-	-	-	-	-	**(12,053)**
Disposals / derecognition	-	-	-	-	(2,838)	-	-	(12)	**(2,850)**
Accumulated depreciation at 31 March 2022	**-**	**-**	**-**	**-**	**49,381**	**351**	**14,280**	**6,411**	**70,423**
Net book value at 31 March 2022	**32,392**	**510,482**	**165**	**12,007**	**37,109**	**156**	**11,371**	**1,312**	**604,994**
Net book value at 1 April 2021	**33,727**	**481,163**	**165**	**7,417**	**37,284**	**199**	**16,563**	**2,775**	**579,293**

Note 15.2 Property, plant and equipment - 2020/21

Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020	**33,627**	**475,599**	**165**	**1,529**	**74,939**	**634**	**30,286**	**7,680**	**624,459**
Additions	-	6,138	-	6,536	13,178	23	5,877	230	**31,982**
Impairments	-	(5,568)	-	(275)	-	-	-	-	**(5,843)**
Reversals of impairments	-	2,743	-	-	-	-	-	-	**2,743**
Revaluations	100	2,028	-	-	-	-	-	-	**2,128**
Reclassifications	-	223	-	(373)	(6)	-	192	(124)	**(88)**
Disposals / derecognition	-	-	-	-	(4,837)	(150)	(10,551)	(87)	**(15,625)**
Valuation/gross cost at 31 March 2021	**33,727**	**481,163**	**165**	**7,417**	**83,274**	**507**	**25,804**	**7,699**	**639,756**
Accumulated depreciation at 1 April 2020	**-**	**-**	**-**	**-**	**44,075**	**400**	**15,590**	**4,373**	**64,438**
Provided during the year	-	11,943	8	-	6,752	58	4,202	655	**23,618**
Revaluations	-	(11,960)	(8)	-	-	-	-	-	**(11,968)**
Reclassifications	-	17	-	-	-	-	-	(17)	**-**
Disposals / derecognition	-	-	-	-	(4,837)	(150)	(10,551)	(87)	**(15,625)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**45,990**	**308**	**9,241**	**4,924**	**60,463**
Net book value at 31 March 2021	**33,727**	**481,163**	**165**	**7,417**	**37,284**	**199**	**16,563**	**2,775**	**579,293**
Net book value at 1 April 2020	**33,627**	**475,599**	**165**	**1,529**	**30,864**	**234**	**14,696**	**3,307**	**560,021**

Note 15.3 Property, plant and equipment financing - 2021/22

Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022									
Owned - purchased	32,392	116,713	165	11,695	33,978	101	7,866	1,307	**204,217**
Finance leased	-	-	-	-	-	-	3,479	-	**3,479**
On-SoFP PFI contracts	-	390,338	-	-	-	-	-	-	**390,338**
Owned - donated/granted	-	3,431	-	312	3,131	55	26	5	**6,960**
NBV total at 31 March 2022	**32,392**	**510,482**	**165**	**12,007**	**37,109**	**156**	**11,371**	**1,312**	**604,994**

Note 15.4 Property, plant and equipment financing - 2020/21

Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	33,727	105,387	165	7,386	33,772	127	11,695	2,762	**195,021**
Finance leased	-	-	-	-	-	-	4,832	-	**4,832**
On-SoFP PFI contracts	-	375,776	-	-	-	-	-	-	**375,776**
Owned - donated/granted	-	-	-	31	3,512	72	36	13	**3,664**
NBV total at 31 March 2021	**33,727**	**481,163**	**165**	**7,417**	**37,284**	**199**	**16,563**	**2,775**	**579,293**

Note 16 Donations of property, plant and equipment (Trust)

In 2020/21 the Trust has received donations in respect of property, plant and equipment and intangible assets. In instances where cash has been received rather than the physical assets, there is no significant difference between the cash provided and the value of the assets acquired.

	2021/22			2020/21			
	Donated from North Bristol NHS Trust Charitable Fund	Grant funded asset additions	**Total**	Donated from North Bristol NHS Trust Charitable Fund	Donated from DHSC	Grant funded asset additions	**Total**
	£000s	£000s	**£000s**	£000s	£000s	£000s	**£000s**
Buildings	229	0	**229**	167	0	0	**167**
Plant & machinery	101	43	**144**	302	1,550	15	**1,867**
Information technology				16	0	0	**16**
Total	**330**	**43**	**373**	**485**	**1,550**	**15**	**2,050**

Note 17 Revaluations of property, plant and equipment (Trust and Group)

The District Valuer, who is a member of the RICS and is independent of the Trust, undertook a valuation of the Trust's land and buildings as at 31 March 2022. These were previously valued as at 31 March 2021. The valuations were carried out in accordance with the RICS Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health & Social Care and HM Treasury. The valuations were undertaken in accordance with the Trust's accounting policy (see note 1) and on a consistent basis with valuations in previous periods.

The valuation has been conducted on the assumption that the assets would remain on their existing sites as an appropriate alternative site to delivery services locally is not readily available.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

The valuation has contributed to net upward valuations of £27,753k (£14,096k 2020/21) and net impairments of £238k (£3,100k 2020/21) within Property, Plant & Equipment.

The overall increase in valuations is a result of the BCIS (all price) Tender Price Index (TPI) increasing to 350 compared with 328 in the prior year, along with the BCIS Location Factor decreasing to 1.02 compared with 1.03 in the prior year.

The land and buildings with the highest upward valuations were as follows:

	2021/22	**2020/21**
	£000s	**£000s**
PFI buildings	20,777	10,915
Blackberry Hill	951	0
Southmead Land	550	0

Note 18 Other investments / financial assets (non-current)

	Group	
	2021/22	2020/21
	£000	£000
Carrying value at 1 April - brought forward	**10,198**	**8,092**
Acquisitions in year	1,788	1,233
Movement in fair value through income and expenditure	404	1,374
Disposals	(2,043)	(501)
Carrying value at 31 March	**10,347**	**10,198**

The investments relate to monies invested by the consolidated Charity.

Note 19 Analysis of charitable fund reserves

North Bristol NHS Trust Charitable Funds have been consolidated within this set of accounts.

	31 March 2022	31 March 2021
	£000	£000
Unrestricted funds:		
Unrestricted income funds	9,850	11,074
Restricted funds:		
Endowment funds	31	31
Other restricted income funds	961	1,000
	10,842	**12,105**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 20 Inventories

	Trust and Group	
	31 March 2022	31 March 2021
	£000	£000
Drugs	2,703	2,563
Consumables	6,442	5,975
Total inventories	**9,145**	**8,538**

Inventories recognised in expenses for the year were £145,009k (2020/21: £147,120k). Write-down of inventories recognised as expenses for the year were £0k (2020/21: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,646k of items purchased by DHSC (2020/21: £10,811k).

Note 21.1 Receivables

	Group		Trust	
	31 March 2022	2021	2022	2021
	£000	£000	£000	£000
Current				
Contract receivables	39,984	30,674	40,265	30,786
Capital receivables	-	4,000	-	4,000
Allowance for impaired contract receivables / assets	(11,481)	(10,014)	(11,481)	(10,014)
Prepayments (non-PFI)	5,661	7,324	5,661	7,324
PFI lifecycle prepayments	1,395	1,467	1,395	1,467
PDC dividend receivable	259	-	259	-
VAT receivable	3,303	2,739	3,303	2,739
Other receivables	107	158	107	158
NHS charitable funds receivables	191	156	-	-
Total current receivables	**39,419**	**36,504**	**39,509**	**36,460**
Non-current				
Other receivables	1,488	1,728	1,488	1,728
Total non-current receivables	**1,488**	**1,728**	**1,488**	**1,728**

Of which receivable from NHS and DHSC group bodies:		
Current	18,982	10,206
Non-current	1,488	1,728

Note 21.2 Allowances for credit losses - 2021/22

	Trust and Group
	Contract receivables and contract assets
	£000
Allowances as at 1 April 2021 - brought forward	**10,014**
New allowances arising	3,397
Changes in existing allowances	930
Reversals of allowances	(1,843)
Utilisation of allowances (write offs)	(1,017)
Allowances as at 31 March 2022	**11,481**

Allowance for credit losses are calculated by class of debtor and the risk assessed for each asset class. A detailed table is provided in Note 21.4.

The principles of the calculation remain the same at 31 March 2022 as at 31 March 2021, however the Trust has used a broader data set in 2022 to establish the likelihood of debts being paid in order to increase the accuracy of the estimate.

The Trust's definition of default is any debt which exceeds its terms of payment. The standard credit terms are 30 days from the date of invoice.

Debts are written off when there is no reasonable expectation of recovery and all routes available for attempting recovery have been exhausted.

Amounts written off in the year are still subject to enforcement activity (IFRS 7, para 35L).

Note 21.3 Allowances for credit losses - 2020/21

	Trust and Group
	Contract receivables and contract assets
	£000
Allowances as at 1 April 2020 brought forward	**8,732**
New allowances arising	3,863
Changes in existing allowances	1,158
Reversals of allowances	(2,857)
Utilisation of allowances (write offs)	(882)
Allowances as at 31 March 2021	**10,014**

Note 21.4 Exposure to credit risk (Trust and Group)

Expected credit losses are calculated and provided for based on different classes of financial asset.

Debt provision table by classification of debtor.

Percentage and Amount provision by class of debtor and debtor days

	Debtor days					
Class of Debtor	**0-30 days**	**31-60 days**	**61-90 days**	**91-180 days**	**181-360 days**	**>360 days**
Non-NHS receivables (£000)	395	194	135	348	592	3,018
Non-NHS receivables (%)	26%	45%	41%	70%	78%	97%
Private and Overseas Patients (£000)	11	242	122	446	463	3,707
Private and Overseas Patients (%)	87%	96%	98%	98%	99%	100%
Staff (£000)	0	0	0	0	0	81
Staff (%)	0%	0%	0%	0%	0%	100%
RTA (£000)	87	47	59	163	219	1,153
RTA (%)	24%	24%	24%	24%	24%	24%

The majority of the Trust's and Group's revenue comes from contracts with other public sector bodies. The private & overseas patient area does have a credit loss risk and is reflected in the above table. In addition to the above, specific identified high risk debt has been provided in full.

Note 22.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2021/22	**2020/21**	**2021/22**	**2020/21**
	£000	**£000**	**£000**	**£000**
At 1 April	**123,467**	**13,282**	**121,458**	**10,746**
Net change in year	(6,243)	110,185	(5,305)	110,712
At 31 March	**117,224**	**123,467**	**116,153**	**121,458**
Broken down into:				
Cash at commercial banks and in hand	17	19	15	19
Cash with the Government Banking Service	116,919	123,448	116,138	121,439
Other current investments	288	-	-	-
Total cash and cash equivalents as in SoFP	**117,224**	**123,467**	**116,153**	**121,458**

Note 22.2 Third party assets held by the Trust and Group

North Bristol NHS Trust held £0k (2020/21 £9k) of cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts. Due to the impact of Covid, patients were advised not to bring large amounts of cash into the hospitals.

Note 23 Trade and other payables

	Group		Trust	
	2022	2021	2022	2021
	£000	£000	£000	£000
Current				
Trade payables	39,967	55,362	39,967	55,362
Capital payables	7,305	7,795	7,305	7,795
Accruals	51,956	45,392	51,956	45,392
Social security costs	5,359	4,698	5,359	4,698
Other taxes payable	4,735	3,833	4,735	3,833
PDC dividend payable	-	146	-	146
Other payables	473	258	473	258
NHS charitable funds: trade and other payables	486	146	-	-
Total current trade and other payables	**110,281**	**117,630**	**109,795**	**117,484**
Of which payables from NHS and DHSC group bodies:				
Current	7,073	27,202		

Note 24 Other liabilities

	Trust and Group	
	31 March 2022	31 March 2021
	£000	£000
Current		
Deferred income: contract liabilities	16,342	8,390
Deferred PFI credits / income	77	77
Total other current liabilities	**16,419**	**8,467**
Non-current		
Deferred income: contract liabilities	3,464	3,790
Deferred PFI credits / income	1,744	1,821
Total other non-current liabilities	**5,208**	**5,611**

Note 25.1 Borrowings

	Trust and Group	
	31 March 2022	31 March 2021
	£000	£000
Current		
Obligations under finance leases	2,090	2,795
Obligations under PFI	15,241	12,284
Total current borrowings	**17,331**	**15,079**
Non-current		
Obligations under finance leases	2,006	3,921
Obligations under PFI	359,302	368,652
Total non-current borrowings	**361,308**	**372,573**

Note 25.2 Reconciliation of liabilities arising from financing activities

Trust and Group - 2021/22	Loans from DHSC	Finance leases	PFI	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021	**-**	**6,716**	**380,936**	**387,652**
Cash movements:				
Financing cash flows - payments and receipts of principal	-	(2,623)	(8,301)	**(10,924)**
Financing cash flows - payments of interest	-	(208)	(20,557)	**(20,765)**
Non-cash movements:				
Application of effective interest rate	-	208	23,473	**23,681**
Other changes	-	3	(1,008)	**(1,005)**
Carrying value at 31 March 2022	**-**	**4,096**	**374,543**	**378,639**

Trust and Group - 2020/21	Loans from DHSC	Finance leases	PFI	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**179,029**	**7,773**	**390,778**	**577,580**
Cash movements:				
Financing cash flows - payments and receipts of principal	(178,461)	(2,720)	(9,059)	**(190,240)**
Financing cash flows - payments of interest	(568)	(261)	(26,815)	**(27,644)**
Non-cash movements:				
Application of effective interest rate	-	261	24,013	**24,274**
Other changes	-	1,663	2,019	**3,682**
Carrying value at 31 March 2021	**-**	**6,716**	**380,936**	**387,652**

Note 26 North Bristol NHS Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	Trust and Group	
	31 March 2022	31 March 2021
	£000	£000
Gross lease liabilities	**4,469**	**7,074**
of which liabilities are due:		
- not later than one year;	2,225	2,960
- later than one year and not later than five years;	1,833	3,622
- later than five years.	411	492
Finance charges allocated to future periods	(373)	(358)
Net lease liabilities	**4,096**	**6,716**
of which payable:		
- not later than one year;	2,090	2,795
- later than one year and not later than five years;	1,638	3,429
- later than five years.	368	492

Significant leasing arrangements include embedded finance lease arrangements with the managed service contracts for the Patient Information System (Lorenzo) and the Trusts IT network.

The contingent rents on the above leases are based on the agreed managed contract arrangements.

Note 27.1 Provisions for liabilities and charges analysis (Trust and Group)

Group	Pensions: early departure costs	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2021	**680**	**46**	**-**	**9,653**	**10,379**
Change in the discount rate	(5)	-	-	-	**(5)**
Arising during the year	47	135	87	338	**607**
Utilised during the year	(180)	(46)	-	(4,488)	**(4,714)**
Reversed unused	-	-	-	(993)	**(993)**
Unwinding of discount	16	-	-	-	**16**
At 31 March 2022	**558**	**135**	**87**	**4,510**	**5,290**
Expected timing of cash flows:					
- not later than one year;	174	135	87	3,022	**3,418**
- later than one year and not later than five years;	335	-	-	173	**508**
- later than five years.	49	-	-	1,315	**1,364**
Total	**558**	**135**	**87**	**4,510**	**5,290**

Note 27.2 Clinical negligence liabilities

At 31 March 2022, £358,325k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of North Bristol NHS Trust (31 March 2021: £249,867k).

Note 28 Contingent liabilities

	Trust and Group	
	31 March 2022	31 March 2021
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(66)	(41)
Gross value of contingent liabilities	**(66)**	**(41)**

£66k (2020/21 £41k) contingent liability relates to the assessed potential liability advised by NHS Resolution on claims currently in progress where a contribution may become liable.

The Trust has received a legal challenge related to a procurement exercise which the Trust was part of together with other NHS organisations. The Trust is contesting the claim and has engaged legal experts to support this process. The Trust does not intend to pay any damages associated with the claim and any damages that could be payable would not be material. The Trust is disclosing this challenge as a contingent liability in accordance with IAS 37.

	Group	
Note 29 Contingent Assets	**2022**	**2021**
	£000	**£000**
Net value of contingent assets	**525**	**-**

The contingent asset relates to legacy income due to the consolidated Charity.

Note 30 Contractual capital commitments

	Trust and Group	
	31 March 2022	31 March 2021
	£000	£000
Property, plant and equipment	3,050	6,400
Intangible assets	1,558	4,857
Total	**4,608**	**11,257**

Note 31 Other financial commitments

The Group / Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Trust and Group	
	31 March 2022	31 March 2021
	£000	£000
not later than 1 year	6,370	1,625
after 1 year and not later than 5 years	1,899	2,603
paid thereafter	-	-
Total	**8,269**	**4,228**

Note 32 On-SoFP PFI

A contract for the development of the new hospital was signed by the Trust and its PFI partner, The Hospital Company (Southmead) Limited on 25 February 2010. The purpose of the scheme was to deliver a modern, state of the art hospital facility on the Southmead site, which the Trust moved into on 26 March 2014 and which has been fully operational since May 2014.

Under IFRIC 12, the PFI scheme is deemed to be on Statement of Financial Position, meaning that the hospital is treated as an asset of the Trust, being acquired under a finance lease. In addition to the above the PFI partner constructed a multi-storey car park as part of the PFI contract which was completed and has been operating since January 2011. This is accounted for in the same way as the hospital.

A final phase of the project with a capital value of £6,553k completed in 2016.

The total construction cost recognised in the accounts to date in relation to these two assets is £437,803k.

An annual unitary payment is payable to our PFI partner. This payment is subject to RPI based indexation in common with most other PFI schemes. Under the contract, the PFI partner provides a facilities management service along with associated services including pest control and grounds and utilities management. The contractual service charge for 2021/22 was £6,631k. As well as being subject to movements in RPI, this element can change as a result of service or performance variations. During the course of 2021/22 the Trust has utilised the contractual mechanisms relating to performance to secure reductions in the payments made to the contractor.

PFI schemes deemed to be off Statement of Financial Position

The capital value of the scheme at the time of construction was £2,800,000. Crestacare constructed a 25 bed brain injury rehabilitation unit and subsequently a further rehab unit as expansion (known as BIRU), as well as constructing accommodation for neuro psychiatry services and the Burden Neurological Institute (known as Burden).

BIRU:

The Trust does not currently make any payment for clinical use of the BIRU building as it is used by Huntercombe Neuro Limited (HNL) to provide services commissioned by NHS England.

In 2021 the original BIRU operating agreement with Crestacare Properties Ltd was replaced by a revised over-arching operating agreement with HNL and extends until 31st March 2031. This agreement sets out the terms on which the Trust provides certain clinical ancillary services to HNL.

A peppercorn head-lease, granted by the Trust for Huntercombe Neuro Limited to use the BIRU land and buildings is in place and will expire in 2100.

Burden:

The original Burden operating agreement whereby the Trust pays an annual charge of £165k pa to Huntercombe Neuro Limited, is due to expire on 31st July 2022, at the end of a 22 year term. However the Trust has bought out HNL's interest in the overall head-lease (for which there were 69 years remaining) for £1,200k plus VAT on 31st March 2022, therefore the £165k charge per annum is no longer payable by the Trust for the remainder of this period.

Depreciation is not charged on the Off SoFP PFI arrangements.

Note 32.1 On-SoFP PFI

The following obligations in respect of the PFI arrangements are recognised in the statement of financial position:

	Trust and Group	
	31 March 2022 £000	31 March 2021 £000
Gross PFI liabilities	**706,579**	**768,917**
Of which liabilities are due		
- not later than one year;	38,135	35,646
- later than one year and not later than five years;	126,531	128,888
- later than five years.	541,913	604,383
Finance charges allocated to future periods	(332,036)	(387,981)
Net PFI obligation	**374,543**	**380,936**
- not later than one year;	15,241	12,284
- later than one year and not later than five years;	41,645	38,758
- later than five years.	317,657	329,894

Note 32.2 Total on-SoFP PFI commitments

Total future commitments under these on-SoFP schemes are as follows:

	Trust and Group	
	31 March 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI	**1,743,058**	**1,702,744**
Of which payments are due:		
- not later than one year;	55,394	51,205
- later than one year and not later than five years;	235,774	217,946
- later than five years.	1,451,890	1,433,593

Note 32.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Trust and Group	
	2021/22	2020/21
	£000	£000
Unitary payment payable to service concession operator	**50,140**	**50,899**
Consisting of:		
- Interest charge	23,473	24,013
- Repayment of balance sheet obligation	8,301	9,059
- Service element and other charges to operating expenditure	6,379	6,332
- Capital lifecycle maintenance	567	548
- Contingent rent	11,420	10,788
- Addition to lifecycle prepayment	-	159

Note 33 Off-SoFP PFI

North Bristol NHS Trust incurred the following charges in respect of off-Statement of Financial Position PFI arrangements:

	Trust and Group	
	31 March 2022	31 March 2021
	£000	£000
Charge in respect of the off SoFP PFI for the period	**165**	**165**
Commitments in respect of off-SoFP PFI:		
- not later than one year;	55	165
- later than one year and not later than five years;	-	55
- later than five years.	-	-
Total	**55**	**220**

Note 34 Financial instruments

Note 34.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust and Group are principally domestic organisations with the great majority of transactions, assets and liabilities being in the UK and sterling based. They have no overseas operations. Therefore there is low exposure to currency rate fluctuations.

Interest rate risk

Within the PFI, the interest is subject to annual uplifts in respect of the Retail Price Index. The Trust does not have any outstanding loans from the government, therefore the Trust has low exposure to interest rate fluctuations.

The Charity invests funds to maximise investment income, partly in the form of interest and so bears some risk. From a Group perspective this risk is insignificant.

Credit risk

Because the majority of the Trust's and Group's revenue comes from contracts with other public sector bodies, there is low exposure to credit risk. The maximum exposures as at 31 March 2022 are in receivables from customers, as disclosed in note 21.

Liquidity risk

The majority of the Trust's and Group's operating costs are financed through the block income and system envelopes. The Trust funds its capital expenditure from a combination of internally generated sources, along with capital PDC received in relation to specific schemes. The Trust and Group are not, therefore, exposed to significant liquidity risks.

Note 34.2 Carrying values of financial assets

Group

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	30,095	-	**30,095**
Cash and cash equivalents	116,153	-	**116,153**
Consolidated NHS Charitable fund financial assets	1,071	10,347	**11,418**
Total at 31 March 2022	**147,319**	**10,347**	**157,666**

Group

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	26,386	-	**26,386**
Cash and cash equivalents	121,458	-	**121,458**
Consolidated NHS Charitable fund financial assets	2,053	10,198	**12,251**
Total at 31 March 2021	**149,897**	**10,198**	**160,095**

Trust

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	30,379	**30,379**
Cash and cash equivalents	116,153	**116,153**
Total at 31 March 2022	**146,532**	**146,532**

Trust

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	26,386	**26,386**
Cash and cash equivalents	121,458	**121,458**
Total at 31 March 2021	**147,844**	**147,844**

Note 34.3 Carrying values of financial liabilities

Group

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Obligations under finance leases	4,096	**4,096**
Obligations under PFI	374,543	**374,543**
Trade and other payables excluding non financial liabilities	89,030	**89,030**
Provisions under contract	5,290	**5,290**
Consolidated NHS charitable fund financial liabilities	486	**486**
Total at 31 March 2022	**473,445**	**473,445**

Group

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Obligations under finance leases	6,716	**6,716**
Obligations under PFI	380,936	**380,936**
Trade and other payables excluding non financial liabilities	96,768	**96,768**
Provisions under contract	10,379	**10,379**
Consolidated NHS charitable fund financial liabilities	146	**146**
Total at 31 March 2021	**494,945**	**494,945**

Trust

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Obligations under finance leases	4,096	**4,096**
Obligations under PFI	374,543	**374,543**
Trade and other payables excluding non financial liabilities	89,030	**89,030**
Provisions under contract	5,290	**5,290**
Total at 31 March 2022	**472,959**	**472,959**

Trust

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Obligations under finance leases	6,716	**6,716**
Obligations under PFI	380,936	**380,936**
Trade and other payables excluding non financial liabilities	96,768	**96,768**
Provisions under contract	10,379	**10,379**
Total at 31 March 2021	**494,799**	**494,799**

Note 34.4 Fair values of financial assets and liabilities

The carrying value of financial assets and liabilities is equal to their fair value.

Note 34.5 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
In one year or less	133,294	143,677	132,808	143,531
In more than one year but not more than five years	128,872	133,089	128,872	133,089
In more than five years	543,688	606,518	543,688	606,518
Total	**805,854**	**883,284**	**805,368**	**883,138**

Note 35 Losses and special payments

	2021/22		2020/21 (restated)	
Group and Trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	-	-	1	8
Bad debts and claims abandoned	402	1,021	324	922
Total losses	**402**	**1,021**	**325**	**930**
Special payments				
Compensation under court order or legally binding arbitration award	6	40	21	46
Ex-gratia payments	47	24	17	14
Overtime corrective payments	-	-	1	349
Total special payments	**53**	**64**	**39**	**409**
Total losses and special payments	**455**	**1,085**	**364**	**1,339**
Of which, special payments of £95,000 or more:				
Overtime corrective payments (nationally funded payment)	-	-	1	349

Overtime corrective payments (Flowers judgement) are considered special payments for which HMT approval was sought nationally by NHS England on local employers' behalf. As the losses and special payments note is prepared on an accruals basis (excluding provisions), these amounts should have been disclosed in 2020/21 accounts.

Note 36 Related parties (Trust and Group)

The Department of Health and Social Care is the parent department of the Trust.

The main entities within the public sector that the Trust has had dealings with.are:

NHS England;
NHS Bristol, North Somerset and South Gloucestershire CCG;
NHS Bath and North East Somerset, Swindon and Wiltshire CCG;
NHS Gloucestershire CCG;
NHS Somerset CCG;

Health Education England;
NHS Resolution;
Department of Health and SocialCare;
Public Health England;
UK Health Security Agency;
NHS Pension Scheme;
HM Revenue and Customs

University Hospitals Bristol and Weston NHS Foundation Trust;
Gloucestershire Hospitals NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust
Avon and Wiltshire Mental Health Partnership NHS Trust

Bristol City Council;
North Somerset Council;
South Gloucestershire Council.

The table below includes information on transactions with related parties as well as potential conflict interests as disclosed by Board Members.

Director, Interest and Related parties	**Receivables at 31.03.22, £**	**Income in 2021/22, £**	**Payables at 31.03.22, £**	**Expenditure in 2021/22, £**
Mr Kelvin Blake (Non-Executive Director) Non Executive Director of BRISDOC	-	73,531	4,076	-
Professor Sarah Purdy (Non Executive Director) Pro Vice-Chancellor and Professor of Primary Care, University of Bristol	169,705	1,754,846	1,053,152	2,389,981
Ms Maria Kane (Chief Executive) Advisory Group Member of CHKS, a provider of healthcare intelligence and quality improvement services	-	-	-	46,000
Mr Tim Whittlestone (Medical Director) Director of Bristol Urology Associates Ltd.	-	-	-	29,986
Mr Richard Gaunt (Associate Non-Executive Director) Non-Executive/Governor of City of Bristol College.	695	370	0	0
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	275,501	914,319	18,582	373,135
Total NHS	275,501	914,319	18,582	373,135
Total Non NHS	170,400	1,828,748	1,057,228	2,465,967
Total	445,901	2,743,067	1,075,810	2,839,102

Note 37 Transfers by absorption

On 1st December 2021 a transfer of urology services was made from University Hospitals Bristol and Weston NHS Foundation Trust to North Bristol NHS Trust. This included the transfer of capital assets with a net book value of £83k and clinical consumables with a value of £18k.

Note 38 Events after the reporting date

There are no events after the reporting period which would affect the figures in these accounts, nor which require disclosure.

Note 39 Better Payment Practice code

Non-NHS Payables	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Total non-NHS trade invoices paid in the year	74,561	427,273	69,828	379,024
Total non-NHS trade invoices paid within target	62,692	378,856	61,061	337,238
Percentage of non-NHS trade invoices paid within target	84.1%	88.7%	87.4%	89.0%
NHS Payables				
Total NHS trade invoices paid in the year	2,491	23,044	2,588	23,136
Total NHS trade invoices paid within target	1,765	16,596	1,520	11,145
Percentage of NHS trade invoices paid within target	70.9%	72.0%	58.7%	48.2%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 40 External financing

The Trust is given an external financing limit against which it is permitted to underspend.

	2021/22 £000	2020/21 £000
Cash flow financing	2,604	(100,743)
External financing requirement	**2,604**	**(100,743)**
External financing limit (EFL)	2,604	(15,771)
Under spend against EFL	**-**	**84,972**

Note 41 Capital Resource Limit

	2021/22 £000	2020/21 £000
Gross capital expenditure	33,528	40,486
Less: Disposals	(3,400)	-
Less: Donated and granted capital additions	(373)	(2,050)
Charge against Capital Resource Limit	**29,755**	**38,436**
Capital Resource Limit	30,908	38,436
Under / (over) spend against CRL	**1,153**	**-**

Note 42 Breakeven duty financial performance

	2021/22 £000	2020/21 £000
Surplus for the period	1,065	3,005
Add back all I&E impairments / (reversals)	2,753	3,100
Adjust (gains) on transfers by absorption	(101)	-
Surplus before impairments	**3,717**	**6,105**
Retain impact of DEL I&E (impairments)	(1,550)	(3,069)
Remove capital donations / grants I&E impact	317	(1,689)
Remove net impact of DHSC centrally procured inventories	351	(351)
Adjusted financial performance surplus / (deficit) (control total basis)	**2,835**	**996**
Remove impairments scoring to Departmental Expenditure Limit	1,550	3,069
IFRIC 12 breakeven adjustment	8,709	6,751
Breakeven duty financial performance surplus	**13,094**	**10,816**

Note 43 Reconciliation between Surplus for the year from continuing operations and Adjusted financial performance surplus for the purposes of system achievement

	2021/22	2020/21
	£000	£000
Surplus for the year from continuing operations	**1,065**	**3,005**
Add back AME net impairments	1,203	31
Adjust (gains) on transfers by absorption	(101)	-
Remove capital donations / grants I&E impact	317	(1,689)
Remove net impact of DHSC centrally procured inventories	351	(351)
Remove gain on sale of Property, Plant and Equipment	(632)	(531)
Adjusted financial performance surplus for the purposes of system achievement	**2,203**	**465**

Note 44 Reconciliation between Surplus for the year from continuing operations and Adjusted financial performance surplus for the purposes of system achievement

	2021/22	2020/21
	£000	£000
Surplus for the year from continuing operations	**1,065**	**3,005**
Remove inter-group income	(1,070)	(1,058)
Surplus for the year within Group SOCIE	**(5)**	**1,947**

Note 45 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		6,177	7,888	9,002	7,002	5,605	(19,740)
Breakeven duty cumulative position	(31,573)	(25,396)	(17,508)	(8,506)	(1,504)	4,101	(15,639)
Operating income		473,815	492,883	519,430	529,896	541,376	552,911
Cumulative breakeven position as a percentage of operating income		(5.4%)	(3.6%)	(1.6%)	(0.3%)	0.8%	(2.8%)

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(51,561)	(42,922)	(12,143)	(7,440)	7,470	10,816	13,094
Breakeven duty cumulative position	(67,200)	(110,122)	(122,265)	(129,705)	(122,235)	(111,419)	(98,325)
Operating income	543,638	530,628	574,469	605,829	667,679	773,284	791,396
Cumulative breakeven position as a percentage of operating income	(12.4%)	(20.8%)	(21.3%)	(21.4%)	(18.3%)	(14.4%)	(12.4%)

IAS 1 requires the Trust to assess, as part of the accounts preparation process, its ability to continue as a going concern. In the context of non-trading entities in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector. These accounts have been prepared on a going concern basis.