Neurosciences and Musculo-Skeletal Division

Neurosurgery

Cases have highlighted the complexity of obtaining consent for patients whose capacity is deteriorating, reinforcing the benefits of bespoke consent forms. Reviews have also highlighted that letters from the department are not always in keeping with the Patterson enquiry recommendations - which require correspondence to be directed to the patient rather than the referrer. Work is underway to bring all communication in line with these standards.

Stroke

Mortality review meetings have prompted several strands of ongoing work. These include targeted feedback to consultants and resident doctors on specific aspects of clinical practice, such as improving electrocardiogram (ECG) interpretation and optimising the management of patients with large hemispheric infarctions.

The team is also collaborating closely with governance and complaints colleagues to produce clearer documentation to support grievance processes raised by relatives. This ensures that families receive transparent communication and that any learning identified is formally recorded and acted upon.

For more complex reviews, Patient Safety Incident Investigations (PSIIs) and structured family meetings are now routinely undertaken. This aligns with our aim to integrate mortality review processes with PSIRF, supporting openness with families while helping multidisciplinary teams to share insights and identify improvement opportunities collaboratively.

The stroke team is also actively participating in the enhanced Structured Judgement Review (eSJR) pilot. This includes testing the new digital mortality review system, which enables automatic case identification, digital assignment of reviewers, and pre-populated templates. This work is reducing the administrative burden on clinical teams and improving the speed and quality of feedback to inform learning and improvement.

The team is continuing work to refine the decompressive hemicraniectomy pathway to ensure it reflects the latest clinical evidence and local learning. In addition, targeted palliative care training is being delivered to ward staff, in response to themes raised through Medical Examiner referrals. This is helping to ensure that patients and families receive high-quality support and communication at the end of life.

4.3 Working together across Bristol, North Somerset and South Gloucestershire

We really value the different perspectives that families, the independent Medical Examiner, and our SJR reviewers bring to our Learning from Deaths processes.

This collaborative approach to learning extends beyond our Trust. As part of Bristol NHS Group, our partnership with University Hospitals Bristol and Weston Trust helps us share learning more widely and deliver on our Joint Clinical Strategy vision of seamless, high-quality, equitable care, ensuring patients receive consistent care regardless of which hospital they attend.

Our Bristol NHS Group Mortality Improvement Programme

Our joint Mortality Improvement Programme made substantial progress during 2024-25, establishing formal partnership arrangements and recruiting dedicated clinical and programme leads.

The programme is creating a robust system-level oversight that will help us to identify patterns more quickly and easily and ensure consistent review quality and sharing of learning across all hospital sites.

Over the course of the year, the mortality improvement programme has grown from being delivered by a single individual to a small, dedicated team. While the team is not yet at full complement, this measured approach ensures that resource growth is aligned with clear value delivery. The team is prioritising projects that have the greatest potential to improve and streamline processes, and to align approaches across both trusts, ensuring the best use of programme investment.

Key developments include NBTs pilot of a jointly developed enhanced Structured Judgement Review (eSJR) question set, which aims to provide a consistent approach to detailed case review and enabling more meaningful cross-site learning.

Early adopter divisions at NBT are now trialling this approach in real cases, providing feedback on usability and data quality. Their input is shaping refinements ahead of wider roll-out, ensuring the final approach supports both learning and operational needs.

At UHBW, early discovery and planning work has begun to explore how improved digital solutions could be rolled out in future, drawing on NBT's piloting and prototyping experience. Full project and implementation plans will follow once the initial pilots conclude in October 2025.

Several specialty-specific pilots have also been scoped, including enhanced reviews for hepatology, frailty, and patients spending more than eight hours between decision to admit (DTA) and admission. The latter builds on research conducted by the NBT ED team in collaboration with BNSSG's system "risk of harm" group.

The NBT ED team has also worked with the Mortality Improvement Programme to pilot automated case identification for patients meeting this eight-hour threshold, linking local quality improvement work and research directly into the enhanced SJR process.

Alongside this, new Application Programming Interface (API) and data-testing projects are helping integrate data from multiple systems, reducing administrative burden and giving clinical teams faster access to the insights that drive timely learning and improvement.

These developments have become increasingly important as we develop Single Managed Services across our group, with cardiac services being our first specialty to operate under unified leadership across both sites.

This year, we have also begun assessing how each trust manages Medical Examiner referrals, completes reviews, and reports on mortality. We have identified areas for improvement and areas of good practice for alignment.

We are currently working to standardise medical examiner referral concern categorisation, ensure consistent referral responses, and develop joint data analysis to identify group-wide learning opportunities. Some additional the highlights of the programme's progress this year include:

Improving the timeliness of the death certification process

This year, we have successfully transitioned to a statutory Medical Examiner (ME) service in line with national requirements. This included implementing new processes for Medical Certificate of Cause of Death (MCCD) completion and removing the need for separate cremation forms.

We also rolled out digital ME scrutiny tool. This has significantly improved data quality and reduced manual processing time by 5 hours per week. We have strengthened the process for completion of forms to ensure timely death certification, and improved coordination between the ME Office and the bereavement team.

Aligning the definition for Severe Mental Illness for mortality review

The mortality programme achieved a significant milestone this year, securing clinical agreement on Severe Mental Illness (SMI) definitions with Avon and Wiltshire Partnership Mental Health Partnership. We are now developing a collaborative review

framework to review approximately 360 deaths a year across BNSSG, reducing duplication and enhancing mental health-specific learning and sharing.

Aligning our reporting schedules and report templates

The programme developed aligned Learning from Deaths reporting schedules and structure across both trusts, with this being our first joint milestone. For 2024-25, we focused on what matters most to the public - making our Learning from Deaths reports clearer and more accessible. Working with patient and public representatives to enhance readability, our aligned reports use the same headings and structure across both trusts, developed collaboratively. We have plans for greater alignment as our Bristol NHS Group work progresses.

Aligning how we use mortality data

We have aligned our SHMI preview data validation processes across Bristol NHS Group. This is the process where we check our mortality data before it is signed off to NHS England for public publication.

This alignment work has prompted us to develop a more systematic approach to understanding care quality across both hospital sites. Since SHMI is not designed to measure care quality or compare trusts, we are exploring how to triangulate this data with other sources including SJR findings, clinical audit data, patient safety incident themes, complaints data, and quality improvement projects and outcomes. This will provide a more comprehensive picture of our performance and learning opportunities.

For example, this approach will help us identify where one hospital site achieves better outcomes for specific patient groups. It will also enable us to share successful approaches across both sites and improve care for all patients.

This work represents the foundation for more intelligent analysis of data and system-wide learning in future years. In line with Penny Dash's 2025 report, it will allow us to move together as a group beyond single indicators to understand the full picture of care quality and improvement opportunities.

Aligning our Medical Examiner referral processes

As part of our mortality programme, we identified that 17.3% of deaths scrutinised by the Medical Examiner were referred to UHBW for further review, compared to 6.6% at NBT. Initial discussions with the Medical Examiner Service suggest this variation reflects different documentation approaches and referral thresholds rather than differences in care quality.

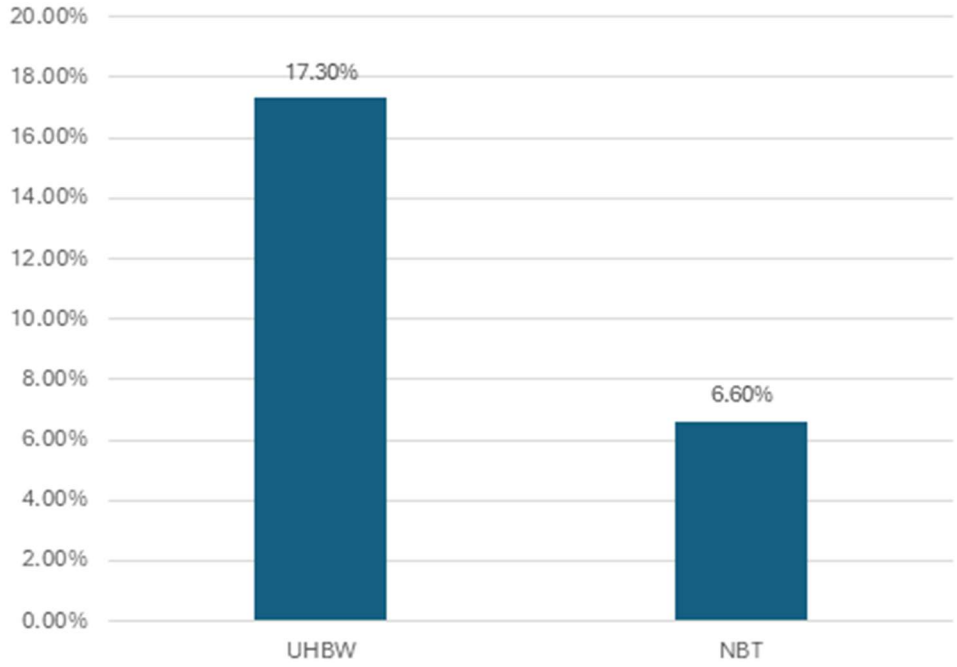


Figure 25: Percentage of deaths being referred to relevant trust for governance

4.4 Looking forward

Current challenges and our plans to address them

We believe in being transparent about the challenges we face in learning from deaths, as acknowledging these honestly is the first step toward meaningful improvement.

Our Learning from Deaths policy is being updated in line with our Bristol NHS Group development. Rather than updating separately and aligning later, we are working directly with North Bristol NHS Trust through our joint Mortality Improvement Programme to develop aligned policies from the outset. This ensures consistency whilst incorporating changes in national guidance, statutory Medical Examiner requirements, and PSIRF alignment. While our current policy requires updating, there are no high-risk concerns with our existing processes.

We aim to improve our tracking of learning and outcomes from all aspects of mortality review, in particular, actions resulting from Medical Examiner Referrals. We hope to do this using the better integrated governance platform *Radar* onto which incident reporting has recently been launched to enable us to track this learning without duplication.

We aim to share data and learning across our hospitals, we will become better at spotting trends in patient care across our local health system. We are also planning to

collaborate with colleagues across BNSSG including Sirona Care and Health and Avon and Wiltshire Partnership to ensure our learning benefits the entire system.

Future Priorities and Commitments

Digital transformation priorities

During 2025-26, we will be updating our Medical Examiner scrutiny system to a new digital platform. Following the national decision not to proceed with a centrally developed system, we are implementing our own solution that will be more suitable for our needs. This will provide enhanced data security and improve reporting capabilities alongside better integration with our joint Bristol NHS Group mortality improvement work.

We will implement enhanced Structured Judgement Review (eSJR) processes to standardise review methods and data collection across Bristol NHS Group, ensuring consistent quality and learning. In addition, we will launch a new digital Medical Examiner referral system to streamline workflow and improve data quality, enabling swifter responses to family concerns.

This year, our mortality improvement programme has focused on understanding what clinical leads would find most valuable in their data dashboards and reports, starting with teams at NBT. Over the next year, we will continue this engagement across UHBW and build digital solutions tailored to each specialty's specific requirements. This approach will take longer but will deliver better outcomes.

For example, we are developing automated flags for cases with the highest learning potential. This includes delays of 8+ hours from decision to admit to actual admission, or patients who move from ward to ward and then to intensive care, which might indicate missed opportunities for earlier intervention. These are not automatically concerns but intelligent filtering to help clinical teams identify cases for mandatory SJR review. This will enable teams to focus their time on completing reviews and implementing and sharing learning.

Aligning and improving Medical Examiner referrals

We recognise there are learning opportunities from both positive feedback and referrals from concerns, and we want to capture both effectively. We have been working with the Medical Examiner Service to develop suitable thresholds for both types of referrals, focusing on feedback that is specific and actionable while ensuring families' voices are heard without creating unnecessary administrative burden.

We will also complete our Medical Examiner referral themes categorisation alignment project. This will enable standardised analysis and cross-trust learning, helping us identify improvement opportunities more effectively across our hospital sites.

Aligning quality governance approaches across our Bristol NHS Group

As part of the mortality programme, we will be working to align our quality governance approaches across Bristol NHS Group, including reporting, categorisation, and underlying review processes.

Integration with Child Death Review and Perinatal Mortality Review Processes

We will also focus on more tightly integrating findings from all mortality review processes with our broader mortality governance. For example, our Child Death Review process and maternal and neonatal MBRRACE-UK processes generate important learning that complements our adult mortality review work, particularly around communication with families, service provision improvements, and inter-agency coordination.

We are exploring opportunities to bring together adult, paediatric, maternal and neonatal mortality review processes where appropriate, whilst not duplicating the excellent specialist work already progressing through our dedicated specialist teams and national groups.

Glossary

Admission

When a person goes into hospital to stay for treatment or care.

BNSSG (Bristol, North Somerset and South Gloucestershire)

Bristol, North Somerset and South Gloucestershire is the area covered by our local NHS services.

Coroner Referrals

Approximately half of all deaths in England and Wales are referred to H.M. Coroner (The Coroners' Society of England & Wales, 2025). Referrals happen for a variety of reasons. Referrals are made mainly by doctors and the Police. Upon receipt of a death report the Coroner will review the information and decide what should be done. Further information can be found on the Avon Coroner website. https://www.avon-coroner.com/

Decompressive Hemicraniectomy

A neurosurgical procedure to remove part of the skull which aims to reduce pressure in the brain. It is only considered in patients with a large stroke with significant swelling and can be lifesaving.

Electrocardiogram (ECG)

A test that records the electrical activity of the heart, including the rate and rhythm.

End of life care

End of life care is support for people who are in the last months or years of their life. The focus is on living as well as possible and to die with dignity. The team providing this care will ask about the person's wishes and preferences and take these into account as they collaborate with them to plan their care. The team will also support families, carers or other people who are important to the person. Further information is available on the NBT website End of Life Care | North Bristol NHS Trust

Hemispheric infarctions

Hemispheric infarction is a large stroke that damages most of one side of the brain. It occurs when a major blood vessel—often the middle cerebral artery—becomes blocked, cutting off blood flow and causing brain cells to die.

Inquest

If a death is reported to a coroner, the coroner must hold an inquest if:

- the cause of death is still unknown
- the person might have died a violent or unnatural death
- the person might have died in prison or police custody

Further information can be found on the Avon Coroner website. https://www.avon-coroner.com/

Learning from deaths

The framework and processes related to reviewing cases where people have died to understand what happened, to assess the quality of care provided, and find ways to improve care for future patients. Further information can be found on the NHS England website https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-deaths-in-the-nhs/

Learning from deaths policy

A policy that sets out how we review deaths in our hospitals, learn from care provided, and make improvements for future patients. The policy explains our review processes and governance arrangements in line with national guidance.

Medical Examiner (ME)

Medical examiners are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

You can find out more about the Medical Examiner's Service in Bristol, North Somerset, and South Gloucestershire on the BNSSG Healthier Together website, at https://bnssghealthiertogether.org.uk/the-medical-examiner-service/information-for-the-public/

Medical Examiner Officer (MEO)

Most bereaved families will speak with a Medical Examiner Officer, who are specially trained staff who support the Medical Examiners in their work.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries UK (MBRRACE-UK)

A national surveillance and investigation programme for deaths of women and babies who die during pregnancy or shortly after pregnancy in the UK. You can find out more about MBRRACE-UK on their website https://www.npeu.ox.ac.uk/mbrrace-uk.

Patient Safety Incident Response Framework (PSIRF)

The structure and processes that NHS organisations must use to look at patient safety incidents. An important aim of PSIRF is to understand how incidents happen, so that we learn and improve, and in turn create a safer care system. Further information can be found on the NBT website Patient Safety | North Bristol NHS Trust

PALS (patient advice and liaison service) and complaints team

The PALS and Complaints Team aim to resolve any concerns, queries, or questions that patients, their families, or members of the public raise with us about our Trust. Further information can be found on the NBT website How to Raise a Concern or a Complaint | North Bristol NHS Trust

PMRT (Perinatal Mortality Review Tool)

A standardised perinatal mortality review programme that runs across NHS maternity and neonatal units in England, Scotland, Wales and Northern Ireland. You can find out more about the PMRT on the programme website https://www.npeu.ox.ac.uk/pmrt

Sepsis

Sepsis is a common and potentially life-threatening condition. Without early identification and treatment there is a significant risk of long-term disability or death. Anyone, at any age can develop sepsis after an injury or minor infection, although some people are at higher risk. Sepsis can be extremely difficult to recognise and diagnose, but sometimes it can be prevented, and it is treatable in many cases. For further information on sepsis, please visit the NHS website https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/sepsis-work/

Statistical Process Control (SPC) Chart

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

action. SPC is used widely in the NHS and more information is available on the NHS England Website https://www.england.nhs.uk/statistical-process-control-tool/

Structured Judgement Review (SJR)

A detailed case notes review method developed by the Royal College of Physicians and recommended by National Learning from Deaths guidance. Trained clinicians assess care quality using structured judgements to identify learning opportunities, areas for improvement, and patterns across multiple cases that can benefit future patients. Further information can be found on the Health Innovation West of England website https://www.healthinnowest.net/wp-content/uploads/NMCRR-clinical-governance-guide-Final.pdf

Supportive and palliative care

The supportive and palliative care team provides care for patients and families with serious illnesses at any stage of their disease. Particularly if symptoms are having a negative impact on quality of life. The aim is to help patients live as actively as possible by providing high quality pain and symptom control as well as psychological, social and spiritual support. Specialists in the team also have expertise in supporting patients and their families who are living with a life limiting conditions. Further information can be found on the NBT website Palliative & End of Life Care | North Bristol NHS Trust

Treatment

The care someone receives to help with their illness or condition. This includes medication, operations, tests, and other care from the hospital's teams.

Appendices

Appendix 1: Regional Mortality Context

Table 6 shows NBT deaths in the context of total deaths recorded by the Office for National Statistics for England and the South West region during 2024-25.

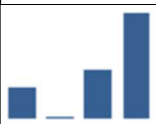
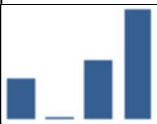
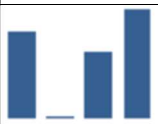
Quarter	Total Deaths England	Total Deaths South West England	Total Deaths NBT
Apr-Jun 24	129,986	15,035	513
Jul-Sep 24	122,110	13,934	484
Oct-Dec 24	134,802	15,503	569
Jan-Mar 25	149,810	16,884	531
			

Table 6: Office of National Statistics (ONS) comparison: Regional mortality context - NBT deaths compared with England and South-West totals, 2024-25

Appendix 2: Medical Examiner NHSE Reporting Categories 2024-25

Quarter	Total	SJR	Patient Safety	PALS	Thematic Feedback	Legal	Safeguarding
Quarter 1	32	11	11	7	8	4	0
Quarter 2	29	2	9	6	11	3	1
Quarter 3	56	7	16	17	21	4	5
Quarter 4	27	5	10	9	6	1	2

Table 7: Medical Examiner NHSE Reporting categories

Appendix 3: About the Summary Hospital-level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die based on average England figures, given the characteristics of the patients treated there. The SHMI covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged.

To help users of the data understand the SHMI, NHS trusts have been categorised into bandings indicating whether a trust's SHMI is 'higher than expected', 'as expected' or 'lower than expected'. The expected number of deaths is a statistical construct and is not a count of patients. The difference between the number of observed deaths and the number of expected deaths cannot be interpreted as the number of avoidable deaths or excess deaths for the trust.

The SHMI is not a measure of quality of care. A higher-than-expected number of deaths should not immediately be interpreted as indicating poor performance and instead should be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance (NHSE England, 2025).

SHMI data can be influenced by many factors including the complexity of patients treated, how conditions are recorded, and statistical variation. SHMI may not show normal patterns when there are clusters of deaths or care quality issues, as this requires detailed clinical review. Further background information and supporting documents, including information on how to interpret the SHMI, are available on the SHMI homepage https://digital.nhs.uk/data-and-information/publications/ci-hub/summary-hospital-level-mortality-indicator-shmi

University Hospitals Bristol and Weston NHS Foundation Trust

Learning from Deaths Annual Report 2024-25

For the period ended

31 March 2025

Contents

Foreword

From Associate Medical Director - Patient Safety, Mortality & Adult Safeguarding

The ability to learn from patient deaths is a vital component of delivering high-quality clinical care. Mandatory review processes play a key role in identifying recurring themes and issues linked to poor outcomes, helping us understand why these occur so that meaningful improvements can be made.

The Joint Mortality Improvement Programme, a collaboration between UHBW and NBT, was initially agreed in principle in 2020. However, due to the impact of the Covid-19 pandemic, it was only formally established as a jointly resourced initiative in February 2025. The programme is working closely with the BNSSG Medical Examiner team and wider system partners to develop a nationally exemplary mortality review model.

This 2024-25 annual Learning from Deaths report marks a significant milestone in our collaborative journey. For the first time, the frameworks used by UHBW and NBT are fully aligned, paving the way for a future combined report.

I would like to express sincere thanks to all colleagues involved in the Joint Mortality Improvement Programme across our Bristol NHS Group. Their expertise, dedication, and adaptability have been instrumental in achieving this progress and delivering this aligned report.

Dr Karin Bradley

Executive Summary

Our learning from deaths processes enables us to identify areas where we can improve care for future patients and recognise the excellent care that many families[1] specifically wanted us to acknowledge.

Key statistics for 2024-25

- **1,865 total deaths -** stable compared to 1,873 in 2023-24, with SHMI consistently 'as expected'
- **324 Medical Examiner referrals (17.3% of deaths) leading to 103 detailed reviews (5.5% of deaths)**
- **43 detailed case note reviews for mandatory priority groups** – 27 learning disability or autism, 16 severe mental illness

Key Achievements

- 96.6% of reviewed cases scored adequate, good, or excellent care
- 0 deaths assessed as "definitely avoidable"
- 81% of learning disability/autism patients had specialist team involvement
- 358 staff received end-of-life care education

Top learning themes

1. **Communication improvements** – changes in ward round practices and enhanced end-of-life communication training.
2. **Pain management enhancements** - improved use of specialist assessment tools.
3. **Care coordination** – improved handovers between teams and wards.

What families told us

Families praised our end-of-life care as "brilliant" and "excellent," whilst also raising communication concerns that led to specific improvements in ward round practices and family involvement.

Looking ahead to 2025-26

We will enhance digital systems for mortality, integrate Learning from Deaths with our Patient Safety Incident Response framework (PSIRF), and further strengthen system-wide partnerships across our region.

This report meets all statutory requirements under NHS Quality Account Regulations and National Quality Board Guidance - see Appendix 1 for detailed compliance mapping.

[1] Throughout this report, 'families' refers to family members, carers, friends, and all those who were important to the patient.

Section 1: Deaths in our care

1.1 Annual overview of deaths in our care

The national guidance on learning from deaths recommends reporting annual information on the total of in-hospital deaths recorded by each Trust. At UHBW, hospital deaths have remained stable year on year, with 1,865 total deaths in 2024-25 and 1,873 in 2023-24. Figure 1 shows the quarterly breakdown.

Across University Hospitals Bristol and Weston (UHBW), most deaths occur in older people with multiple long-term health conditions, often following acute deterioration of their condition. While these deaths may not be unexpected given the person's underlying health, we systematically review selected cases to identify ways to improve care and share good practice.

Child deaths, stillbirths, and maternal deaths

At UHBW, we provide dedicated services for children through the Bristol Royal Hospital for Children and Women's and Children's Services, including maternity services, through St Michael's Hospital.

Child deaths are excluded from this report as they follow separate specialist Child Death Review (CDR) processes with different timelines. CDR meetings are typically arranged within 3 months. However, post-mortem and investigation reports can take several months or years to complete, meaning data becomes available later than adult mortality data.

The CDR process at Bristol Royal Hospital for Children follows statutory guidance and is integrated with our quality and patient safety processes, which report through our Women & Children's Divisional Mortality Oversight Committee and Trust Mortality Steering Group.

The most recently published report covers 2022-23. During this period, 48 children died under our care, with modifiable factors identified in 5 cases and 30 improvement actions completed. Further details can be found in the 2022-23 Annual Child Death Review report. The 2023-24 report is due to be published in early autumn 2025.

Stillbirths, late fetal losses, neonatal deaths, and direct maternal deaths (deaths during pregnancy or within 42 days of delivery) are also excluded from this report as they follow separate national review processes.

Stillbirths, late fetal losses, and neonatal deaths are reviewed through the Perinatal Mortality Review Tool (PMRT), while maternal deaths are reviewed through the national Mothers and Babies: Reducing Risk through Audits and Confidential

Enquiries (MBRRACE-UK) process. These reviews involve teams from across divisions and follow specialised national guidance.

During 2024-25, we established new organisational oversight arrangements for perinatal mortality data, ensuring these reviews now feed through our Mortality Surveillance Group (MSG) for dedicated clinical scrutiny and learning, rather than being held only within the Women's & Children's directorate as they had historically.

The first report under this new arrangement was presented in April 2025 covering 2023 data, with 2023 neonatal data due to be presented shortly and 2024 data presentations to follow during 2025-26. Late maternal deaths (occurring more than 42 days after delivery) may be reviewed through the standard adult processes outlined in this report if they meet criteria for detailed case note review.

Total hospital deaths

The figures in this report include all deaths in our hospitals, with 'deaths reviewed' referring to adult deaths only due to separate processes for neonatal, child, and maternal deaths. Figure 1 demonstrates stable year-on-year mortality with normal quarterly variation. Regional mortality context is provided in Appendix 2.

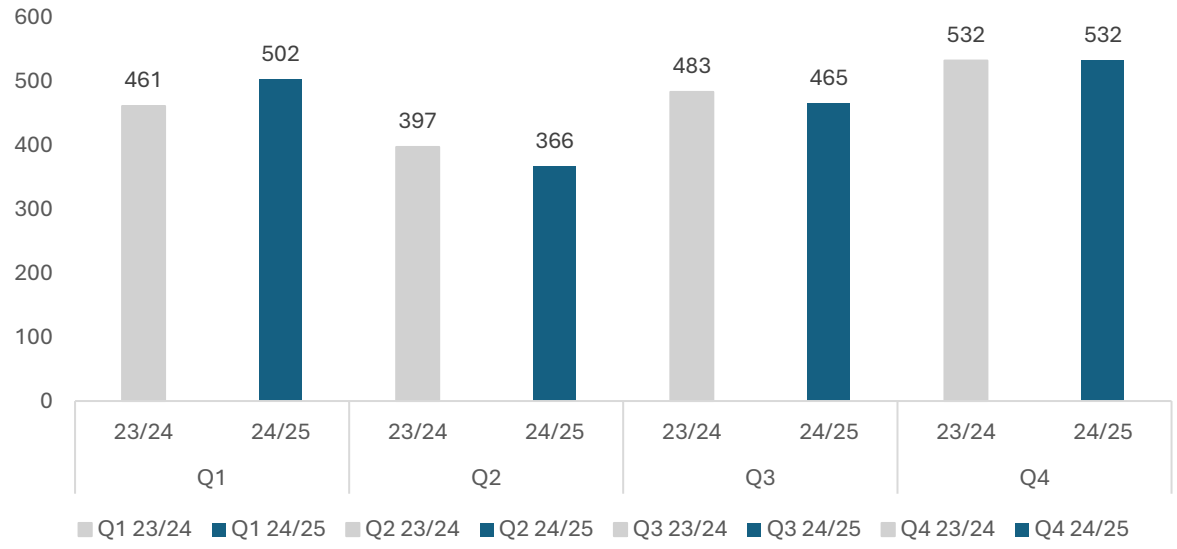


Figure 1: UHBW total deaths by quarter, 2023-23 and 2024-25 comparison

Hospital deaths by site

We monitor hospital inpatient deaths by site and division. Table 1 shows the total number of deaths by site. The variation reflects the different types of services provided at each hospital. For detailed breakdowns by site and division see Appendix 5.

Site	Number of Deaths
Bristol Royal Infirmary	1,115
Weston General Hospital	574
Bristol Haematology and Oncology Centre	104
Bristol Royal Children's Hospital	44
St Michael's Hospital	28

Table 1: UHBW Hospital deaths by site, 2024-15

1.2 Summary Hospital-level Mortality Indicator (SHMI)

We monitor our Summary Hospital-level Mortality Indicator (SHMI) alongside our mortality review processes to understand the factors contributing to our banding. SHMI helps organisations identify areas where deeper exploration through Learning from Deaths processes might be needed. For further information about SHMI, see Appendix 3.

We review our SHMI data every month to check for any changes or patterns such as statistical variations. We report this to our Trust Board every quarter, alongside information about Medical Examiner referrals and detailed death reviews, giving us robust oversight and surveillance, and a complete picture of mortality across our Trust. For further information about how we use our data alongside our review processes for learning from deaths, see Appendix 4.

The most up to date data for SHMI covers the period March 2024 – February 2025. UHBW's value for that full period is 89.44. The SHMI for UHBW has been consistently classified by NHS England as 'as expected' throughout 2024-25.

As illustrated in Figure 2, we have seen some normal variation in our in-month SHMI values, with values ranging from 74.54 to 101.68. This has not been outside the process limits; indicating statistical stability with no individual months outside of the control limits prompting concern.

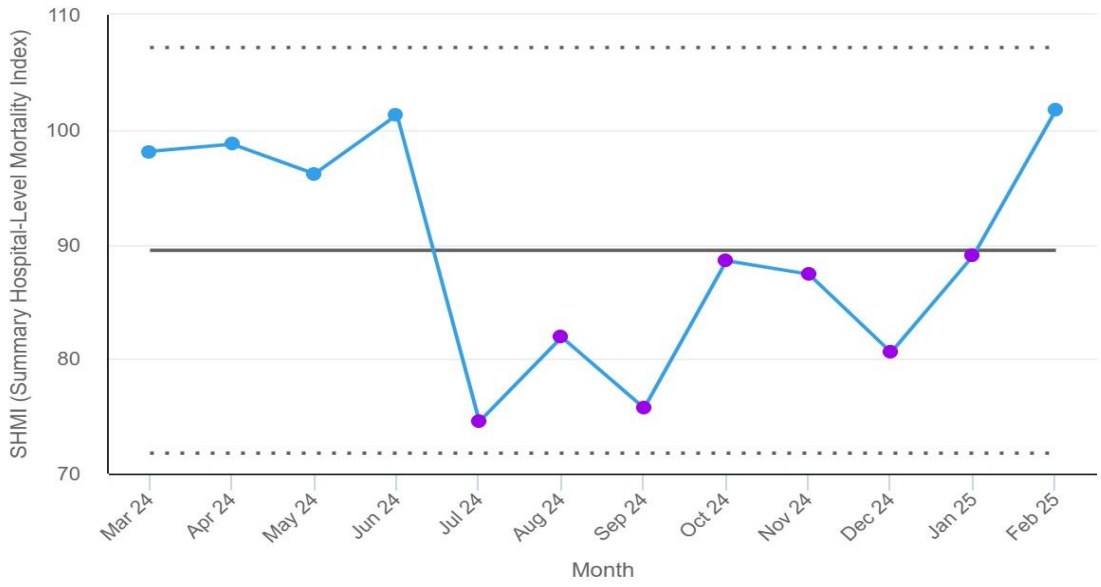


Figure 2: UHBW SHMI Monthly values with statistical process control (SPC) limits, March-2024-February 2025 (data extracted from CHKS, latest available at time of publication)

Our trajectory for SHMI shows more variation monthly than that of our peer organisations and is lower for nine months, showing a slightly higher figure for Mar 24, Apr 24 and Feb 25 as illustrated in Figure 3. The peer organisation figure is derived by averaging the SHMI totals of all acute NHS trusts and should show a greater consistency each month as an averaging of a large sample.

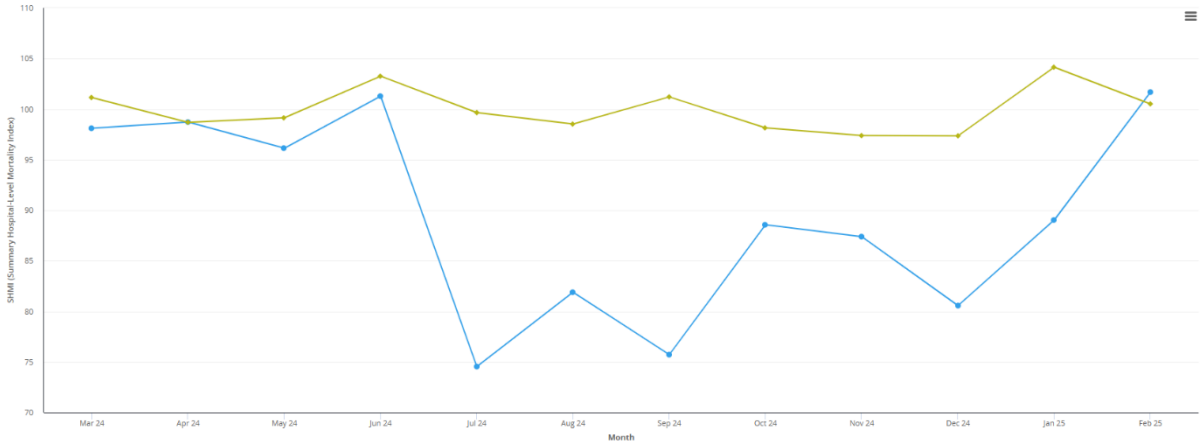


Figure 3: UHBW SHMI time series chart (UHBW in blue, peer group average in yellow), March-2024-February 2025 (data extracted from CHKS, latest available at time of publication).

Our peer distribution chart, see figure 4 below, shows that UHBW is at the lower end of the SHMI banding for the 12-month reporting period, which would be expected given that the majority of months UHBWs SHMI was lower than the peer average.

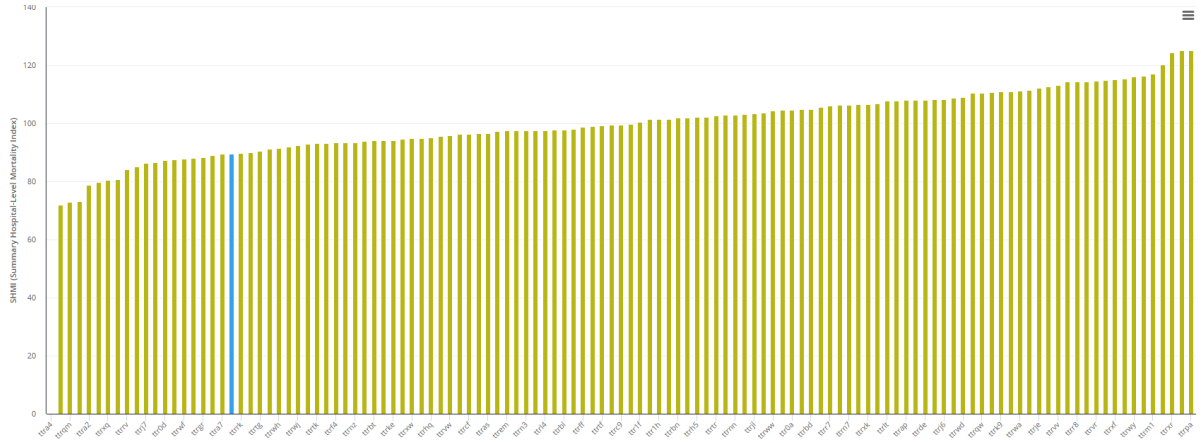


Figure 4: SHMI peer distribution chart. March-2024 to February 2025 (data extracted from CHKS, data latest available at time of publication). UHBW highlighted in blue.

While SHMI tells us about patterns across all our patients, our Learning from Deaths processes tell us about the quality-of-care patients receive. Through detailed reviews of individual cases, Medical Examiner scrutiny, and systematic learning, we can identify specific issues and improvements that overall statistics cannot reveal. Together, they give us a complete picture of both our statistical performance and the real experiences of patients and families.

1.3 Independent scrutiny of every death

The Medical Examiner Service

When a patient dies at UHBW, their care record is updated and the care received by the patient is independently reviewed by the Medical Examiner.

Since 9 September 2024, all deaths in England and Wales that are not investigated by a coroner must now be reviewed by NHS Medical Examiners, following the Department of Health and Social Care's Death Certification Reforms.

Bristol, North Somerset and South Gloucestershire (BNSSG) Service

In 2020, we worked together with North Bristol NHS Trust to establish the BNSSG Medical Examiner service ahead of the statutory requirement date, ensuring we had independent scrutiny of deaths and care quality four years before it became legally required.

During 2024-25, the service scrutinised all UHBW adult deaths not referred to the coroner. Following the introduction of the statutory Medical Examiner requirements in September 2024, the service also scrutinised 100% of child deaths not referred to the coroner. This provided independent assurance for cause of death accuracy and gave every bereaved family the opportunity to raise concerns or receive answers about the care provided.

We also work closely with the Senior Coroner and with the Medical Examiner Service providing clinical input on coroner referrals where appropriate, helping to maintain comprehensive oversight across deaths in our hospitals.

Section 2: How we review and learn from deaths

2.1 Our approach to reviewing deaths

We follow the National Learning from Deaths guidance for reviewing adult in-hospital deaths, and we meet all statutory reporting requirements under the NHS Quality Account Regulations. For detailed compliance data, see Appendix 1.

Deaths at UHBW receive Medical Examiner scrutiny in line with statutory requirements. Where this scrutiny identifies concerns or where deaths meet specific criteria, we undertake the appropriate type of further review as detailed in our Learning from Deaths policy.

Some deaths require a full detailed review regardless of whether concerns are raised, as described in section 2.2.

Our responses to Medical Examiner referrals

The Medical Examiner service enables families and carers to provide both positive and negative feedback. When the Medical Examiner identifies a concern or learning opportunity, this is referred into our Trust Governance team. The UHBW trust mortality lead (Associate Medical director) reviews each Medical Examiner referral to ensure the right response and next steps are taken. Further details on the different responses and processes used are available in the UHBW Learning from Deaths Policy.

Between April 2024 and March 2025, the Medical Examiner Service referred 324 cases to UHBW. The breakdown of referral type is illustrated in table 2 and Figure 5 below.

Medical Examiner Referral Type	Number of Referrals
Concern only	277
Positive feedback and care concerns	15
Positive feedback only	32

Table 2: Medical examiner referrals to UHBW by type of referral, 2024-25

Referral rates vary between trusts, reflecting differences in case mix, reporting thresholds, and operational models. We continue to work with the Medical Examiner service to ensure consistent approaches across our Bristol NHS Group.

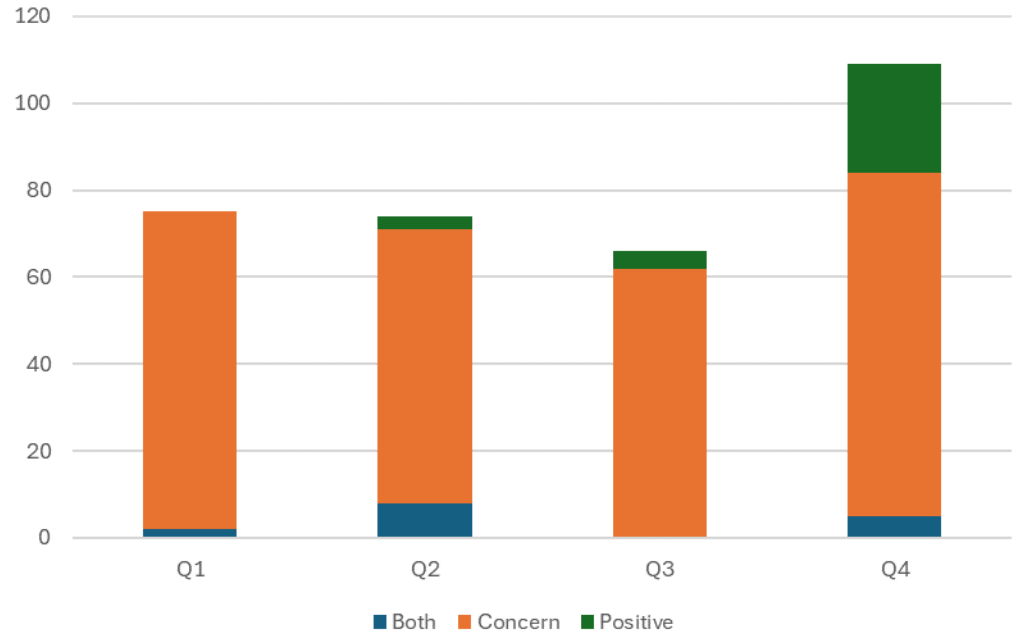


Figure 5: Medical examiner referrals by type and quarter, 2024-15

Our responses included providing feedback to clinical teams about specific care improvements, connecting families with our Patient Advice and Liaison Service (PALS) for support, and initiating Patient Safety learning response, ensuring any identified incidents are reported and any learning explored through established patient safety processes.

For cases referred following a concern, 103 cases were identified as suitable for a detailed case note review, called a Structured Judgement Review (SJR). Figure 6 shows how we responded during 2024-25. A full quarterly breakdown is available in Appendix 6.

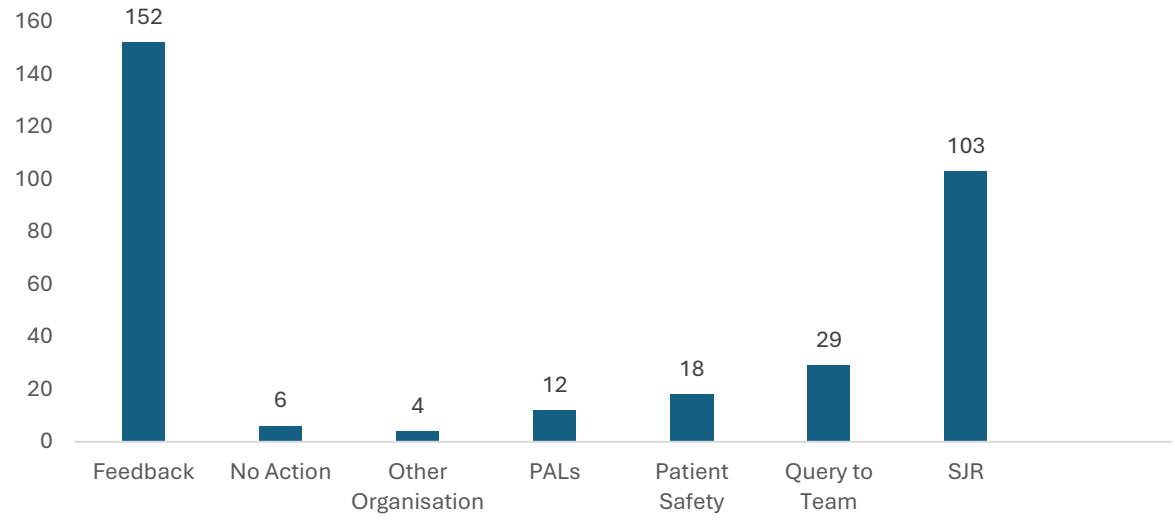


Figure 6: UHBW responses to Medical examiner referrals by type, 2024-25

This year, we responded to Medical Examiner referrals in a range of ways. We shared feedback with clinical teams, initiated SJRs, and referred cases to patient safety or PALS teams. Each response is carefully considered to support bereaved families and ensure learning while being mindful of staff wellbeing. For example, feedback may go to the ward matron or consultant rather than individual staff members, depending on the situation and what will be most constructive for learning and improvement. This reflects our continued work to embed the Patient Safety Incident Response Plan and to refine how we respond to concerns and feedback.

In relevant cases, we used more than one response. For example, completing an SJR while also referring families to PALS for additional support. Our shared goal is to ensure each referral leads to meaningful action and learning.

As expected, Weston General Hospital and Bristol Royal Infirmary have generated the most reviews, as they house our medical inpatient services caring for elderly, frail patients with complex care needs.

We monitor referral variations closely, noting changes across quarters and compared to previous years. While the Medical Examiner service operates independently, we maintain regular communication and have confirmed that recent variations are not concerning. The variation partly reflects the service becoming statutory in September 2024, and we expect to see further natural variation in referral patterns as the service continues to mature.

Learning from family feedback

The Medical Examiner Service contacts bereaved families to discuss the cause of death and ensure death certificates are accurate. As independent senior doctors, Medical Examiners can answer questions about the cause of death and provide an independent perspective on care.

During these conversations, families can raise concerns or share positive feedback about any aspect of care. This feedback is passed to our Trust Governance Team through referrals, and families are also given details of our Patient Advice and Liaison Service (PALS) and bereavement support services if they need additional help.

The Medical Examiner's office submits data to NHS England on a quarterly basis outlining the nature of referrals. Further information about the Medical Examiner process and coroner referrals is available on the BNSSG Healthier Together website https://bnssghealthiertogether.org.uk/the-medical-examiner-service/information-for-the-public/

2.2 Which deaths we review in detail

Beyond the Medical Examiner's scrutiny of every death, we conduct detailed case note reviews, called Structured Judgement Reviews (SJRs) for specific cases. This is in line with National Quality Board Guidance.

We use SJRs to learn from deaths in several situations:

- When families, carers, or staff have raised concerns about the care provided.
- When a person had learning disabilities or severe mental illness, as these groups are known to experience poorer health outcomes.
- When the Medical Examiner has identified potential learning opportunities.
- When there are patterns in data or alerts from regulators that suggest we need to look more closely at care in particular areas.
- When deaths happen in situations where they wouldn't normally be expected. For example, during a planned procedure.
- When reviewing deaths will help us improve care we're already working on. For example, if we have a quality improvement priority relating to a specific condition or treatment.

During the reporting period, no alerts or alarms from external sources, such as the CQC, triggered SJRs. We introduced an aligned approach to NHSE VLAD chart monitoring with NBT in Q4 of the reporting period and we have seen both upper and lower control limit breaches; however, these did not trigger case note reviews.

When we identify alerts or variations outside control limits in our mortality data, we follow the NHS England's 'pyramid of investigation for special cause variation' approach – first checking coding accuracy, triangulating with national clinical audit data, and undertaking case note reviews only when clinically indicated. As part of our mortality improvement programme, we are further developing proportionate and aligned responses to statistical variations to ensure appropriate review and oversight across our Bristol NHS Group.

The combination of Medical Examiner scrutiny and SJRs helps us identify the most significant learning opportunities, and ensures we promptly direct cases to the right review process.

Mortality review completion and referral outcomes

All adult in-hospital deaths at UHBW are scrutinised by the Medical Examiner unless referred to the coroner. This scrutiny supports accurate certification and provides an opportunity to identify and respond to any concerns raised during the process.

What happens when patient safety concerns are raised

Most patient safety concerns are identified and acted on immediately through staff logging an incident on our patient safety incident reporting system, Datix. This means we can respond quickly, before the death certification and mortality review process.

If a Medical Examiner referral identifies as a patient safety concern, a patient safety response is initiated rather than an SJR. This is because Patient Safety Incident Response Framework (PSIRF) responses are specifically designed for these events. Inquests or PSIRF responses may supersede the need for an SJR.

In the less likely event that an SJR itself identifies a significant care or safety concern; we immediately initiate a patient safety response. As part of this, we communicate with families and all relevant parties, in line with our duty of candour responsibilities. Our PSIRF plan outlines how we undertake investigations and other learning responses to patient safety incidents. Further information our PSIRF plan is available on the UHBW website https://www.uhbw.nhs.uk/assets/1/uhbw_psirf_plan_v1.2_updated_approved.290824.pdf

This is in line with the National Patient Safety Strategy. Further information on the national strategy is available on the NHS England website https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

Structured judgement review (SJR) distribution

During 2024-25, we undertook SJRs on 5.7% of adult deaths, all of which were initiated in line with NQB guidance. There is no target for the number of SJRs that should be undertaken.

The total number of SJRs completed at UHBW and the reasons for their initiation are detailed in Table 3.

Death Review Process	Q1	Q2	Q3	Q4	All
Adult In-hospital Patient Deaths Scrutinised by Medical Examiner	485	341	447	513	1794
Patient deaths referred to UHBW by the Medical Examiner	75	74	66	109	324
Patient had a diagnosis that put them at risk of poorer healthcare outcome – Learning disability or autism	*7*	*9*	*6*	*5*	*27*
Patient had a diagnosis that put them at risk of poorer healthcare outcome – Severe Mental Illness	*8*	*4*	*1*	*3*	*18*
Treatment or care concern	*14*	*13*	*11*	*22*	*60*
Total Structured Judgment Reviews Initiated	**29**	**26**	**18**	**30**	**103**

Table 3: Table showing breakdown of SJR reviews as a result of a medical examiner referral, 2024-25

Over 2024-25, the number of SJRs undertaken across UHBW has not been evenly distributed. This is illustrated in Figure 7. This is because some divisions have more deaths due to the types of patients they treat. However, we recognise that we should make sure there are not areas in the Trust where no reviews are undertaken. Therefore, we will work to refine our SJR process in 2025-26 to ensure we have a representative sample of SJRs from across all bed-holding divisions where SJRs are the primary review method for adult deaths.

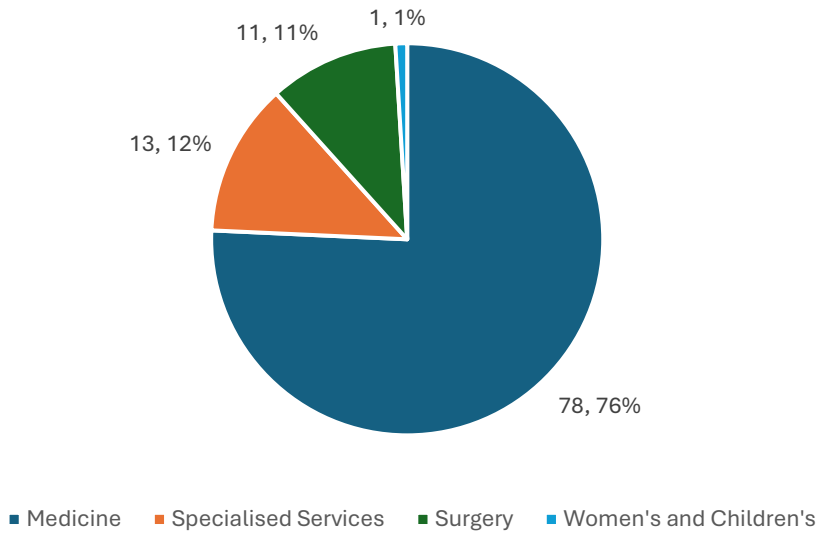


Figure 7: Distribution of SJRs by Division, April 2024-March2025

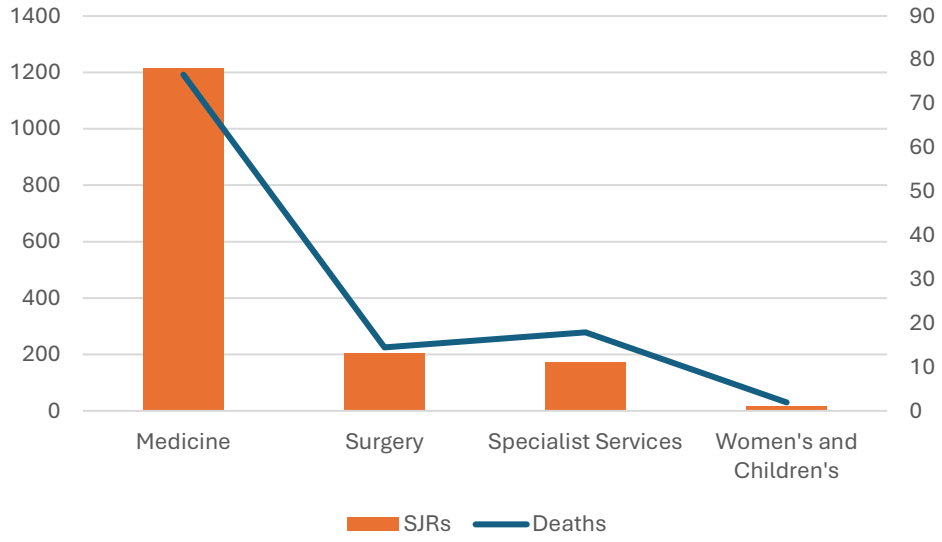


Figure 8: Total deaths by division with corresponding SJR numbers, 2024-25

Figure 8 illustrates the relationship between total deaths and SJR numbers by division, demonstrating that SJR distribution broadly reflects the volume of deaths in each area.

This year, we initiated 43 reviews because patients had conditions that put them at higher risk of poorer health outcomes, and 60 reviews following concerns raised by the Medical Examiner or families.

For referrals involving patients with a learning disability, autism, or severe mental illness, as well as elective admissions and cases referred due to care concerns, we monitor the initial decision made following Medical Examiner scrutiny. This includes whether the case proceeded to SJR, a PSIRF response, or was subject to inquest proceedings.

Table 4 shows the number of cases where each response type was initiated. It reflects decisions at the point of referral but does not capture review completion or overlapping pathways.

Response	Inquest	No Inquest
SJR	15	88
Patient Safety Response	3	15
Other Response	3	168

Table 4: Table showing initial responses to Medical Examiner Referrals by inquest status, 2024-25

During the reporting period, 324 referrals were made by the Medical Examiner. Of these, 103 met the criteria for SJR. The remaining cases resulted in a range of responses, including clinical team feedback, PSIRF responses, and PALS support. Some cases triggered more than one response (e.g. SJR and PALS), but only one response type is counted per row for reporting clarity.

While each referral decision is recorded, the manual nature of our current systems makes it difficult to produce a consolidated view across all review pathways. We are working to improve this through our digital development programme, as outlined in Section 5.4.

2.3 Mortality review completion times

We aim to complete all mortality reviews as soon as practical to ensure that relevant parties receive feedback promptly and that learning can be implemented without delay.

In 2024- 25, the median time from death to final Mortality Surveillance Group (MSG) sign-off for a Structured Judgement Review (SJR) was 152 days, with an average of 106 days to divisional sign-off. However, this varies depending on the type of review required and the stage at which it is initiated. In some instances, divisional leads

initiate reviews when prompted by the mortality review administrator, meaning that initiation and completion can appear concurrent in our data.

Table 5 and Figure 9 summarises the average time taken to complete each stage of the SJR process.

Review Phase	Average Days to Complete
Patient Death to SJR Opened	43.29
SJR Opened to Learning Disability Specific Review	12.72
SJR Opened to Mental Health Specific Review	78.38
SJR Opened to Clinical Team Review	98.54
SJR Opened to Divisional Sign Off	106.44
SJR Opened to Mortality Surveillance Group Sign Off	152.10

Table 5: Table showing average time to complete SJR stages, 2024-25

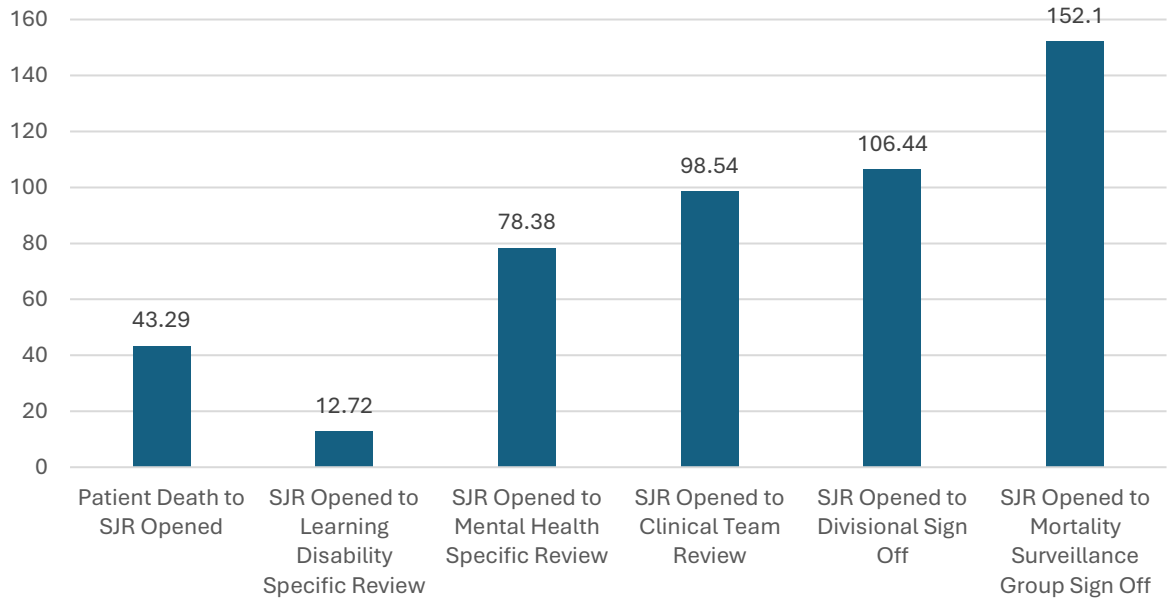


Figure 9: Bar chart showing average time to complete SJR stages, 2024-25

During 2024-25, we faced several challenges that affected our review timelines. A vacancy in our Medicine Division mortality lead role from April 2024 to January 2025 caused temporary delays in completing reviews. We addressed this by training Clinical Fellows in the Emergency Department to complete Medicine Division reviews, successfully clearing the backlog. We appointed our new Medicine Division lead in January 2025.

The Medical Examiner team also experienced staffing pressures in the final quarter, which led to an 8-week delay in referrals during our busiest period. We worked

closely with the Medical Examiner team to restore timely processes and ensure feedback from families continued to flow to clinical teams.

Our current manual data collection processes also limit our ability to analyse data in real-time. As part of our improvement programme, we will be investing in digital solutions to address these limitations and reduce manual administration time.

2.4 Assessing the quality of care we provided

In all SJRs, a number from “very poor” (1) to “excellent” (5) is used to indicate how good the care was during different phases of a patient's time in hospital. These scores are standard in NHS Trusts. They are the reviewer's professional and initial judgement based on what they can see in the medical notes at the time of the review. If there are concerns about the care, this will always trigger a further review to make sure the right process is followed.

When we identify areas for improvement in care, we work collaboratively with teams to understand what happened and prevent similar issues. Examples of improvements we have made are detailed in Section 4.

If a SJR identifies a potential problem in care that may have led to harm, NHS trusts are required to assess whether the death might have been avoided with different care or treatment. To do this, NHS trusts use a national scale from “definitely not avoidable” (1) to “definitely avoidable” (6). These ratings are the reviewer's professional and initial judgement only and are based on what they can see in the medical notes. An initial judgement of a potentially avoidable death is not an assignment of blame and will always trigger a further review to make sure the right process is followed.

If a review identifies poor care, a problem in care, or where the death might have been avoidable, we take further action to investigate and ensure appropriate action is taken. This is always in line with our commitment to openness and transparency, and with our Patient Safety Incident Response Plan (PSIRP).

Mortality and Morbidity Meetings

Alongside clinical audits, monitoring of mortality data, SJRs, and other responses described in this report, all clinical specialties in UHBW hold regular Mortality and Morbidity (M&M) meetings. These meetings are an essential element in clinical governance, and key practice in our drive towards continuous quality improvement.

M&M meetings examine both deaths and morbidity, including complications that cause patients to need further intervention or a prolonged stay in hospital. This includes specifically defined complications, incidents or misadventures causing morbidities, and any other unexpected morbidity based on clinical judgement.

The meetings are used to review cases, data, and to share learning within specialties and divisions. Cross divisional learning is shared through upward thematic reporting of the outcomes of mortality and morbidity reviews.

Our meetings are conducted in a spirit of learning and continuous improvement, and there is open and transparent review of individual cases. Teams use meetings to develop action plans and prevention strategies, without resorting to blaming others. The aim is to help colleagues deliver safer care.

The learning from these meetings feeds into the broader mortality surveillance processes described throughout this report, ensuring that insights from frontline clinical practice inform Trust-wide improvements.

2.5 What we learned

Overall care scores

Of the 103 SJRs initiated in 2024-25, 74 have been completed and 29 remain in progress.

The majority of completed SJRs scored overall care as good (4) or excellent (5).

The percentage of cases reviewed with an overall care score of adequate, good, or excellent for 2024-25 was 94.6%. Table 6 shows the complete breakdown of SJR overall care scores by quarter.

			Overall Care Score				
Quarter	Total SJRs	Open	Excellent	Good	Adequate	Poor	Very Poor
Q1	29	6	5	15	3	0	0
Q2	26	11	6	7	2	0	0
Q3	18	6	2	8	0	2	0
Q4	30	6	7	6	9	1	1

Table 6: Table showing SJR overall care score by quarter, 2024-25

A review of SJR scores over 2024-25 shows that we are consistent in our care ratings with minimal fluctuation. Our analysis indicates that significant learning opportunities exist across all care score categories, including cases rated as adequate to excellent.

Three reviews in 2024-25 scored overall care as poor (2). The learning from these cases related to patient safety incidents involving factors such as winter pressures, National Early Warning Score (NEWS) monitoring, and discharge protocols.

Nine reviews scored overall care as adequate (3). These reviews identified learning and triggered improvements in relation to cardiac investigations and recognition of end-of-life care needs. The full distribution of care scores is shown in Figure 10.

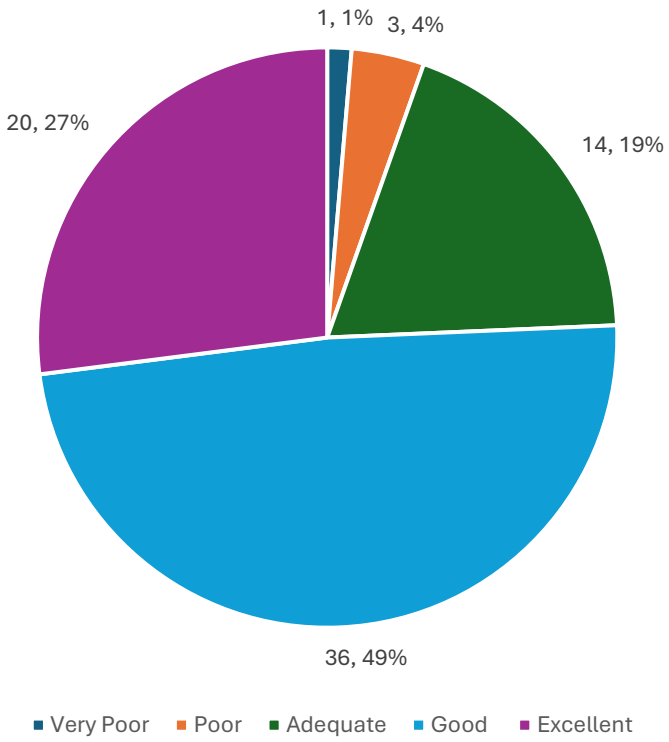


Figure 10: Pie chart showing overall SJR care score distribution for 2024-25

Avoidability Ratings (1-6 scale)

Across all quarters, most completed reviews were scored as slight evidence of avoidability (23%) or definitely unavoidable (73%). 2 reviews were scored as probably avoidable but unlikely – less than 50:50, and 1 was scored as possibly avoidable - more than 50:50. The full breakdown is shown in Table 7. Figure 11 illustrates the quarterly distribution of these avoidability assessments.

No deaths were assessed as definitely avoidable or strong evidence of avoidability. This pattern is expected, as the Medical Examiner service would likely identify cases with more immediate concerns about avoidability and direct them to the appropriate investigation processes rather than for SJR.

			Avoidability Score					
Quarter	Total SJRs	Open	Definitely Unavoidable (6)	Slight Evidence of Avoidability (5)	Possibly Avoidable but Unlikely, less than 50:50 (4)	Probably Avoidable, more than 50:50 (3)	Strong Evidence of Avoidability (2)	Definitely Avoidable (1)
Q1	29	6	18	4	1	0	0	0
Q2	26	11	13	2	0	0	0	0
Q3	18	6	8	3	1	0	0	0
Q4	30	6	15	8	0	1	0	0

Table 7: Table showing avoidability scores by quarter, 2024-25

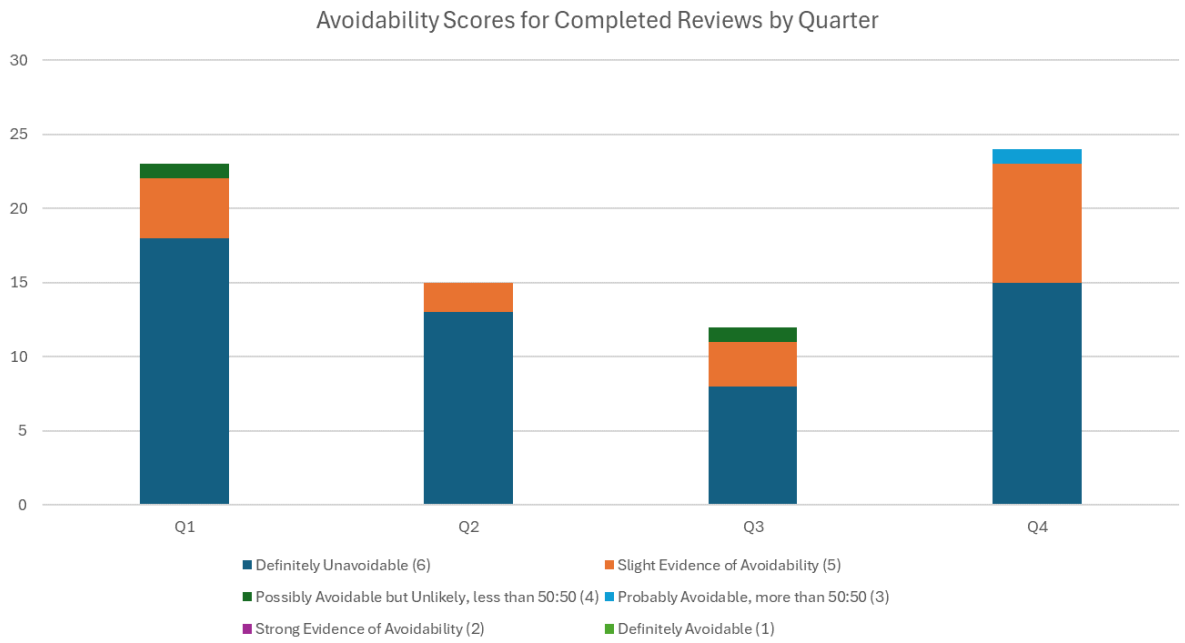


Figure 11: Clustered bar chart showing avoidability scores by quarter, 2024-25

Common themes and our responses

The vast majority of cases reviewed receive positive feedback or raise no concerns about care quality. However, we take every concern seriously and use this feedback as an opportunity to learn and improve.

We categorise the referrals we receive to help us understand patterns in what families and the Medical Examiner Service are telling us. Figure 12 shows the five most common themes in 2024-25.

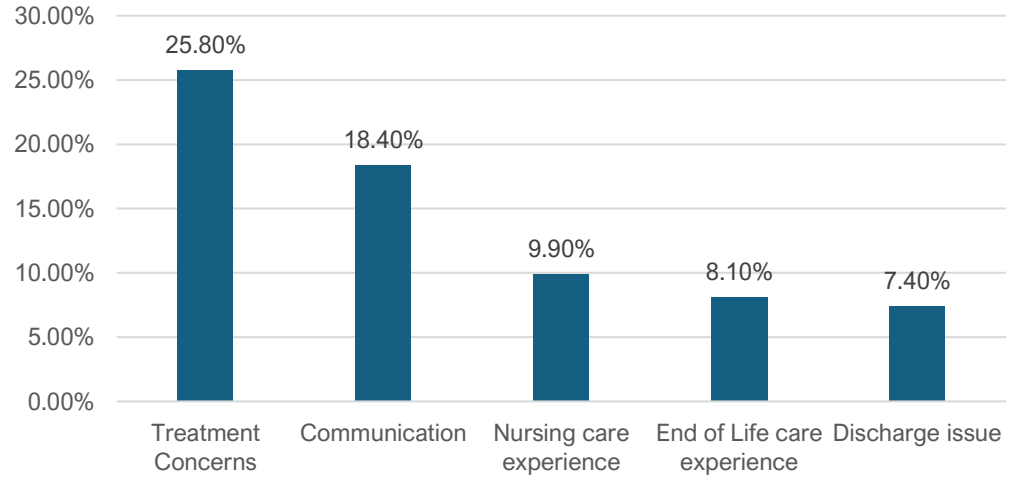


Figure 12: Top 5 Medical examiner referral themes by frequency, 2024-25

Treatment concerns

Treatment-related concerns were the most frequent theme in 2024-25, with referrals related to the timeliness and communication around treatment decisions. One family raised concerns around a potential diagnostic delay, and that test results were not reviewed promptly. Another highlighted that supportive and palliative treatment options were not fully discussed following a poor prognosis. A third felt that delays in cardiac surgery and a prolonged hospital stay may have had an impact on their family member's wellbeing. Each concern was fully reviewed and actions taken to improve care.

Communication with patients, families and between our staff

Following feedback, we have also reviewed concerns about how sensitive information and care decisions were communicated. One family felt that important care decisions were made without adequate discussion with them, leaving them feeling excluded from the process. Another felt frustration about inconsistent messaging from different staff members, which created confusion about prognosis. A third was distressed by how difficult news was communicated in what they felt to be an inappropriate setting. In response, we've strengthened our approach to involving families in ward rounds and provided targeted training for senior clinicians on sensitive communication.

Nursing care experience

Some families shared concerns about aspects of nursing care, particularly in relation to symptom management and responsiveness to individual needs. One family felt that staff did not adequately respond to their observations about changes in the patient's condition. Another raised concerns about delays in addressing comfort care needs. A third described how symptoms were not well controlled overnight despite nurses being kind and doing their best.

Following review of these concerns, feedback was shared with the responsible clinical teams and ward matrons for local action and learning. We have strengthened our handover processes to ensure better symptom monitoring and family communication, with particular focus on incorporating families' observations into care planning.

Discharge processes

During the year, we have listened to and learned when people felt we could improve discharge planning for patients who remained unwell. One family described concerns about discharge decisions when their relative appeared to still need hospital care. Another reported inadequate planning for home support needs. A third felt that delays in planned procedures and extended hospitalisation may have had an impact

on their family member's wellbeing. Following review of these concerns, feedback was shared with relevant teams for local learning and action.

End of life care experience

Across 2024-25 we have also reviewed feedback from family member's experiences around the timing and coordination of end-of-life care. One family raised concerns about delays in transitioning to comfort-focused care and late specialist involvement. Another felt that opportunities for earlier specialist input were missed. A third raised concerns about delays in recognising changing care needs despite clinical indicators. In response, we have strengthened our end-of-life care recognition processes and improved coordination between teams to ensure more timely palliative care involvement.

Learning from coroner's inquests

Following any coroner's inquest or Regulation 28 report, we work closely with our colleagues in legal services to identify learning and review our own processes to determine what improvements we should make.

Our monthly Inquest Core Group meeting involves the Trust Medical Director and Director of Nursing along with mortality, patient safety and divisional representatives to plan for complex inquests and to disseminate learning from completed inquests. Our legal team also produces a quarterly briefing note on Prevention of Future Deaths reports to advise the Trust on local and national themes arising from these reports and consider actions to mitigate future risks.

We maintain regular liaison with the coroner's office and continue to monitor developing cases to ensure appropriate learning is captured when inquests conclude.

Learning from excellent care

Positive feedback from the Medical Examiner and from families is a vital part of our learning. It helps us recognise excellent care and share examples across the Trust and the Bristol NHS Group so that good practice can be celebrated and spread.

Several families shared praise for the care their loved ones received. One family described the oncology and ward teams as "absolutely fantastic" and "second to none," highlighting the dedication shown across multiple wards. Another family commended the "first-class" care provided in A&E and on the ward during a final admission. A third family described the staff as "phenomenal," going "above and beyond" in their care. These reflections offer a powerful reminder of the compassion, professionalism, and excellence shown by staff during some of the most difficult moments for patients and their families.

Section 3: Learning from Lives and Deaths – People with a Learning Disability and Autistic People (LeDeR)

The Learning from Lives and Deaths (LeDeR) programme was set up by NHS England in 2017. The aims of the programme are to:

- Improve care for people with a learning disability and autistic people
- Reduce health inequalities for people with a learning disability and autistic people
- Prevent people with a learning disability and autistic people from early deaths

"A LeDeR review is not a mortality review. It does not restrict itself to the last episode of care before the person's death. Instead, it looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. LeDeR reviews take account of any mortality review that may have taken place following a person's death." (NHS England, 2025)

When someone with a learning disability or autism dies within UHBW, we share information with the LeDeR team. This helps the team understand the full picture of that person's care and identify ways to improve services for other people.

The LeDeR team publish their findings in annual reports. Further information can be found on the NHS England website https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/

Supporting people with a learning disability and autistic people

We have specialist teams working seven days a week to support patients with a learning disability or autism during their admission. The Sirona Learning Disability and Autism Team provides expert advice on reasonable adjustments and capacity assessments, while our UHBW Adult Learning Disability and Autism Service helps patients communicate their needs. Our Learning Disability and Autism Lead Nurse coordinates with the national LeDeR programme and our mortality governance processes.

3.1 Learning disability and autism reviews

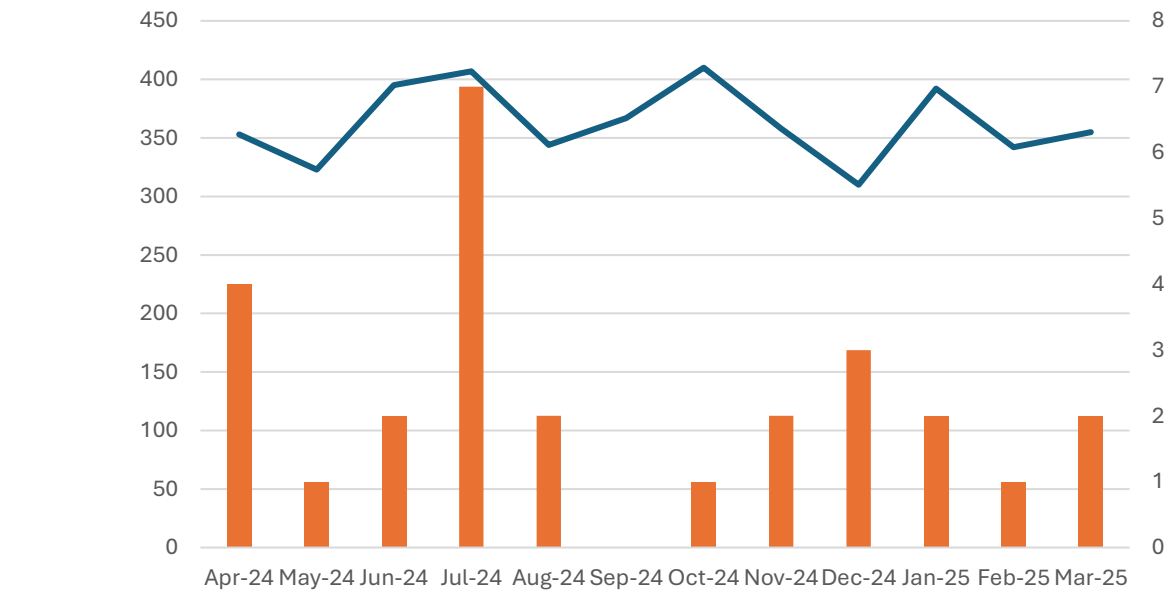
We complete a priority review for all patients who have died at UHBW with a learning disability or autism diagnosis. Because these patients are known to experience poorer health outcomes due to healthcare inequalities, we ensure that all Learning Disability and Autism deaths are subject to an enhanced review process which involves specialist questions and input from the Learning Disability and Autism Team in addition to a senior doctor completing an SJR.

When we complete a review, the findings are shared with senior staff in the relevant department for immediate local action. All learning is reported to our Learning Disability and Autism Steering Group, which oversees trust-wide improvements for this patient group.

All deaths are also reviewed by the Bristol, North Somerset, and South Gloucestershire (BNSSG) multi-agency LeDeR panel. This panel brings together health and social care professionals to identify system-wide patterns and issues affecting multiple organisations. This process ensures improvements benefit all people with a learning disability or autism and help prevents problems recurring elsewhere.

Annual overview

Mortality and admission rates for patients with a learning disability or autism have been tracked throughout 2024-25, as illustrated in figures 13 and 14. Despite fluctuations during the year, admissions for patients with a learning disability or autism have remained relatively consistent.



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Mortality	4	1	2	7	2	0	1	2	3	2	1	2
Admissions	353	323	395	407	344	367	410	358	310	392	342	355

Figure 13: Admission and Mortality rates for patients with a diagnosis of a learning disability or Autism

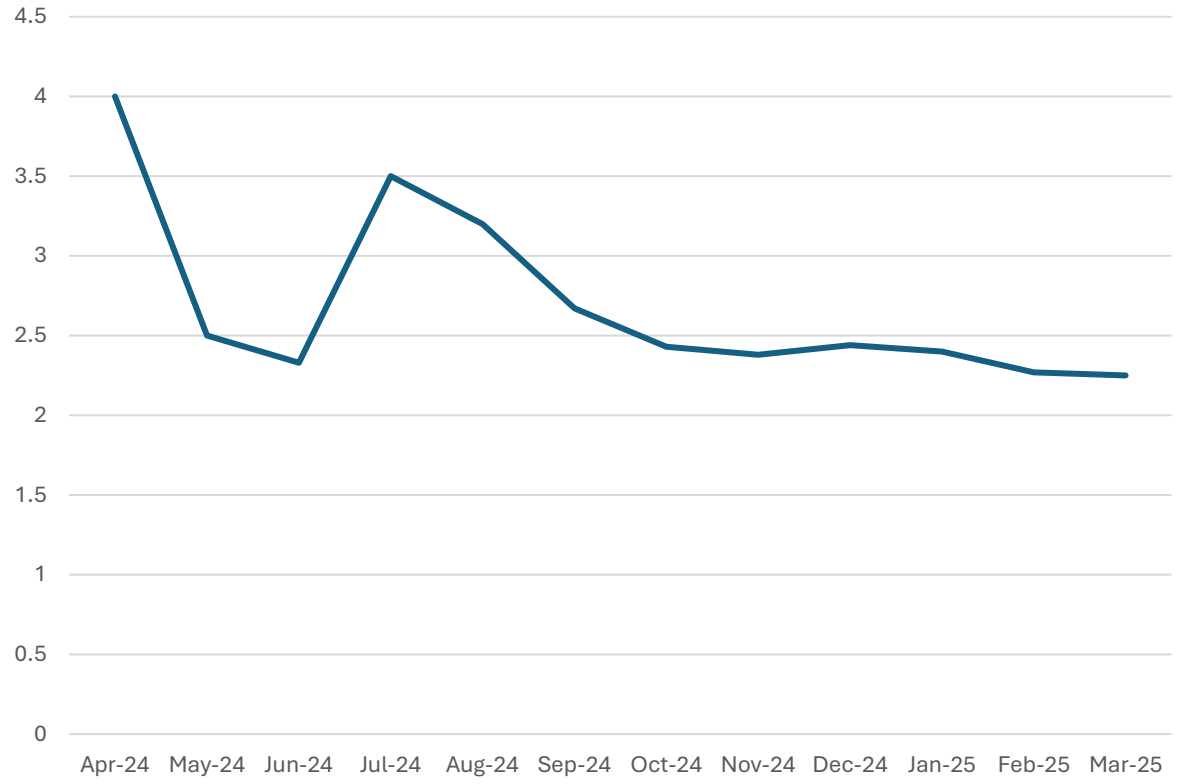


Figure 14: Chart showing the average monthly number of learning disability and autism deaths beginning April 2024 calculated to March 2025, based on date of death

The monthly mortality data shows that whilst there was an increase in deaths in July 2024 (7 deaths compared to 1-2 in other months), all cases were reviewed through our enhanced processes with no common themes identified that would suggest systematic care issues. Rates then returned to previous levels for the remainder of the year.

Due to the number of data points we have access to for 2024-25, it is difficult to determine statistically whether this July increase represented genuine variation or expected fluctuation. As we build up sufficient baseline data over the coming years, we plan to implement statistical process control (SPC) charts to better distinguish between normal variation and genuine signals requiring further investigation.

We are assured that all deaths of people with a learning disability or autism are reviewed, and we work closely with the BNSSG LeDeR panel and national LeDeR programme to understand whether our patterns reflect wider regional or national trends in care quality and outcomes.

During the reporting period, 27 people with a learning disability or autism died within UHBW. This is similar to 29 in the previous year. This represents about one-third of

the 86 deaths across our BNSSG health system, indicating that fewer people with a learning disability or autism are dying in hospital compared to community settings.

The stability in UHBW hospital death numbers, alongside the proportion dying in community settings, suggests several positive trends that will be explored by the LeDeR teams. People with learning disabilities and autism may be receiving more appropriate care closer to home, with hospital admission reserved for when specialist acute care is genuinely needed. This aligns with national policy promoting community-based support and reducing unnecessary hospitalisation.

However, we remain vigilant about ensuring appropriate access to hospital care when required. Our enhanced SJR process ensures each death is reviewed to identify and address any barriers to appropriate care or concerns about the person's experience.

The consistent numbers may also reflect improved identification and coding of diagnoses, helping us better identify and support people with a learning disability or autism during their hospital stay.

3.2 Learning disability and autism mortality review completion times

The specialist review process for people with a learning disability or autism may take longer than other SJR categories. It is our view that the added benefit of a more thorough review justifies this extended timeline.

Other governance routes, such as PSIRF responses, complaints, and PALS are in place to address any immediate concerns should they arise prior to SJR completion.

During 2024-25, we initiated 30 reviews for patients with a learning disability. Of these 29 have been completed by the Learning Disability Team. The remaining review is in progress at the time of writing this report.

The average time from death to review initiation is 43 days, with sign off at the Mortality Surveillance Group taking place on average 152 days after the review was opened, as illustrated in Section 2.3. These timelines reflect the detailed nature of the reviews and the need for LeDeR compliance.

3.3 What we learned

Our reviews have identified several areas for improvement alongside examples of excellent care.

Overall care scores

Over the reporting period, 20 reviews were completed and signed off for patients who died with a learning disability or autism. 5 reviews had an overall score of 5 or Excellent, 13 reviews scored 4 or Good, and 1 as adequate or 3. There was one

review where the overall care score was poor. The breakdown of overall care scores is illustrated in Figure 15.

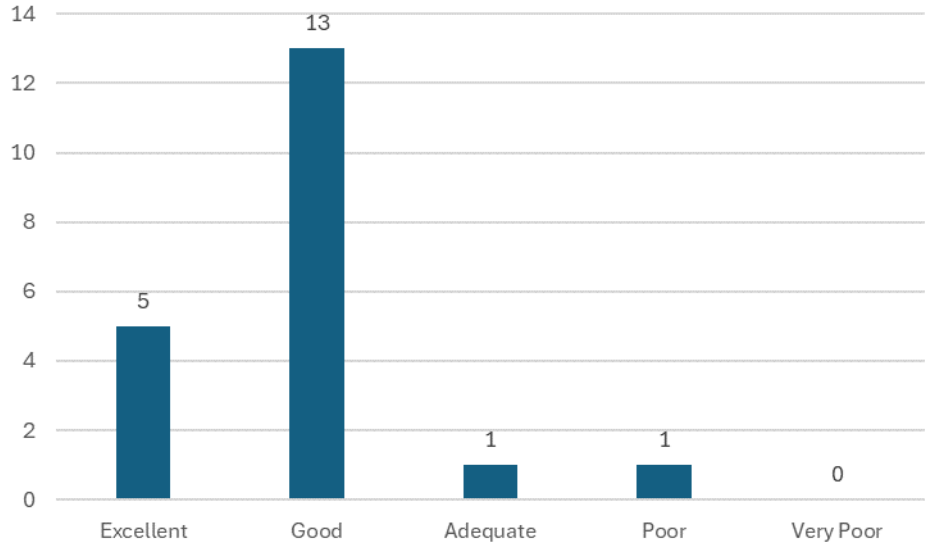


Figure 15: Bar chart showing the SJR overall care scores for patients with a learning disability or autism for 2024-25

Areas for improvement

Our reviews found that while ReSPECT forms were being completed, the quality of information could be enhanced. Pain management also needed attention, which is particularly important as people with a learning disability or autism may find it difficult to communicate their discomfort clearly. We also identified that some staff were still using the term "learning difficulty" instead of "learning disability," which can affect access to specialist services and reasonable adjustments.

Examples of excellent care

Reviews also highlighted many positive aspects of care. Communication with families was consistently praised, with staff having sensitive, honest and open conversations. This is especially important as families often act as advocates and need to understand what is happening with their family member's care.

We provided reasonable adjustments widely and delivered prompt end-of-life care with good symptom control. Our specialist learning disability and autism team was involved with 81% of patients before they died, working alongside other specialists to provide comprehensive support.

Adult Learning Disability and Autism Services annual report

Our Adult Learning Disability and Autism Services team produces an annual report highlighting all the learning from the previous year. The report is discussed at our

Mortality Surveillance Group and the lead nurse then shares all learning with the BNSSG and National LeDeR teams.

This report identified that the main causes of death were pneumonia, aspiration pneumonia (when food or liquid gets into the lungs), and cancer. This differs from the previous year when sepsis and heart-related conditions were the main causes. We monitor these patterns to understand how we can improve care.

The causes of death at UHBW align with national LeDeR patterns, with respiratory causes representing both a local and national trend.

The shift from sepsis and cardiac conditions to respiratory causes appears to be due to improved sepsis prevention. However, this pattern highlights the need for continued focus on vaccination uptake and dysphagia management.

Over the reporting period, 100% of cases reviewed had completed ReSPECT forms. This demonstrates a greater awareness of advance care planning; however, the quality of completion requires improvement, particularly regarding Mental Capacity Act (2005) knowledge and skills.

3.4 Improvements we have made

Once a review has been completed, it is discussed at our Mortality Surveillance Group where we identify learning and determine actions. Our mortality governance arrangements include the Clinical Quality Group, Quality Intelligence Group, Mortality Surveillance Group, and Trust Board. Full details are available in our Learning from Deaths Policy.

We then share this learning across UHBW, and where appropriate with external organisations, to help improve care for future patients.

The key learning from 2024-25 includes improvements in the following three areas:

Pain management

An audit of pain control which showed we weren't using the Abbey Pain Scale enough, particularly at Weston General Hospital. This tool is specially designed to help assess pain in people who may not be able to communicate clearly about their discomfort. We have implemented specific training at Weston General Hospital and will complete a follow-up audit in quarter 3 to measure improvement in Abbey Pain Scale usage rates.

Using the right terminology

Our audit found that 31% of ReSPECT forms incorrectly described learning disability as "learning difficulty," which can affect access to specialist services. This is an issue that is not unique to UHBW. We have addressed this through targeted training and

communications, recognising that outdated terminology is sometimes used within the learning disability community itself. Our learning disability practitioners continue working to correct diagnoses in real time.

Working as Bristol NHS Group

As part of our joint mortality improvement programme, we have been working with colleagues at North Bristol NHS Trust to develop a new shared approach to reviewing deaths of people with a learning disability or autism. This will reduce duplication and help our teams focus on what matters most, which is ensuring people get the reasonable adjustments they need.

Sharing good practice

Our reviews also identified examples of excellent communication with families and effective use of reasonable adjustments. This includes the development of a new Health Passport, bespoke easy read leaflet for Bristol Eye Hospital, use of sensory equipment at end of life and easy read communication for family members who have a learning disability.

We have shared these examples across Bristol NHS Group through our Annual learning disability and autism report and representation at BNSSG ICB LeDeR governance meetings.

Section 4: How we have improved

4.1 Learning and improvement from Medical Examiner Referrals

The following examples of learning highlight how concerns raised through Medical Examiner referrals and family feedback have directly shaped improvements in the care we provide across all divisions.

Our processes for positive feedback

As with concerns, the volume of positive feedback varies for several reasons. Many families tell the Medical Examiner Service that they were grateful for the care their loved one received. However, because the statutory focus of the Medical Examiner role is on identifying and escalating concerns, positive comments are not always consistently captured through governance referral processes.

Following the introduction of statutory Medical Examiner arrangements in September 2024, we noticed a reduction in the number of positive referrals being recorded. On review, we found that many teams were receiving feedback directly via Greatix, an internal UHBW system designed to share timely, informal recognition with staff. While this has proved more efficient for both families and teams, it meant that our central reporting no longer reflected the full picture.

We have since updated our approach to include Greatix feedback in our Learning from Deaths reporting, ensuring that excellent care continues to be recognised and shared.

Timely death certification for faith communities

Following the introduction of statutory Medical Examiner requirements in September 2024, we became aware that some families experienced delays in death certification, particularly those with religious needs for prompt burial. We worked with our Operations Matrons and the Medical Examiner service to introduce a clear escalation pathway, ensuring timely certification.

This new process has already helped families to meet important cultural and spiritual requirements, including for an out-of-hours death requiring urgent documentation.

Pain management for patients with learning disabilities

A concern was raised about a patient with a learning disability who experienced delays in receiving pain relief after their medication chart went missing. This case prompted us to review how medication charts are stored and transferred between clinical areas.

As a result, we strengthened our local processes for managing and securing charts and worked with clinical teams to improve how urgent issues are escalated. We are currently reviewing whether these changes have reduced delays and improved patient experience.

End-of-life communication

We received feedback from families who described feeling “invisible” on the ward and receiving different messages from different staff about their family member's condition.

In response, we reviewed how ward rounds were conducted and made changes to support more consistent family involvement. Senior clinicians received targeted training on end-of-life communication, and teams were encouraged to document key conversations clearly and consistently. We are now measuring the impact of these changes on family experience.

End-of-Life Care Documentation

We are implementing a phased rollout of a new ‘Butterfly Bundle’. This is a new, standardised approach to documenting care in the last days of life. The bundle supports consistent, high-quality end-of-life care across all divisions and will be fully in place across UHBW by August 2025.

End-of-Life Care eLearning

We have launched a comprehensive end-of-life care e-learning module, available to all clinical staff. The training is mandatory for registered nurses and optional for doctors and allied health professionals, providing flexible access to core end-of-life care education.

Sepsis

Sepsis is a priority workstream for UHBW due to the NICE guidance updates in March 2024. During this period, SJRs identified learning points around sepsis recognition and management, including challenges with sepsis recognition in the Emergency Department, incomplete completion of protocols and pathways, and instances where identification and management could be strengthened.

This learning has been incorporated into our major investment in sepsis improvement during 2025-26. As part of this broader work, we have established a dedicated sepsis improvement team, created 12-month fixed-term sepsis lead posts across the organisation to drive improvement work and identify a sustainable model for business as usual once these posts end in March 2026, updated pathways in line with new NICE guidance, implemented enhanced staff education including updated eLearning modules.

This demonstrates how our learning from deaths processes drives real improvements in care, even when there is no indication of incident or harm, which represents the vast majority of cases.

4.2 Learning and improvements within our divisions

Our divisional leads and clinical teams oversee the review of deaths within their areas. The following summaries set out how learning from mortality reviews has informed governance, education, and quality improvement activity across our divisions during 2024-25.

Medicine Division

Our Medicine Division has established a new systematic process to identify and address learning from mortality reviews. Our new mortality lead attends divisional patient safety and governance meetings, highlighting learning outcomes from structured judgement reviews to individual teams and specialties, and will present findings at the Divisional Patient Safety Afternoons to ensure learning is embedded across all clinical areas.

Through this enhanced governance approach, we identified opportunities to improve end-of-life recognition and advance care planning, with some patients continuing to receive active treatment when palliative care would have been more appropriate. We

found ReSPECT forms were sometimes incomplete or poorly completed, affecting care coordination and patient wishes, particularly around capacity assessments for learning disability patients. Reviews also highlighted opportunities to improve sepsis pathway documentation and compliance with one-hour sepsis bundle targets, alongside enhancing symptom control, particularly pain management in dying patients.

The division is working with patient safety leads to address these areas. Quality improvement initiatives for ReSPECT form completion are being developed. An action plan for capacity assessment improvements is in development, and end-of-life symptom management is being addressed through divisional patient safety processes alongside the palliative care education programme detailed below.

Supportive and Palliative Care Team

At UHBW, around 60% of patients who die are seen by the palliative care team in their final admission, meaning non-specialist teams have a crucial role in caring for dying patients.

Our mortality reviews during 2024-25 identified key learning themes including delayed recognition of end-of-life, inadequate symptom control particularly for pain management, communication concerns where families felt "invisible" during ward rounds, and issues with incomplete ReSPECT forms affecting care coordination.

We responded through targeted education including induction training for new Foundation Year 1 doctors on ReSPECT principles, rotation-based teaching for haematology and oncology residents, specialist training for international medical graduates, and anticipatory prescribing training for pharmacists. However, staffing capacity constraints limited our ability to fulfil all teaching requests during 2024-25.

With increased consultant numbers, we are expanding our education programme for 2025-26, including ICU communication skills training, advance care planning simulation, and specialty-specific training.

The End of Life Care Education Programme

Between March and July 2025, our end-of-life care education programme reached 348 staff members across the trust. This included 52 registered nurses and healthcare support workers through study days, 137 newly qualified professionals through preceptorship communication skills sessions, 40 new healthcare support workers through trust induction and upskilling sessions, and 119 staff through divisional teaching sessions and bespoke ward-based training.

For 2025-26, we have planned six additional study days (three on Bristol site, three on Weston site) between September and December, alongside five further bespoke

training programmes requested by clinical areas. This demonstrates the growing recognition across our trust of the importance of end-of-life care education in improving patient experience and quality of care.

We have also launched dedicated End-of-Life Care Practice Education Facilitator roles to work alongside divisional teams, focusing on raising awareness and making end-of-life care part of everyday conversation across our trust.

Surgery, Head and Neck Division

Our Surgery Division holds monthly meetings where we review all deaths and significant complications from surgical procedures. This enables us to discuss cases together and share learning across our teams. Through these meetings, and mortality reviews, we have identified several key areas for improvement.

Like our Medicine Division colleagues, our surgical reviews have identified opportunities to improve recognition of when patients would benefit from comfort-focused care rather than continuing active treatment. This learning aligns with themes identified across our trust and is being addressed through our enhanced education programme delivered by our Supportive and Palliative Care Team.

Oesophago-Gastric Surgical Team

Our oesophago-gastric surgical team reviews have identified specific improvements for managing patients who have had complex operations. We have established that if complications develop and they need readmission to a local hospital, they should be transferred back to Bristol Royal Infirmary to ensure continuity of specialist care. We also identified technical improvements in wound closure techniques to reduce infection risk and have developed protocols around post-operative nutrition timing to improve recovery.

Reviews led to improved recognition of complications requiring surgical intervention. We have also improved our approach to operations for patients receiving palliative care and have developed improved guidance for surgical techniques.

Intensive care unit (ICU) and outreach

Case reviews highlighting challenges with out-of-hours ICU discharges prompted establishment of a working group to review overall processes and reduce the number of out of hours discharges.

Due to the number of highly specialist services admitting to ICU at the BRI, several joint meetings have been established with specialist teams to ensure shared learning. For example, the team now attends the haematology MDT and there is a joint surgical meeting. There has also been the development of a cardiogenic shock team, and

since its introduction, cases reviewed show patients are receiving earlier organ support with the pathway now well embedded in practice.

The team has discussed the process of weaning patients from high-flow nasal oxygen (HFNO) and non-invasive ventilation (NIV) in the palliative care setting, and decision-making around treatment escalation plans for patients with long stays, particularly when the medium-term prognosis appears poor.

Specialised Services Division

Mortality reviews within Specialised Services have identified opportunities to strengthen coordination between the Bristol Haematology and Oncology Centre (BHOC) and the Bristol Royal Infirmary (BRI), particularly in relation to continuity of care and specialist treatment pathways. As a result, enhanced coordination arrangements have been developed to improve handovers, discharge planning, and communication between site-based teams.

Reviews and M&M within other services in the division have also provided valuable insights into care quality. This has helped teams to highlight good practice and take action where needed.

Cardiac Teams

In 2024, drawing on themes identified from the joint cardiac and cardiac surgical mortality meetings in conjunction with the SJRs, a review of the cases was undertaken by a consultant cardiac anaesthetist. The final report is currently progressing through Clinical Governance and will be discussed at the Bristol Heart Institute (BHI) Governance Meeting. Once this is complete, key learning will be shared across teams. The review highlights important opportunities to strengthen care for patients undergoing complex cardiac procedures, and we are committed to ensuring this learning informs future practice.

System wide learning

We also supported our community partner, Sirona Care and Health, with a targeted mortality review of patients who died whilst on their heart failure waiting list. One of our senior consultants contributed to the clinical review of these cases, which found that the patients were typically older and living with significant frailty.

In 20% of cases, very rapid heart failure review (less than 2 weeks) might have altered the place of care but was unlikely to have changed the outcome. Learning was that heart failure, frailty and palliative care services need to be more visible to GPs and joined up. This working is ongoing within the Integrated Care Board (ICB) led by a UHBW clinician. This collaborative review is an example of how we work with system partners to share expertise and support joined-up learning across BNSSG.

Weston Management Team

Weston General Hospital has some integrated patient services within medicine, surgery and specialised services and shares many learning themes with our Medicine Division due to its large medical bed base. Learning from Weston Care of the Elderly inpatients and the emergency department has been focused around end-of-life care timing and symptom management. In Weston, ReSPECT form documentation also remains a focus, particularly capturing what our patients value most and completing capacity assessments.

Communication has been identified as a key theme across all divisions, and Weston has proactively addressed this, including communication between hospital teams and with relatives. Reviews highlighted priority areas to improve where we have transfers between wards and hospitals. We identified that there was sometimes insufficient handover, with relatives feeling they had to repeat themselves to new teams, and patients becoming confused and deteriorating, with medical examiners and relatives linking frequent moves to potentially worsening delirium.

To address this, we have discussed the Royal College of Physicians learning tool on managing uncertainty (‘Talking about uncertain Recovery’) in the Care of the Elderly grand round and Weston medical grand round as a learning tool to help guide discussions. We have also discussed cross-site issues and how to minimise these through handovers, recognising this will also come up in critical care and surgery divisions which are delivered across different UHBW sites.

To improve documentation, our trust ReSPECT lead has delivered interactive training in Weston medical grand round and resident teaching including the role of consent, ReSPECT plus and guide to ReSPECT form completion. We have also included learning about end-of-life care in Parkinson's disease from our Care of the Elderly meetings, and with the Parkinson's emergency care plan supporting clinical guidance.

Following the trust-wide update to our sepsis screening tool in July 2024, specific teaching was delivered at Weston through Grand round by the outreach team, contributing to improved sepsis recognition and management across the hospital.

Looking ahead, we are working to ensure divisional compliance with Oliver McGowan training to improve care for patients with learning disabilities and autism. We are also reviewing Emergency Department sepsis clinical audit data to assess the impact of the updated screening tool and identify further improvement opportunities. Enhanced monitoring of transfer protocols and handover processes will also continue to be developed to reduce unnecessary patient moves and improve care continuity.

4.3 Working together across Bristol, North Somerset, and South Gloucestershire

We really value the different perspectives that families, the independent Medical Examiner, and our SJR reviewers bring to our Learning from Deaths processes.

This collaborative approach to learning extends beyond our Trust. As part of Bristol NHS Group, our partnership with North Bristol NHS Trust helps us share learning more widely and deliver on our Joint Clinical Strategy vision of seamless, high-quality, equitable care, ensuring patients receive consistent care regardless of which hospital they attend.

Our Bristol NHS Group Mortality Improvement Programme

Our joint Mortality Improvement Programme made substantial progress during 2024-25, establishing formal partnership arrangements and recruiting dedicated clinical and programme leads.

The programme is creating a robust system-level oversight that will help us to identify patterns more quickly and easily and ensure consistent review quality and sharing of learning across all hospital sites. This has become increasingly important as we develop Single Managed Services across our group, with cardiac services being our first specialty to operate under unified leadership across both sites.

This year, we began assessing how each trust handles Medical Examiner referrals, completes reviews, and reports on mortality. We have identified areas for improvement and areas of good practice for alignment.

We are currently working to standardise medical examiner referral concern categorisation, ensure consistent referral responses, and develop joint data analysis to identify group-wide learning opportunities. Some of the highlights of the programme's progress this year include:

Improving the timeliness of the death certification process

This year, we have successfully transitioned to a statutory Medical Examiner (ME) service in line with national requirements. This included implementing new processes for Medical Certificate of Cause of Death (MCCD) completion and removing the need for separate cremation forms.

We also rolled out digital ME scrutiny tool. This has significantly improved data quality and reduced manual processing time by 5 hours per week. We have strengthened the process for completion of forms to ensure timely death certification, and improved coordination between the ME Office and the bereavement team.

Aligning the definition for Severe Mental Illness for mortality review

The mortality programme achieved a significant milestone this year, securing clinical agreement on Severe Mental Illness (SMI) definitions with Avon and Wiltshire Partnership Mental Health Partnership. We are now developing a collaborative review framework to review approximately 360 deaths a year across BNSSG, reducing duplication and enhancing mental health-specific learning and sharing.

Aligning our reporting schedules and report templates

The programme developed aligned Learning from Deaths reporting schedules and structure across both trusts, with this being our first joint milestone. For 2024-25, we focused on what matters most to the public - making our Learning from Deaths reports clearer and more accessible. Working with patient and public representatives to enhance readability, our aligned reports use the same headings and structure across both trusts, developed collaboratively. We have plans for greater alignment as our Bristol NHS Group work progresses.

Aligning how we use mortality data

We have aligned our SHMI preview data validation processes across Bristol NHS Group. This is the process where we check our mortality data before it is signed off to NHS England for public publication.

This alignment work has prompted us to develop a more systematic approach to understanding care quality across both hospital sites. Since SHMI is not designed to measure care quality or compare trusts, we are exploring how to triangulate this data with other sources including SJR findings, clinical audit data, patient safety incident themes, complaints data, and quality improvement projects and outcomes. This will provide a more comprehensive picture of our performance and learning opportunities.

For example, this approach will help us identify where one hospital site achieves better outcomes for specific patient groups. It will also enable us to share successful approaches across both sites and improve care for all patients.

This work represents the foundation for more intelligent analysis of data and system-wide learning in future years. In line with Penny Dash's 2025 report, it will allow us to move together as a group beyond single indicators to understand the full picture of care quality and improvement opportunities.

Aligning our Medical Examiner referral processes

As part of our mortality programme, we identified that 17.3% of deaths scrutinised by the Medical Examiner were referred to UHBW for further review, compared to 6.6% at NBT, as illustrated in Figure 16. Initial discussions with the Medical Examiner Service

suggest this variation reflects different documentation approaches and referral thresholds rather than differences in care quality.

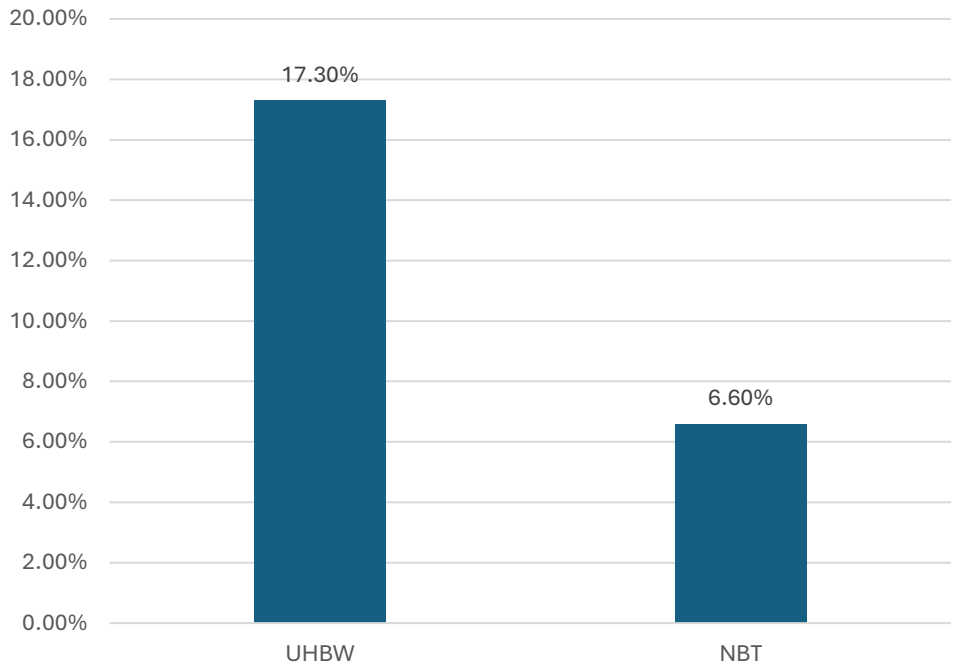


Figure 16: Medical Examiner Referral rate comparison between UHBW and NBT

To address this, we are launching a dedicated project to understand this variation. We will examine referral patterns across different specialties, review how referral criteria are applied, and develop consistent standards across Bristol NHS Group. This will ensure families receive the maximum benefit from Medical Examiner scrutiny while maintaining efficient review processes across both hospital sites.

Enhancing our digital tools for mortality review

To strengthen data quality and streamline review processes, we have begun developing aligned and enhanced Structured Judgement Review (SJR) templates in collaboration with North Bristol NHS Trust. This work supports our planned transition to digital reporting tools, including greater use of Power BI and automation, which will significantly reduce administrative workload and enable real-time trend analysis to support organisational learning and improvement.

Increasing our national collaboration

We host a national Mortality and Learning from Deaths Leads Community of Practice for NHS mortality and Learning from Deaths leads. We volunteered to host this meeting when the previous national team no longer existed within NHS England as we understood that there was great desire for shared learning and collaboration. This community has grown by over 150% in the last 12 months. It brings together leads from acute hospitals, community health providers, ambulance services, and mental health organisations.

We run bi-monthly online sessions with additional sharing between meetings, making the network accessible while minimising resource impact. During 2024-25, we hosted high-profile guest speakers and covered topics including implementation science, with our sessions attracting NHS colleagues from across England and Wales. This national network enables us to learn from innovations elsewhere and share our own approaches, including our Bristol NHS Group collaboration.

We are planning an annual national event to further strengthen these collaborations and advance shared learning from deaths across the NHS.

4.4 Looking forward

Current challenges and our plans to address them

We believe in being transparent about the challenges we face in learning from deaths, as acknowledging these honestly is the first step toward meaningful improvement.

Our Learning from Deaths policy is being updated in line with our Bristol NHS Group development. Rather than updating separately and aligning later, we are working directly with North Bristol NHS Trust through our joint Mortality Improvement Programme to develop aligned policies from the outset. This ensures consistency whilst incorporating changes in national guidance, statutory Medical Examiner requirements, and PSIRF alignment. While our current policy requires updating, there are no high-risk concerns with our existing processes.

Our data collection and tracking relies heavily on manual processes rather than automated digital systems. While our data is accurate, this approach requires significant administrative time and limits our ability to analyse trends as efficiently as we would like.

These challenges aren't unique to UHBW. Through our discussions with our national Community of Practice, we know many organisations are grappling with similar issues as new frameworks are implemented.

For 2025-26, we're investing in digital systems to address these limitations, track reviews more effectively, and reduce administrative burden on clinical staff. This will free up more time for measuring the impact of improvements and ensuring learning translates into better care.

This work is central to our mortality improvement programme. By sharing data and learning across our hospitals, we will become better at spotting trends in patient care across our local health system. We're also planning to work with colleagues across BNSSG including Sirona Care and Health and Avon and Wiltshire Partnership to ensure our learning benefits the whole system.

Future Priorities and Commitments

Digital transformation priorities

During 2025-26, we will be updating our Medical Examiner scrutiny system to a new digital platform. Following the national decision not to proceed with a centrally developed system, we are implementing our own solution that will be more suitable for our needs. This will provide enhanced data security and improve reporting capabilities alongside better integration with our joint Bristol NHS Group mortality improvement work.

We will implement enhanced Structured Judgement Review (eSJR) processes to standardise review methods and data collection across Bristol NHS Group, ensuring consistent quality and learning. In addition, we will launch a new digital Medical Examiner referral system to streamline workflow and improve data quality, enabling swifter responses to family concerns.

This year, our mortality improvement programme has focused on understanding what clinical leads would find most valuable in their data dashboards and reports, , starting with teams at NBT. Over the next year, we will continue this engagement across UHBW and build digital solutions tailored to each specialty's specific requirements. This approach will take longer but will deliver better outcomes.

For example, we are developing automated flags for cases with the highest learning potential. This includes delays of 8+ hours from decision to admit to actual admission, or patients who move from ward to ward and then to intensive care, which might indicate missed opportunities for earlier intervention. These are not automatically concerns but intelligent filtering to help clinical teams identify cases for mandatory SJR review. This will enable teams to focus their time on completing reviews and implementing and sharing learning.

Aligning and improving Medical Examiner referrals

We recognise there are learning opportunities from both positive feedback and referrals from concerns, and we want to capture both effectively. We have been working with the Medical Examiner Service to develop suitable thresholds for both types of referrals, focusing on feedback that is specific and actionable while ensuring families' voices are heard without creating unnecessary administrative burden.

We will also complete our Medical Examiner referral themes categorisation alignment project. This will enable standardised analysis and cross-trust learning, helping us identify improvement opportunities more effectively across our hospital sites.

Aligning quality governance approaches across our Bristol NHS Group

As part of the mortality programme, we will be working to align our quality governance approaches across Bristol NHS Group, including reporting, categorisation, and underlying review processes.

Integration with Child Death Review and Perinatal Mortality Review Processes

We will also focus on more closely integrating findings from all mortality review processes with our broader mortality governance. For example, our Child Death Review process and maternal and neonatal MBRRACE-UK processes generate important learning that complements our adult mortality review work, particularly around communication with families, service provision improvements, and inter-agency coordination.

We are exploring opportunities to bring together adult, paediatric, maternal and neonatal mortality review processes where appropriate, whilst not duplicating the excellent specialist work already being done through our dedicated specialist teams and national groups.

Report prepared by

Karin Bradley

Charlotte Devereaux

Rose Bosnell

Heather Collins

Report period

April 2024 - March 2025

Publication date

September 2025

Glossary

Admission

When a person goes into hospital to stay for treatment or care.

Advance care planning (ACP)

A discussion and record of a person's wishes about their future care, including what care they would or would not want if they became unable to communicate.

Bereavement services

Teams that support families and carers after someone has died, helping with practical and emotional needs. Further information can be found on the UHBW website https://www.uhbristol.nhs.uk/patients-and-visitors/patient-affairsbereavement-services/

Bristol NHS Group

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) partners with North Bristol NHS Trust (NBT) as the Bristol NHS Group, working together to deliver high-quality, equitable care across Bristol, South Gloucestershire, and the wider South West. Further information can be found on the UHBW website https://www.uhbw.nhs.uk/p/about-us/bristol-nhs-group/

BNSSG (Bristol, North Somerset and South Gloucestershire)

Bristol, North Somerset and South Gloucestershire is the area covered by our local NHS services.

Coroner Referrals

Approximately half of all deaths in England and Wales are referred to H.M. Coroner (The Coroners' Society of England & Wales, 2025). Referrals happen for a variety of reasons. Referrals are made mainly by doctors and the Police. Upon receipt of a death report the Coroner will review the information and decide what should be done. Further information can be found on the Avon Coroner website. https://www.avon-coroner.com/

Clinical audit

A way to find out if healthcare is being provided in line with specific standards. Audits let care providers and patients know where services are doing well and where there could be improvements. More information can be found on the NHS England website https://www.england.nhs.uk/clinaudit/

Clinical Health Knowledge System (CHKS)

CHKS is a company and system that provides data to compare NHS Trust performance, including mortality indicator data.

End of life care

End of life care is support for people who are in the last months or years of their life. The focus is on living as well as possible and being able to die with dignity. The team providing this care will ask about the person's wishes and preferences and take these into account as they work with them to plan their care. The team will also support families, carers or other people who are important to the person. Further information is available on the UHBW website https://www.uhbristol.nhs.uk/patients-and-visitors/end-of-life-care-at-uh-bristol/adult-end-of-life-care-at-uh-bristol/

Dysphagia

When a person has problems swallowing. Further information is available on the NHS website https://www.nhs.uk/symptoms/swallowing-problems-dysphagia/

Haematological malignancy

This refers to the presence of cancerous cells in blood, bone marrow, and lymph nodes. Information on the basic techniques we use to diagnose haematological malignancy are on the UHBW website https://www.uhbristol.nhs.uk/for-clinicians/uhb-hods/techniques/

(Sen, et al., 2016).

Inquest

If a death is reported to a coroner, the coroner must hold an inquest if:

- the cause of death is still unknown
- the person might have died a violent or unnatural death
- the person might have died in prison or police custody

Further information can be found on the Avon Coroner website. https://www.avon-coroner.com/

Learning from deaths

The framework and processes related to reviewing cases where people have died to understand what happened, to assess the quality of care provided, and find ways to improve care for future patients. Further information can be found on the NHS England website https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-deaths-in-the-nhs/

Learning from deaths policy

A policy that sets out how we review deaths in our hospitals, learn from care provided, and make improvements for future patients. The policy explains our review processes and governance arrangements in line with national guidance.

Medical Examiner (ME)

Medical examiners are senior medical doctors who are contracted for a number of sessions a week to provide independent scrutiny of the causes of death, outside their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

You can find out more about the Medical Examiner's Service in Bristol, North Somerset, and South Gloucestershire on the BNSSG Healthier Together website, at https://bnssghealthiertogether.org.uk/the-medical-examiner-service/information-for-the-public/

Medical Examiner Officer (MEO)

A Medical Examiner Officer is are specially trained staff member who supports the Medical Examiners in their work. They will often speak to bereaved families.

Morbidity

Used in medical settings, morbidity means illness or disease and is not to be confused with mortality, which means death.

Mortality Governance Structure

The committees and teams responsible for overseeing how we review deaths and ensure learning leads to improvements in patient care. This includes our Clinical Quality Group, Mortality Surveillance Group, and other committees that each have specific roles in mortality review and learning processes. Full details are available in our Learning from Deaths Policy.

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries UK (MBRRACE-UK)

A national surveillance and investigation programme for deaths of women and babies who die during pregnancy or shortly after pregnancy in the UK. You can find out more about MBRRACE-UK on their website https://www.npeu.ox.ac.uk/mbrrace-uk.

Misadventure

An injury or adverse reaction resulting from any medical treatment.

Multidisciplinary Team (MDT)

A group of health and care staff who may be from different organisations and professions, that work together to make decisions regarding the treatment of patients and service users.

Mental Capacity Act (MCA)

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. Further information can be found on the NHS website https://www.nhs.uk/social-care-and-support/making-decisions-for-someone-else/mental-capacity-act/

Oesophagectomy

Surgery to remove the oesophagus (often referred to as the gullet). Further information on our oesophago-gastric can be found on the UHBW website https://www.uhbristol.nhs.uk/patients-and-visitors/your-hospitals/bristol-royal-infirmary/what-we-do/ogteam/

Patient Safety Incident Response Framework (PSIRF)

The structure and processes that NHS organisations must use to look at patient safety incidents. An important aim of PSIRF is to understand how incidents happen, so that we learn and improve, and in turn create a safer care system. Further information can be found on the UHBW website https://www.uhbw.nhs.uk/assets/1/uhbw_psirf_plan_v1.2_updated_approved.290824.pdf

PALS (patient advice and liaison service) and complaints team

The PALS and Complaints Team aim to resolve any concerns, queries or questions that patients, their families, or members of the public raise with us about our Trust. Further information can be found on the UHBW website https://www.uhbristol.nhs.uk/patients-and-visitors/support-for-patients/patient-support-and-complaints/

PMRT (Perinatal Mortality Review Tool)

A standardised perinatal mortality review programme that runs across NHS maternity and neonatal units in England, Scotland, Wales and Northern Ireland. You can find out more about the PMRT on the programme website https://www.npeu.ox.ac.uk/pmrt

Pneumonectomy

The removal of a lung. A glossary of thoracic operations is available on the UHBW website https://www.uhbristol.nhs.uk/patients-and-visitors/your-hospitals/bristol-royal-infirmary/what-we-do/thoracic-surgery/glossary-of-thoracic-operations/

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)

The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they cannot make decisions or express their wishes. The process is intended to respect both patient preferences and clinical judgement. Further information can be found on the Remedy BNSSG website https://remedy.bnssg.icb.nhs.uk/adults/end-of-life-care-and-hospice/respect-plus/

Sepsis

Sepsis is a life-threatening condition caused by a dysregulated host response to infection. Without early identification and treatment there is a significant risk of long-term disability or death. Anyone, at any age can develop sepsis after an injury or minor infection, although some people are at higher risk. Sepsis can be extremely difficult to recognise and diagnose, but sometimes it can be prevented, and it is treatable in many cases. For further information on sepsis, please visit the NHS website https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/sepsis-work/

Sepsis bundle (Sepsis Six)

A set of six actions that should be initiated within one hour of suspecting sepsis. A factsheet on the implementation of the sepsis six care bundle is available on the NHS website https://www.england.nhs.uk/wp-content/uploads/2014/02/rm-fs-10-1.pdf

Single managed services

Single managed services are a new way of delivering clinical services across our two trusts in BNSSG. Our vision is for more joined-up, more resilient, and more patient-focused services. You can find out more on our Bristol NHS Group website https://www.uhbw.nhs.uk/p/about-us/bristol-nhs-group

Statistical Process Control (SPC) Chart

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

action. SPC is used widely in the NHS and more information is available on the NHS England Website https://www.england.nhs.uk/statistical-process-control-tool/

Structured Judgement Review (SJR)

A detailed case notes review method developed by the Royal College of Physicians and recommended by National Learning from Deaths guidance. Trained clinicians assess care quality using structured judgements to identify learning opportunities, areas for improvement, and patterns across multiple cases that can benefit future patients. Further information can be found on the Health Innovation West of England website https://www.healthinnowest.net/wp-content/uploads/NMCRR-clinical-governance-guide-Final.pdf

Supportive and palliative care

The supportive and palliative care team provides care to help improve quality of life for patients and families with life- limiting illness that is usually progressive. The aim is to providing holistic care through high quality pain and symptom control as well as psychological, social and spiritual support. Specialists in the team also have expertise in supporting patients and their families who are living with a life limiting conditions. Further information can be found on the UHBW website https://www.uhbristol.nhs.uk/patients-and-visitors/your-hospitals/bristol-royal-infirmary/what-we-do/supportive-and-palliative-care/

Treatment

The care someone receives to help with their illness or condition. This includes medication, operations, tests, and other care from the hospital's teams.

Variable Life-Adjusted Display (VLAD) Chart

A visual way of monitoring clinical outcomes adjusted for risk used by NHS England. Further information on the VLAD method, implementation, and caveats can be found on the UCL website https://www.ucl.ac.uk/clinical-operational-research-unit/sites/clinical_operational_research_unit/files/vladmethods.pdf

References

NHS England, 2025. *Learning from lives and deaths – People with a learning disability and autistic people (LeDeR).* [Online]
Available at: https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/
[Accessed 02 08 2025].

NHSE England, 2025. *NHS England.* [Online]
Available at: https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2024-08

The Coroners' Society of England & Wales, 2025. *The Coroners' Society of England & Wales.* [Online]
Available at: https://www.coronersociety.org.uk/faqs/

Appendices

Appendix 1 How we align with national requirements - detailed statistics and data tables

Table 8 shows how this report meets all requirements under the NHS Quality Account Regulations 2010 (2017 Amendment No.744) and National Quality Board Guidance on Learning from Deaths (March 2017).

Total deaths reported	Section 1.1 (1,865 deaths)
Total adult deaths reported	Section 1.1
Case record reviews completed	Section 2.2
Avoidable deaths assessed	Section 2.5
Learning themes identified	Sections 2.5, 4.1, 4.2
Actions taken documented	Sections 4 (all subsections)
Impact assessment provided	Sections 4.3, 4.4
Quarterly public board reporting requirements	Quantitative data elements reported quarterly throughout 2024-25. Qualitative learning themes documented with Trust Board oversight. Mandatory priority patient group reviews completed (learning disability, autism, severe mental illness)

Table 8: Table showing statutory requirements and sections within the 2024-25 learning from deaths annual report

The specific wording below follows the exact format required by the NHS Quality Account Regulations 2010 (2017 Amendment No.244).

These regulations specify the precise language that must be used when reporting Learning from Deaths data, ensuring consistency across all NHS trusts and enabling meaningful comparison of mortality review activity nationally.

103 case record reviews and 0 investigations have been carried out in relation to 1794 of adult deaths included in item 27.1. In 0 cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was

- 29 in the first quarter;
- 26 in the second quarter;
- 18 in the third quarter;
- 30 in the fourth quarter.

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter;
- 0 representing 0% for the second quarter;
- 0 representing 0% for the third quarter;
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review methodology developed by the Royal College of Physicians.

This report fulfils all mandatory requirements under:

- NHS Quality Account Regulations 2010 (2017 Amendment No.744) sections 27.1-27.6.
- National Quality Board Guidance on Learning from Deaths (March 2017).
- CQC inspection requirements for learning from deaths.
- Medical Examiner statutory guidance.

Table 9 demonstrates our compliance with the statutory data requirements under the NHS Quality Account Regulations 2010 (2017 Amendment No.244) year on year.

Reg	Requirement	2023 24	2024 25	Change	%Change
27.1	Total Hospital Deaths (all)	1873	1865	-8	-0.4%
27.1	Total Adult in-hospital Deaths (quarterly breakdown required)	1,807	1,794	-13	-0.7%
27.2	Deaths Reviewed (quarterly breakdown required) (adult in-hospital)	82	103	21	25.6%
27.2	Review Rate %	4.54%	5.74%	1.20%	26.5%
27.3	Deaths Due to Problems in Care (quarterly + methodology)	1	0	-1	-100.0%
27.3	Problems in Care Rate %	0.06%	0%	-0.06%	-100.0%
27.4	Summary of Learning	Narrative			
27.5	Actions Taken/Proposed	Narrative			
27.6	Impact Assessment	Narrative			
27.7	Late Reviews from Previous Year	0	0	0	
27.8	Late-Identified Problems in Care	0	0	0	
27.9	Revised Previous Year Estimate	N/A	N/A	N/A	

Table 9: Data requirements under the NHS Quality Account Regulations 2010 (2017 Amendment No. 244)

Appendix 2 Regional Mortality Context

Table 10 shows UHBW deaths in the context of total deaths recorded by the Office for National Statistics for England and the South West region during 2024-25.

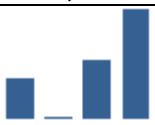
Quarter	Total Deaths England	Total Deaths South West England	Total Deaths UHBW
Apr-Jun 24	129,986	15,035	502
Jul-Sep 24	122,110	13,934	366
Oct-Dec 24	134,802	15,503	465
Jan-Mar 25	149,810	16,884	532
			

Table 10: Office of National Statistics (ONS) comparison: Regional mortality context - UHBW deaths compared with England and South-West totals, 2024-25

This data provides regional context for UHBW mortality volumes, demonstrating that hospital deaths represent a small proportion of total deaths in the region, with most deaths occurring in community settings.

Appendix 3 UHBW Summary Hospital Mortality Indicator (SHMI) Data

About the Summary Hospital-level Mortality Indicator (SHMI)

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged.

To help users of the data understand the SHMI, NHS trusts have been categorised into bandings indicating whether a trust's SHMI is 'higher than expected', 'as expected' or 'lower than expected'. The expected number of deaths is a statistical construct and is not a count of patients. The difference between the number of observed deaths and the number of expected deaths cannot be interpreted as the number of avoidable deaths or excess deaths for the trust.

The SHMI is not a measure of quality of care. A higher-than-expected number of deaths should not immediately be interpreted as indicating poor performance and instead should be viewed as a 'smoke alarm' which requires further investigation. Similarly, an 'as expected' or 'lower than expected' SHMI should not immediately be interpreted as indicating satisfactory or good performance (NHSE England, 2025).

SHMI data can be influenced by many factors including the complexity of patients treated, how conditions are recorded, and statistical variation. SHMI may not show

normal patterns when there are clusters of deaths or care quality issues, as this requires detailed clinical review. Further background information and supporting documents, including information on how to interpret the SHMI, are available on the SHMI homepage https://digital.nhs.uk/data-and-information/publications/ci-hub/summary-hospital-level-mortality-indicator-shmi

Trust-level Summary University Hospitals Bristol and Weston NHS Foundation Trust for the data period March 2024 to February 2025 SHMI: 0.89

Provider Spells	115,955
Observed Deaths	2,460
Expected Deaths	2,765
SHMI Banding	As expected

Table 11: SHMI overall totals for March 2024-February 2025, latest available data at time of publication

Site	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding
Bristol Royal Infirmary	43,335	1,385	1,425.00	0.97	As expected
Weston General Hospital	25,475	775	930.00	0.83	Lower than expected
Bristol Haematology & Oncology Centre	5,085	215	320.00		
St Michaels Hospital	22,965	40	40.00		
Bristol Royal Hospital for Children	16,905	40	40.00		
University Hospital Bristol and Weston Virtual	200		10.00		

Table 12: SHMI overall totals broken down by Hospital Site for March 2024 to February 2025, latest available data at time of publication

Appendix 4 Understanding our data and review processes

We use multiple data sources as no single review method can capture the full complexity of healthcare delivery. Our approach to learning from deaths combines independent medical review, detailed case review, statistical monitoring, patient, and family feedback to build a comprehensive understanding of care quality and learning opportunities.

This ensures we identify both specific areas for improvement and system-wide patterns, enabling targeted quality improvement whilst maintaining awareness of our overall performance context.

Our approach to learning from deaths uses multiple complementary approaches to understand and improve care quality:

- SHMI data provides population-level performance monitoring within national benchmarks
- Medical Examiner scrutiny of every death provides independent oversight
- Structured Judgement Reviews offer detailed analysis of approximately 6% of deaths where learning opportunities are most likely
- Complaints, patient experience, clinical audit, and staff feedback give additional context and feedback.

Appendix 5 Detailed UHBW Death Data

UHBW Adult Deaths Data

Quarter	Number of adult deaths
Q1 2024-25	490
Q2 2024-25	343
Q3 2024-25	448
Q4 2024-25	513

Table 13: Total adult deaths for UHBW by quarter

Site Comparison Data

Hospital Site	Division	April 2024 to March 2025				Total
		Q1	Q2	Q3	Q4	
Bristol Haematology and Oncology Centre (BHOC)	Specialised Services	19	27	29	28	103
	Women's & Children's		1			1
	BHOC Total	*19*	*28*	*29*	*28*	***104***
Bristol Royal Children's Hospital (BRCH)	Died in Emergency Care	1	1	1		3
	Women's & Children's	7	12	13	9	*41*
	BRCH Total	*8*	*13*	*14*	*9*	**44**
Bristol Royal Infirmary (BRI)	Died in Emergency Care	20	9	10	20	59
	Medicine	201	139	182	197	719
	Specialised Services	48	30	47	48	173
	Surgery	40	35	36	52	163
	Women's & Children's				1	1
	BRI Total	*309*	*213*	*275*	*318*	***1,115***
St Michaels Hospital (MH)	Women's & Children's	5	10	4	9	28
	MH Total	*5*	*10*	*4*	*9*	***28***
Weston General Hospital (WGH)	Emergency Care	13	1	10	13	37
	Medicine	128	83	122	139	472
	Specialised Services		1		1	2
	Surgery	20	17	11	14	62
	WGH Total	*161*	*102*	*143*	*168*	***574***
Total		**502**	**366**	**465**	**532**	**1,865**

Table 14: Total deaths by Hospital site by quarter for UHBW

CHKS – Benchmarking UHBW performance on the SHMI against acute trust peers.

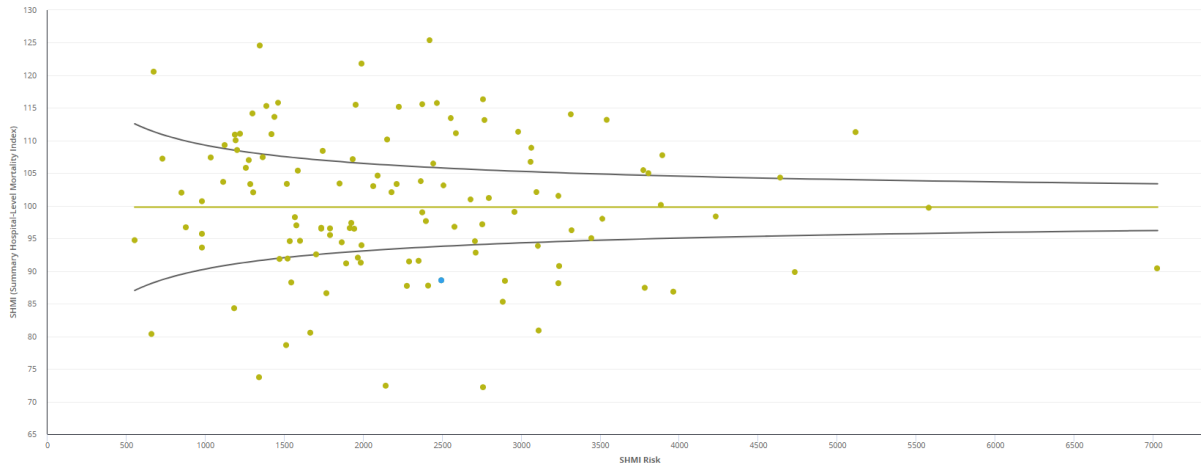


Figure 17: Funnel plot produced by CHKS, showing UHBW position against over acute NHS Trusts for March 2024 to February 2025 on the SHMI measure

CHKS – Benchmarking UHBW performance on the SHMI last 12 months

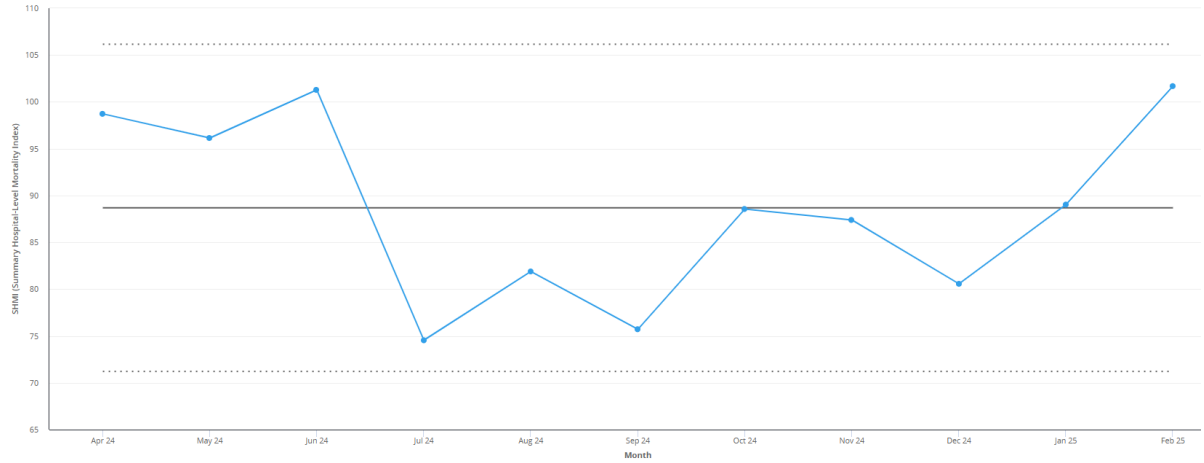


Figure 18: SPC chart produced by CHKS, showing UHBW performance on the SHMI metric over 12 months (March 2024 to February 2025)

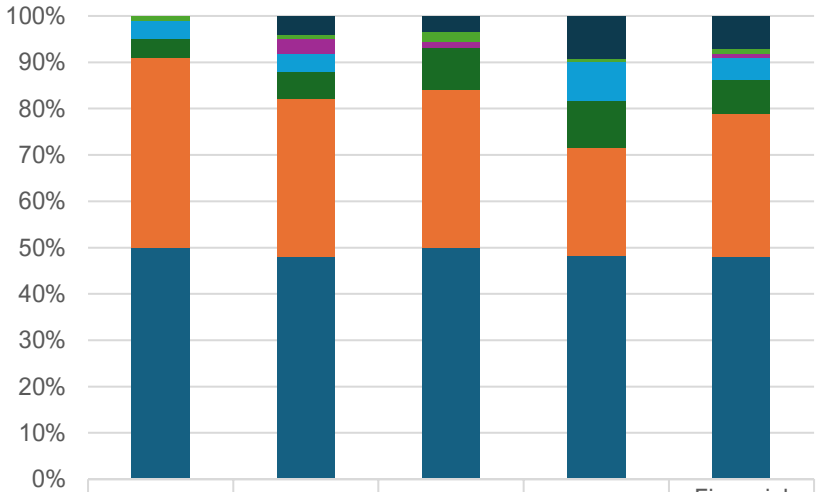
Appendix 6 Detailed UHBW Medical Examiner Referrals Data

Medical Examiner Referrals by Quarter

Quarter	Number of Medical Examiner referrals	% of adult deaths
Q1 2024-25	75	15.5%
Q2 2024-25	74	22%
Q3 2024-25	66	14%
Q4 2024-25	109	21%

Table 15: Table showing number of medical examiner referrals by quarter and proportion of SJRs against adult deaths

Process initiated following a Medical Examiner Referral by Quarter and Financial Year



	Q1	Q2	Q3	Q4	Financial Year
Reviewed by Clinical Team for additional insight	0%	4%	3%	9%	7%
No further action taken	1%	1%	2%	1%	1%
Reported to alternative organisation	0%	3%	1%	0%	1%
Managed by Patient Advice and Liaison Service	4%	4%	0%	8%	5%
Reviewed by Patient Safety Incident Response	4%	6%	8%	10%	7%
Initiated a Structured Judgement Review	41%	34%	30%	23%	31%
Provided feedback to the relevant clinical team	50%	48%	44%	48%	48%

Figure 19: Outcome by quarter of Medical Examiner Referrals

Appendix 7 Detailed UHBW SJR Completion Data

SJR Completion by quarter

Quarter	Number of Mandatory Category SJRs	Number of Care Concerns
Q1 2024-25	15	14
Q2 2024-25	13	13
Q3 2024-25	7	11
Q4 2024-25	8	22

Table 16: Total number of mandatory SJRs and number of care concern SJRs by quarter for UHBW

SJRs initiated by reason by quarter

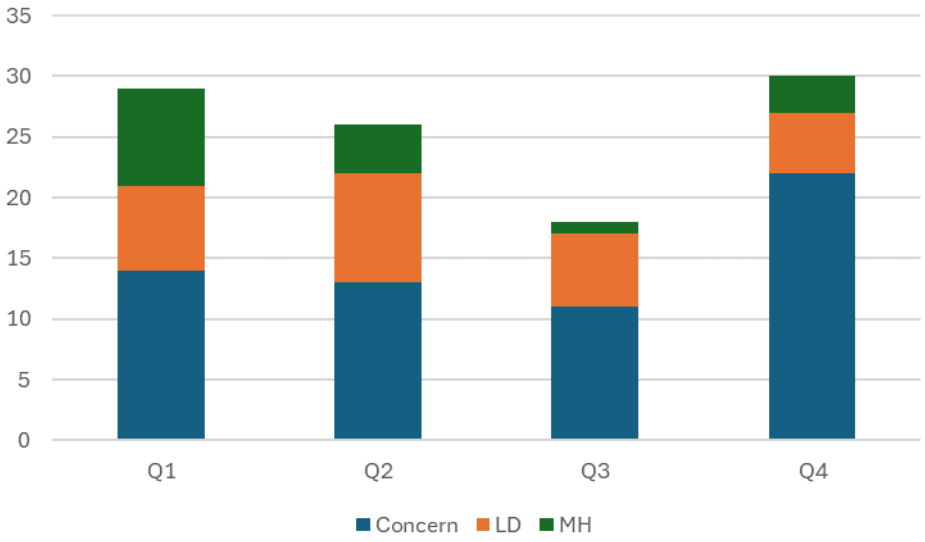


Figure 20: SJRs initiated by type of review

Weston General Hospital and Bristol Royal Infirmary SJR comparison across the financial year

	Weston				BRI			
Financial Year Quarter	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
SJR initiated for treatment/care concern	6	6	3	7	8	6	8	13
Total deaths within hospital site	159	102	143	168	307	213	304	344
Percentage of care concern SJRs by total deaths	3.8 %	5.9 %	2.1 %	4.2 %	2.6 %	2.8 %	2.6 %	3.8 %
Bed base	279	279	279	279	400	400	400	400
Approximate % of bed base occupied by 'medical' in-patients	~75 %	~75 %	~75 %	~75 %	~61 %	~61 %	~61 %	~61 %

Table 17: Total deaths, total SJRs raised as a care concern by Weston General Hospital and Bristol Royal Infirmary

Cover Note

This briefing accompanies the individual 2024–25 Learning from Deaths Annual Reports for North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW).

It provides a comparative analysis across the two organisations, highlighting:

- areas of common strength;
- where systems, processes, and reporting currently differ;
- progress made in aligning approaches since the joint Mortality Improvement Programme was established; and
- priorities and risks as the programme develops through 2025–26.

The Mortality Improvement Programme began at NBT in 2024 and became a joint Bristol NHS Group initiative in early 2025, with dedicated team members in place from February and March. This year marks a transitional phase, focused on:

- Maintaining statutory compliance and robust assurance across both Trusts;
- Delivering early alignment in report structure and language;
- Piloting shared improvement initiatives such as enhanced Structured Judgement Reviews (eSJR) and automated case identification; and
- Preparing the foundations for unified Group-level reporting and oversight.

Both reports demonstrate that statutory requirements have been fully met and that mortality governance remains strong, with over 98% of reviewed cases rated as adequate, good, or excellent care, and no deaths assessed as definitely avoidable.

The comparative briefing sets out a clear pathway towards aligned quarterly reporting, shared digital tools, and standardised referral and review processes during 2025–26.

These developments provide key board assurance during the expansion and acceleration of Group Clinical Services and related pathway changes in line with the Joint Clinical Strategy and will ensure a smooth transition to fully unified Group-level governance and reporting, supporting the planned organisational merger.

Boards are invited to:

- Note the progress achieved in aligning approaches during 2024–25;
- Endorse the proposed focus areas for 2025–26; and

- Support the continued delivery of the joint programme to maintain momentum on ensuring learning from deaths drives meaningful improvements in care quality.

Bristol NHS Group Learning from Deaths - Board Briefing Comparative Analysis 2024-25

Context

The Mortality Improvement Programme began at North Bristol NHS Trust (NBT) in 2024 to strengthen mortality review and learning processes. In early 2025, the programme formally expanded to a joint Bristol NHS Group initiative with University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). Dedicated programme team members joined in February and March 2025, enabling the first steps towards aligned systems, processes, and reporting across the Group.

The aim is to create a unified, best-practice approach to mortality surveillance and learning. This year's annual reports provide a shared baseline, setting the foundation for full Group-level governance and reporting in 2025–26.

What is the Same

- **Compliance** – Both NBT and UHBW continue to meet all statutory Learning from Deaths requirements and National Quality Board (NQB) guidance.
- **Quality of care** – Over 96% of reviewed cases in both trusts were assessed as adequate, good, or excellent care, with no deaths rated as definitely avoidable.
- **Independent scrutiny** – Every death requiring Medical Examiner review under statutory requirements received scrutiny, ensuring robust assurance and opportunities for family feedback.
- **Commitment to learning** – Both reports evidence learning being translated into meaningful improvements in clinical practice.

What's Different

- **Systems and processes** – NBT and UHBW currently operate separate systems for case identification, review, and reporting, which limits ability to align all data.
- **Report emphasis**
    - NBT focuses on early digital automation pilots and API integrations to streamline reviews and enhance cross-division and cross-group data analysis.

    - UHBW highlights workforce development and service-level quality improvement, particularly in sepsis and end-of-life care.
- **Referral patterns** – Variations in Medical Examiner referral categorisation and escalation result in differing referral volumes and proportions across the two trusts.

Progress Since 2023–24

- **Aligned structure and language** – For the first time, both NBT and UHBW reports use a shared structure and plain-English style, improving accessibility and comparability.
- **Shared improvement initiatives** – Enhanced Structured Judgement Reviews (eSJR) and automated case identification pilots are now underway.
- **Coding and documentation** – Both trusts have strengthened coding and documentation processes, improving the accuracy of mortality data and reducing statistical noise in indicators such as SHMI and VLAD. While this gives a clearer reflection of clinical reality, some variation will always remain due to case-mix complexity and the way national indicators are risk-adjusted.

Future Alignment and Next Steps

During 2025–26, the programme will focus on:

- **A transition to joint quarterly reporting**, offering a Group-wide view of mortality trends, learning, and improvement.
- **Roll out aligned and, where possible, shared digital tools**, enabling real-time case tracking, automated alerts, and consistent analytics.
- **Standardise Medical Examiner referral categorisation and review processes** to create common thresholds and approaches, improving comparability and ability to learn from deaths across Bristol NHS Group.
- **Support organisational merger preparations**, embedding unified processes and Group-level assurance.

Key Risks and Mitigations

Risk	Impact	Mitigation
Separate systems and manual processes	Limits efficiency and prevents real-time Group-wide analysis	Digital alignment programme underway; joint dashboards to be piloted in 2025–26
Variability in Medical Examiner referral categorisation	Reduces comparability and risks inconsistent assurance	Joint review of referral thresholds and themes in progress; alignment planned for 2025–26

Resource constraints during transition	Risk of slower progress on automation or review backlogs	Prioritised resourcing plan; automation and API pilots reducing administrative burden
Complexity of merger and Group governance shift	Risk of duplication or gaps in assurance	Aligned quarterly reporting from Q1 2025–26, moving to joint reporting to maintain visibility and support smooth transition.
Statistical interpretation challenges (e.g., SHMI/VLAD context)	Risk of misinterpretation in public or regulatory settings	Enhanced commentary and use of clinical audit benchmarking; aligned validation processes across the Group

Summary

The 2024–25 reports confirm that both NBT and UHBW are delivering safe, transparent, and effective mortality governance while laying the foundations for a single, integrated Group approach. Aligning systems and processes will take time, but key milestones have been achieved. Planned developments during 2025–26 are expected to support a smooth transition to fully unified governance and reporting.

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	9 September 2025		
Report Title:	Annual Medical Revalidation and Appraisal Report		
Report Author:	Sue Nutland, Associate Director of Medical Workforce Strategy and Professional Standards Professor Sanjoy Shah, Trust Medical Director, NBT Tiffany Patten-Lawrence, Head of Medical Workforce Strategy		
Report Sponsor:	Tim Whittlestone, Group Chief Medical Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	x		
	The purpose of this report is to assure the NBT & UHBW Boards in Common that both Trusts are compliant with the NHSE Framework for Medical Revalidation and Appraisal. In addition, it asks for the approval of the annual submission to NHSE.		

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

This report asks NBT & UHBW Boards in Common to note three key areas:

1. The approval required for the sign-off of the annual framework return to NHS England for quality assurance and improvement. It is a statutory requirement to provide an assurance report to NHSE on Medical revalidation and appraisal to provide assurance that their professional standards processes meet the relevant statutory requirements and support quality improvement.
2. Since the 2023 report to the Board, the NBT has introduced a Responsible Officers Advisory Group (ROAG) to monitor compliance with appraisal and revalidation, and oversight of the quality of appraisals. The group has been established to provide assurance that the Responsible Officer manages doctors' appraisal, revalidation and performance, ensuring that these are in line with 2024 Good Medical Practice and aligns with UHBW processes.
3. As we move forward into the group model, the CMO team will foster stronger links and align our systems and processes around appraisal and revalidation, where practicable.

Strategic and Group Model Alignment

The annual board report and statement of compliance support both NBT and UHBW's strategic priorities, especially Patient Safety, Experience, and Investing in Our People, by ensuring annual appraisal and revalidation for all licensed medical staff, upholding high standards, governance, and improving patient outcomes aligned with Good Medical Practice (2024).

The report also outlines the formal merger, synchronising appraisal systems and governance. The procurement of a shared digital appraisal and revalidation platform is underway, promoting consistent standards, clinical accountability, a connected workforce, and cost efficiency.

Risks and Opportunities
There are no risks identified in this report, only actions which are underway with review of the current Appraisal and Revalidation policy and re-procurement of the current Appraisal and Revalidation electronic platform. The opportunities come with the development of the Group model between NBT and UHBW. This will provide us with a move to a shared managed services which fulfil the objectives within our joint clinical strategy.
Recommendation
This report is for **Approval and Discussion** This report is for discussion and approval of the Statement of Compliance for the Framework of Quality Assurance for Responsible Officers.

History of the paper (details of where the paper has <u>previously</u> been received)	
Trust Board	October 2024
Appendices:	Appendix A: NBT Annual Board Report and Statement of Compliance Appendix B: UHBW Annual Board Report and Statement of Compliance

1. Purpose

1.1. This paper informs NBT & UHBW Boards in Common that the processes in place for medical appraisal and revalidation remain robust and that the organisations are compliant with General Medical Council (GMC) requirements, including the 2024 edition of Good Medical Practice.

1.2. The paper assures that both Trusts meet NHSE's Framework for Quality Assurance and Improvement (FQAI) for Responsible Officers (RO) and seeks Board approval to submit the annual board report and statement of compliance to NHSE, with agreement for this to be signed by the Chief Executive Officer.

2. Background

2.1. All NHS Trusts must have systems in place to ensure that medical staff meet the standards set out by the GMC and that their fitness to practise is maintained through a process of annual appraisal and five-yearly revalidation.

2.2. Medical appraisal and revalidation processes are central to ensuring that doctors are supported in their professional development and able to deliver safe, effective care. Each appraisal year runs from 1 April to 31 March, with expectations that doctors complete one appraisal annually unless mitigating circumstances apply (e.g. long-term sickness or parental leave).

2.3. NHS Trusts have a statutory obligation to submit an annual compliance return (Annex A) to NHSE, outlining governance, performance data, and quality assurance measures for medical appraisal and revalidation. The report must be reviewed by the NBT & UHBW Boards in Common and signed by the Chief Executive Officer.

3. Introduction

3.1. At 1st April 2024 the number of doctors with a prescribed connection to the Trusts for revalidation below:

NBT 1004 UHBW 1262

3.2. NBT provides appraisal and revalidation oversight for consultants, SAS doctors, clinical fellows, Trust locums, and academics. Doctors in training remain connected to NHS England.

3.3. From the end of 2024, following GMC regulatory changes, Responsible Officers will also be accountable for appraisal and revalidation governance of Physician Associates (PAs) and Anaesthetic Associates (AAs) employed by the Trust.

3.4. NHSE requires all doctors to undergo an annual whole-practice appraisal, incorporating all roles and responsibilities, and covering relevant information, including complaints, significant events, and clinical outcomes. Where an appraisal is not completed, the reasons must be understood and documented, with appropriate follow-up.

4. NHSE Statement of Compliance for NBT & UHBW

4.1. Appraisal completion is tracked using the FourteenFish system. Appraisals must be completed annually unless a valid exception applies.

4.2. The appraisal process captures practice scope and fitness to practise indicators, including declarations of complaints, incidents, and conflicts of interest. Doctors must confirm appropriate indemnity coverage as part of their appraisal.

4.3. The FourteenFish contract expires in March 2025. NBT has initiated a procurement process for a new system, which may involve a continuation with FourteenFish or a transition to an alternative provider. System implementation is planned for March 2026.

5. 2024/2025 Appraisal Compliance

		NBT	UHBW
5.1	Total appraisals completed	873	1018
5.2	Approved missed appraisals	5	38
5.3	Unapproved missed appraisals:	84	104
5.4	Total revalidation recommendations made:	229	211
5.5	Late recommendations:	0	0

1. Key Developments Over the Past 12 Months

1.1. **Responsible Officer Advisory Group (ROAG)**: ROAG continues to provide oversight and assurance on appraisal and revalidation governance. It brings together senior clinical and HR leaders to advise the RO, oversee quality assurance, and escalate concerns.

1.2. **National Clinical Improvement Programme (NCIP)**: The Trusts continue to engage with NCIP tools, supporting improved use of data in appraisal discussions.

1.3. **Physician Associates and GMC**: As of 2024, the General Medical Council (GMC) officially became the statutory regulator for Physician Associates (PAs) and Anaesthesia Associates (AAs), bringing these professions under its regulatory umbrella to ensure consistent standards of education, conduct, and patient care across the UK. This transition marks a significant step in professionalising the PA workforce and aligning their governance with that of doctors. Our Trusts now serve as the designated Responsible Officer (RO) for our employed PAs, meaning we oversee their appraisal processes, ensure they meet GMC standards, and make revalidation recommendations where required. This new responsibility reinforces our commitment to clinical excellence and accountability across all professional groups

1.4. **Hospital Merger:** Over the past 12 months, the Chief Medical Officer (CMO) teams at both North Bristol Trust (NBT) and University Hospitals Bristol and Weston (UHBW) have undertaken a series of collaborative initiatives to foster a unified and seamless approach to medical workforce matters. Key areas of joint working include:

1.4.1. Harmonisation of Pay Structures: Alignment of agency and locum doctor pay scales, including the introduction of enhanced remuneration for out-of-hours work and emergency rota cover.

1.4.2. Coordinated Industrial Action Planning: A unified strategy for managing the impact of resident doctor strikes, ensuring continuity of care and operational resilience.

1.4.3. Policy Sharing and Alignment: Joint development and dissemination of policies related to job planning, appraisal, and revalidation to promote consistency across both organisations.

1.4.4. System-Wide Responsible Officer (RO) Meetings: Regular cross-organisational meetings to share sensitive information regarding doctors under investigation or

facing challenges under the Maintaining High Professional Standards (MHPS) framework.

1.4.5. Collaborative Engagement with Education Partners: Joint working with the university and deanery to uphold and enhance standards in teaching, training, and medical education.

1.4.6. Integrated Decision-Making Forums: Establishment of joint panels to address concerns related to MHPS or General Medical Council (GMC) standards, applicable to undergraduate students, resident doctors, and senior medical professionals.

1.5. Medical staff engagement: The CMO team at NBT has developed a comprehensive programme of medical engagement initiatives aimed at fostering collaboration, improving communication, and supporting the professional development of medical staff across all levels. These events and forums are designed to ensure that clinicians are well-informed, empowered, and actively involved in shaping the Trust's strategic direction. The key engagement activities include:

1.5.1. Senior Medical Engagement Event: A dedicated forum for senior medical staff to engage with executive leadership, discuss strategic priorities, and contribute to decision-making processes affecting clinical services and workforce planning.

1.5.2. New Consultant Onboarding Programme: A structured induction programme tailored for newly appointed consultants, providing orientation on Trust policies, clinical governance, leadership expectations, and available support systems. This initiative ensures a smooth transition into the organisation and promotes early integration into the clinical leadership community.

1.5.3. Weekly Meetings with Clinical Directors: Regular touchpoints between the CMO team and Clinical Directors to discuss operational challenges, workforce issues, and service developments. These meetings serve as a vital conduit for two-way communication and agile decision-making.

1.5.4. Biannual Appraisal Updates: Twice-yearly sessions to update appraisers and appraisees on best practices, regulatory changes, and internal processes related to medical appraisal and revalidation. These updates help maintain high standards of professional development and compliance.

1.5.5. Bimonthly Statutory and Mandatory Training Updates: Integrated into the Trust's mandatory training programme, these sessions provide clinicians with essential updates on governance, safety, and regulatory requirements, ensuring alignment with national standards.

1.5.6. Guardian of Safe Working (GOSW) Resident Doctors Forum: Facilitated by the Guardian of Safe Working, this bi-monthly forum is specifically designed for resident doctors. It provides a safe space to discuss rota issues, working conditions, training concerns, and wellbeing support, ensuring junior doctors are heard and supported.

1.5.7. Monthly All-Staff Town Hall Meetings: Open to all staff, these sessions promote transparency and inclusivity by sharing organisational updates, celebrating achievements, and addressing questions from across the workforce.

2. Actions for 2025/2026

2.1. Complete the re-procurement of the medical appraisal and revalidation system.

2.2. Finalise the revised Medical Appraisal and Revalidation Policy (early 2026).

2.3. Complete a peer review of appraisal processes.

2.4. Develop and implement appraisal and revalidation processes for PAs and AAs.

2.5. Continue delivery of EDI priorities, including rollout of anti-racism programmes.

3. Summary and Recommendations

3.1. Note the contents of this report and the full Statements of Compliance in the appendices.

3.2. Approve the submission of the 2025 Framework for Quality Assurance and Improvement return (Annex A) to NHS England.

3.3. Approve that the Joint Chief Executive Officer may sign the Statement of Compliance on behalf of the Trusts.

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers; however, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged, therefore, to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: North Bristol NHS Trust

can confirm that:

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

Y/N	Yes
Action from last year:	
Comments:	The Trust continues to have an appropriately trained and licensed Responsible Officer (RO) in Mr Tim Whittlestone, Group Chief Medical Officer. The Interim Site Medical Director NBT is also a trained deputy RO.
Action for next year:	

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Continue the Appraisal and Revalidation procurement process.
Comments:	Sufficient funds, capacity and resources remain in place to support the RO role. Funding continues from the Medical Workforce budget. Additional support has been factored in to accommodate work with University Hospitals Bristol and Weston NHS

	Foundation Trust (UHBW) in light of the Hospital Group's strategy.
Action for next year:	Procurement of our Medical Appraisal and Revalidation system by March 2026, jointly with UHBW.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	
Comments:	Records of prescribed connections are maintained via ESR, FourteenFish and GMC Connect, with ongoing data integrity reviews conducted jointly by the CMO, Medical Workforce, and Appraisal & Revalidation teams.
Action for next year:	

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Finalise the Medical Appraisal and Revalidation Policy.
Comments:	There was a delay in the refresh of the policy due to ongoing review Physicians and Anaesthetics roles and responsibilities. The NBT LNC objected to the inclusion of these roles within the Medical Revalidation Policy. Agreement was reached to continue with the policy as was pending the Leng Review. Now this has been completed we will progress with a joint Medical and PA appraisal and revalidation policy. As we move closer as a Hospital Group, we will be looking to align all our medical policies where practical.

Action for next year	Finalise the Medical Appraisal and Revalidation Policy to include PAs and AAs.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	Peer review to be conducted
Comments:	A regional Peer Review was conducted in 2023 where a small number of recommendations were made including developing super appraisers and development of a ROAG meeting. All of which have been implemented. A comparison of the Trust's appraisal and revalidation processes was carried out within the system procurement in collaboration with UHBW. Key findings and actions have been fed into the 2025/26 work plan.
Action for next year:	A detailed review of the appraisal and revalidation process at NBT and conducting a Peer Review with UHBW. The aim to have a single Group process within two years.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	
Comments:	Enhanced support for locums and short-term doctors remains in place. The induction programme was updated in October

	2024, with specific revalidation guidance added. A review of appraisal eligibility for longer-term locums is underway. There is a specific section in our local processes to support short term locums and those on NBT Locums Nest.
Action for next year	

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	
Comments:	Our doctors undergo an annual appraisal that covers their whole scope of practice for which a GMC licence to practise is required. This includes all clinical and non-clinical roles undertaken within and outside the organisation during the appraisal period. The process ensures that all relevant information relating to a doctor's fitness to practise is reviewed, including complaints, significant events, and outlying clinical outcomes where applicable. Appraisers are trained to explore this information constructively and support reflection and learning. The appraisal system enables the recording and review of this data in line with GMC and NHS England guidance. There is joint working with our Group partner UHBW plus quarterly meetings with private sector partners to discuss any new or ongoing issues with medical practitioners which would feed into their appraisal and revalidation.
Action for next year:	As the Group comes together a formal appraisal and revalidation joint process to be developed.

1B(ii) Where in Question 1B(i) this does not occur, there is a full understanding of the reasons why and suitable action is taken.

Y/N	N/A
Action from last year:	
Comments:	.
Action for next year:	

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Review and ratify the Appraisal and Revalidation policy by January 2025
Comments:	Please see 1A(iv) Our current Appraisal and Revalidation policy remains in place and has been risk assessed through the Trust People Oversight Group. Moving forward the policy will be aligned with UHBW
Action for next year:	Joint policy alignment

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	
Comments:	NBT maintain sufficient numbers of trained medical appraisers to ensure the timely completion of annual appraisals for all licensed medical practitioners. Appraiser capacity is monitored by the Appraisal and Revalidation Team and is supported by 0.25 SPA. Appraiser numbers are reviewed quarterly, and additional training is commissioned as needed to address any emerging shortfall across clinical divisions.
Action for next year:	To have joint training for appraisers across the Group.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	
Comments:	Medical appraisers participate in ongoing performance review and development activities to maintain the quality and consistency of appraisals. This includes annual refresher training, peer review discussions, and attendance at appraisal network events. All appraisers are expected to engage in regular calibration activities to support alignment of professional judgements and adherence to national standards. Performance feedback is gathered through appraisee surveys and quality checks on submitted appraisals, with outcomes reviewed by the Appraisal and Revalidation Team and the ROAG.
Action for next year:	As above – joint training to be developed across the Group

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process, and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	
Comments:	The appraisal system for doctors is subject to a robust quality assurance process, overseen by the Appraisal and Revalidation Team. This includes an audit of appraisal completion rates, quality of supporting information, timeliness, and appraiser feedback. The findings are reviewed through the ROAG, which reports to the Medical Professionals Group, and the People governance structure though to the Trust Board. Areas for improvement are identified through this process and inform appraiser development, policy updates, and system enhancements.
Action for next year:	

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	
Comments:	Recommendations to the GMC regarding the fitness to practise of doctors with a prescribed connection to our RO are made following GMC requirements. These are submitted within the expected timescales and are based on a thorough review of the doctor's appraisal portfolio and supporting information. The majority of deferrals relate to missing feedback; steps have been taken to engage doctors earlier in their revalidation cycle to mitigate this issue and improve compliance.
Action for next year:	

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	
Comments:	Revalidation recommendations made to the GMC are confirmed promptly to the doctor. In cases where a deferral or non-engagement recommendation is being considered, the reasons are discussed with the doctor in advance wherever possible. The Appraisal and Revalidation Team reviews the portfolio and flags any gaps early, allowing time for the doctor to address them. Where a discussion cannot take place before submission, the reasons are documented and reviewed by the RO. This process ensures transparency, maintains engagement, and supports the doctor's understanding of the recommendation made on their behalf.
Action for next year:	

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	
Comments:	Governance structures such as the ROAG and MPG provide oversight of appraisal, revalidation, and professional standards. These groups ensure alignment with national guidance and offer a platform for raising and addressing clinical governance concerns. The Trust also promotes a culture of openness, learning, and accountability, underpinned by Just Culture principles and supported by processes such as Freedom to Speak Up, incident reporting, and regular clinical audit and peer review.
Action for next year:	

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	
Comments:	Effective systems are in place to monitor the conduct and performance of all doctors working within the organisation. This includes regular review of appraisal outputs, incident and complaint data via the Trust's risk management system (Radar), and formal processes under the Maintaining High Professional Standards (MHPS) framework. The Decision-Making Group (DMG), oversees complex cases, ensuring consistent application of policy and early intervention where needed. All concerns are assessed with reference to GMC Good Medical Practice, and outcomes are monitored through ROAG to ensure appropriate action, learning, and support.
Action for next year:	

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	
Comments:	All relevant information required for appraisal is made available to doctors in a convenient and accessible format via the FourteenFish appraisal system. This includes previous appraisal outputs, colleague and patient feedback, complaint and incident data (where applicable), and records of statutory and mandatory training. The platform allows doctors to upload and reflect on supporting information across their whole scope of practice. Guidance and support are provided by the Appraisal and Revalidation Team to ensure doctors understand what is required and how to access or present the necessary information.
Action for next year:	

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	
Comments:	A clear process is in place for responding to concerns about a doctor's fitness to practise, supported by the Trust's approved Maintaining High Professional Standards (MHPS) policy. This framework outlines arrangements for managing concerns related to conduct, capability, health, and fitness to practise. Concerns are initially reviewed by the Decision-Making Group (DMG), which determines whether a formal investigation is required. Where appropriate, interventions may include occupational health support, additional supervision, training, or formal action. The process is underpinned by Just Culture principles and is designed to ensure fairness, timeliness, and patient safety.
Action for next year:	

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	
Comments:	The system for responding to concerns about doctors is subject to a formal quality assurance process. Data on the number, type, and outcomes of concerns is captured through the Employee Relations system (Conformity). A quarterly report is submitted to the private Trust Board relating to doctors undergoing formal investigation, which includes analysis by protected characteristics.
Action for next year:	Strengthen the information contained within the Private Board report on country of primary qualification.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	
Comments:	A process is in place to ensure the timely and effective transfer of information and concerns between the NBT's RO and the ROs or governance leads in other organisations. This applies to: a) doctors connected to our RO who also practise elsewhere, and b) doctors whose prescribed connection lies with another organisation but who also work within our Trust. Information is shared in line with GMC and NHS England guidance, and confidentiality is maintained following data protection requirements. The Appraisal and Revalidation Team coordinates the transfer of information, ensuring a clear audit trail is maintained. The process is regularly reviewed by the RO to ensure accuracy, timeliness, and compliance with national standards.
Action for next year:	

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors, including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	
Comments:	Safeguards are in place to ensure that clinical governance arrangements, including the management of concerns about a doctor's practice, are fair, consistent, and free from bias or discrimination, in line with the GMC governance handbook. All staff involved in investigations and formal processes receive training in the MHPS framework, equality and diversity. The Trust applies Just Culture principles throughout its MHPS processes. Cultural Ambassadors are involved in formal cases where appropriate, supporting fair decision-making and identifying any systemic or individual bias including at the Decision Making stage.
Action for next year:	

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	
Comments:	Systems are in place to capture governance-related developments and opportunities arising from the wider system, including national reviews, reports, and enquiries. Relevant updates are monitored by the Responsible Officer and Medical Workforce team, with key findings discussed at ROAG and the Medical Professionals Group. Where appropriate, these are integrated into local policy, procedures, and training.
Action for next year:	

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	
Comments:	Systems are in place to review professional standards arrangements across all healthcare professionals, with actions taken to promote consistency in line with the recommendations of the Messenger Review. Oversight is provided through the ROAG, which reviews standards and governance processes for doctors, including Consultants, SAS doctors, Locally Employed Doctors, and Physician Associates. Feedback from the MPG supports alignment across specialties. Work is underway to align appraisal processes more closely across professions, with plans to integrate PAs and AAs into the medical appraisal and revalidation policy.
Action for next year:	

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	
Comments:	Systems are in place to ensure all doctors, including locum and short-term appointments, undergo appropriate pre-employment background checks. This includes verification of qualifications, employment history, references, and enhanced DBS checks. Professional registration is confirmed via GMC Connect, and employment checks are carried out in line with NHS Employers' standards. Locum doctors sourced through NBTeXtra are subject to the same checks, which are audited regularly under framework agreements. All new doctors must complete a comprehensive induction programme before commencing clinical duties, ensuring they are suitably skilled and prepared for their role.
Action for next year:	

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	
Comments:	A system is in place to ensure that professional standards activities actively support a positive organisational culture where excellence in clinical care can thrive and continuously improve. This is underpinned by clear leadership commitment, regular Medical Engagement events, and governance structures such as ROAG and the MPG. These forums enable open discussion of clinical standards, feedback from senior medical staff and multi-professional colleagues, and identification of areas for development. A senior medical engagement programme is in place where Consultant and SAS doctors meet with senior leaders in the organisation on a monthly basis.
Action for next year:	

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	
Comments:	A system is in place to ensure that compassion, fairness, respect, diversity, and inclusivity are proactively promoted throughout the organisation. Our ED&I plan published late 2023 set out our four priorities over the next three years which include: a. Ensuring EDI ownership and accountability b. Eliminating discrimination, harassment, bullying and violence. c. Embedding fair and diverse recruitment processes d. Closing the pay gap These principles are embedded in Trust policies, leadership behaviours, and day-to-day practice. The Trust is committed to becoming an anti-racist organisation, with dedicated training programmes for current and future leaders. Cultural Ambassadors are involved in formal processes to promote fairness and reduce bias, and staff are supported through initiatives such as Freedom to Speak Up, EDI networks, and inclusive recruitment practices.
Action for next year:	

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	
Comments:	A system is in place to ensure that the values and behaviours of openness, transparency, freedom to speak up, and a learning culture are embedded and continually strengthened across the organisation. Freedom to Speak Up Guardians provide confidential support and report directly to the Board, while the Guardian of Safe Working (GoSW) ensures resident doctor concerns are raised and addressed. Staff are encouraged to report concerns via Radar (new quality governance tool), with assurance that whistleblowers are protected. These principles are also reflected in onboarding programmes, Medical Engagement events, and forums such as ROAG and MPG, reinforcing a culture where learning, reflection, and improvement are valued at every level.
Action for next year:	

1F(iv) Mechanisms exist that support feedback about the organisation’s professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	
Comments:	Mechanisms are in place to support feedback from connected doctors on the organisation’s professional standards processes, including a formal complaints procedure. Doctors can raise concerns through Radar or the Freedom to Speak Up route, with assurances of confidentiality and appropriate follow-up. Feedback is also gathered through appraisal quality assurance processes, Medical Engagement events, and onboarding sessions. Information on how to provide feedback or raise a complaint is included in induction materials and available on our internal LINK platforms.
Action for next year:	

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	
Comments:	Data is captured through the Employee Relations tracker (Conformity) and ethnicity data is included within our Private Trust Board report on Medical Professionals under investigation. Cultural Ambassadors are involved in formal processes to support fairness and identify any potential bias. The Just Culture framework underpins all case management, ensuring consistent application of standards and appropriate support for all doctors, particularly those from underrepresented or minority backgrounds.
Action for next year:	Tighten up the practice of recording country of primary qualification in reporting.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	To ensure consistency in professional standards processes, collaborate with UHBW as we move into a formal Hospital Group. Attend network meetings, engaging in higher-level RO quality review processes, and participating in peer review programmes.
Comments:	The Trust takes active steps to ensure that its professional standards processes remain consistent with those of other organisations. This includes participation in network meetings and collaboration with the GMC's Employer Liaison Adviser. Over the past year, we have progressed in joint working with UHBW in preparation for forming a formal Hospital Group. This collaborative approach will continue to be developed to support consistency and reduce duplication across the Group.
Action for next year:	

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025.

All data points are about this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	1004
Total number of appraisals completed	873
Total number of appraisals approved missed	5
Total number of unapproved missed	84
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	229
Total number of late recommendations	0
Total number of positive recommendations	174
Total number of deferrals made	55
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	1
Total number of trained case investigators	13
Total number of trained case managers	6
Total number of concerns received by the Responsible Officer[2]	11
Total number of concerns processes completed	8
Longest duration of concerns process of those open on 31 March (working days)	250
Median duration of concerns processes closed (working days)[3]	N/A
Total number of doctors excluded/suspended during the period	2
Total number of doctors referred to GMC	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	1
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	598
Total number of new employment checks completed before commencement of employment	3588
Total number claims made to employment tribunals by doctors	1
Total number of these claims that were not upheld[4]	Not yet heard at ET

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Since the 2024 Designated Body Annual Board Report and Statement of Compliance, North Bristol NHS Trust has continued to strengthen its governance structures within medical appraisal, and revalidation. The Responsible Officers Advisory Group and Medical Professionals Group have become well-established, offering clear oversight and governance into quality assurance, policy development, and concerns management processes. The Trust completed an informal peer review of its appraisal and revalidation framework in Q4 2024/25 by comparing its processes with our Group partner UHBW, using the findings to inform future quality improvement. Work has also progressed on the development of an appraisal and revalidation framework for Physician Associates and Anaesthetic Associates, in preparation for GMC regulation in late 2024. Although the Medical Appraisal and Revalidation Policy was due for ratification in early 2025, the LNC raised objection to the inclusion of Physicians Associates into the policy, this caused delay in progressing the review and it was agreed the policy would remain as was until the Leng review recommendations were made. The revised policy will now be reviewed and aligned with UHBW with a view to completion by early 2026. A risk assessment has been undertaken of the current policy so that we are able to continue its use until an aligned policy is developed.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

The procurement of a replacement for the FourteenFish appraisal system is underway. A specification has been developed based on engagement across both NBT and UHBW, with procurement and implementation required by April 2026. The Trust continues to use FourteenFish with full support and data integrity assurance in the interim. Quarterly Senior Medical Engagement events have continued to provide a valuable platform for discussion on Trust priorities, clinical governance, and professional standards. Alongside these sessions the Resident Doctors Forum continues led by the Guardian of Safe Working, and in which Clinical Fellows are included. The Trust has also expanded its equality, diversity and inclusion (EDI) work, including pilot anti-racism training for medical leaders and increased involvement of Cultural Ambassadors in formal processes.
Actions still outstanding
Finalisation of the revised Medical Appraisal and Revalidation Policy (expected early 2026). Implementation of a formal appraisal and revalidation framework for Physician Associates and Anaesthetic Associates. Completion of appraisal system procurement and preparation for April 2026 implementation.
Current issues
There are no significant concerns or compliance risks currently identified.
Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1):
Finalise and launch the revised Medical Appraisal and Revalidation Policy. Complete procurement and begin implementation planning for the new appraisal system. Establish a formal appraisal and revalidation process for Physician Associates. We currently do not have any Anaesthetics Associates in place. Continue strengthening RO collaboration and shared governance across the Hospital Group.

Overall concluding comments (consider setting these out in the context of the organisation’s achievements, challenges and aspirations for the coming year):
Over the past year, North Bristol NHS Trust has made good progress in strengthening its medical professional standards systems, supporting both GMC compliance and clinical governance. The next 2–3 years will focus on aligning professional standards processes across the Hospital Group, embedding revalidation for newly regulated roles, and continuing to raise the quality of appraisals through data-informed, reflective practice. The Trust remains committed to fostering a fair, inclusive, and learning-oriented culture that supports high standards of care and professional accountability.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:

can confirm that:

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

Y/N	Yes
Action from last year:	Update roles as appropriate

Comments:	UHBW is due to be merged with NBT when the group trust RO will be Bristol Hospitals Group Chief Medical Officer Tim Whittlestone in April 2026. Currently the UHBW RO remains as: Dr Rebecca-Anne Maxwell Medical Director Dr Rebecca Thorpe is deputy RO and deputy medical director. Dr Helen Rees Revalidation and Appraisal lead Dawn Shorten – Revalidation admin officer Previous RO Stuart Walker remains at UHBW but as Managing Director.
Action for next year:	Update as appropriate.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Continue working with HR and Divisions around approaches to appraisers and job planning. Explore potential for more shared appraisers with North Bristol Trust and continue working with divisions around job planning for appraisers.
Comments:	Group model and merger with NBT will progress towards a fully supported integrated approach to appraisal across both organisations.
Action for next year:	Explore alignment of policies and possible integration of processes with NBT

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained to ensure changes to medical staff are swiftly amended on all relevant systems.

Comments:	Our online appraisal portfolio system automatically links to the GMC list to ensure visibility of all connected doctors. A regular review of the list of prescribed connections is undertaken alongside a regular information feed from HR to ensure it remains up to date.
Action for next year:	Nil identified

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Review Medical Appraisal and Revalidation Policy for minor amendments should changes occur
Comments:	Regular reviews ongoing, from Dec 24 policy now also includes PAs. A joint policy will be drafted over the next 12 months
Action for next year	Joint UHBW/NBT policy to be drafted.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	Consider future peer reviews with NBT and UHD.
Comments:	Peer review completed and the collaboration with UHD is ongoing. We also maintain a regular review of processes with NBT. Sirona have also requested a peer review to take place in Autumn 2025
Action for next year:	Continue to invite and participate in peer reviews

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	Continue to actively ensure that all Clinical fellows and bank/locum doctors are designated a supervisor within 3 months of starting within the trust to guide on appraisal.
Comments:	All doctors have access to Fourteen Fish, an appraiser and are contacted upon joining to ensure awareness of appraisal/revalidation systems and requirements including joint appraisals. This is also reinforced at induction events. There is provision on Fourteen Fish to appraise at UHBW and maintain a connection with another Trust and this portfolio for their revalidation. Doctors are contacted on an individual basis by the Medical Appraisal Manager, and if there are any issues also guided by the Appraisal Lead and an individualised plan made. For Clinical Fellows compliance is good, and we have visibility of locum and bank doctors though these doctors remain the most challenging group.
Action for next year	Align processes with NBT when the Trusts merge.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Nil
Comments:	All appraisals are all reviewed prior to revalidation to ensure full scope of practice is covered and there is an additional check built into the

	appraisal system to require doctors to declare if they undertake private practice. There is close liaison with local private sector providers to ensure appropriate information transfer. There is a regular complaints feed into the appraisal process and a regular feed of low-level concerns at divisional level. Regular appraiser updates sessions are offered to support the appraisers, discuss challenging conversations, provide peer support and also to identify issues in the appraiser processes
Action for next year:	Nil

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Continue this process
Action from last year:	Nil
Comments:	Where a doctor has not completed an appraisal in year (other than approved missed appraisals) the appraisal date is bought forward to the beginning of the next year to ensure that the length of time between appraisals is minimised. Communications always detail outstanding requirements and actions. Every effort is made to work Doctors locally with support from our appraisal lead and GMC ELA. In May 2024 we commenced sending REV 6 notifications where no response is received. These doctors are discussed at our internal ROAG meeting and an appropriate action plan put in place
Action for next year:	Nil

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Nil
Comments:	Completed and approved July 2023
Action for next year:	Nil

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	Continue to ensure that appraisal capacity is maintained.
Comments:	This is continuously monitored. We continue to recruit and train new appraisers twice a year.
Action for next year:	Continue to ensure that appraisal capacity is maintained.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Continue to develop and refine this process

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	We programme external web-based training for appraisers alongside local informal feedback/workshop updates. Outputs and feedback comments are reviewed to assess training needs etc..
Action for next year:	Work with NBT providing joint training and quality assurance activities.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Continue to develop and refine this process
Comments:	All outputs and feedback reports are reviewed by senior members of the RO team. The QA process is also been picked up through the peer review process. There remains ongoing training with appraisers to ensure high quality appraisal outputs. Any notable findings are included in the Board report.
Action for next year:	Continue to develop and refine QA process

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Work with our GMC liaison officer to issue REV6 non-engagement notices.
Comments:	All recommendations are submitted by the due date. for This is the first year we have issued REV6 notices, all of which have resulted in immediate and successful engagement. This is now a standard process for non engagement.

Action for next year:	None identified

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Nil
Comments:	All doctors are contacted a minimum of 6 and then 4 months prior to revalidation to outline any remaining requirements and a plan to ensure these are met. In addition, the trust Appraisal Lead will review portfolios of those doctors due up to a year in advance of revalidation to ensure readiness. Where doctors may require a deferral they contacted and given an explanation and plan to work to ensure revalidation is not deferred on a second occasion. All doctors are contacted as soon as the recommendation for revalidation has been made to make them aware.
Action for next year:	Nil

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	None identified

Comments:	UHBW has an active patient safety, audit and effectiveness culture overseen by the Quality team at the Trust. The work of this team is outlined in the UHBW Quality Strategy
Action for next year:	Nil

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	None identified
Comments:	All capability and conduct concerns are dealt with according to policy and monitored by ROAG. Information feeds from appraisal, complaints and divisional teams are regularly reviewed by the RO team.
Action for next year:	None identified

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	None identified
Comments:	The web based portfolio provides an accessible clear and user friendly appraisal template for Drs to complete. Any correspondence for inclusion in portfolios is sent to Drs online. Complaints and concerns can be downloaded from

	incident reports to upload to portfolios, and screenshots of the online training record can be used as proof of training compliance etc..
Action for next year:	None identified

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	None identified
Comments:	Robust policies are in place which follow nationally approved procedures for reviewing and responding to any concerns raised. This includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns. All concerns are monitored by the Responsible Officer Approval Group.
Action for next year:	Ensure alignment of processes with NBT over merger period.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes

Action from last year:	Consider regular EDI audit every 3-5 years for assurance.
Comments:	EDI Audit scheduled for next year prior to implementation of merger with NBT
Action for next year:	Schedule EDI audit for spring summer 2026

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	None identified
Comments:	The Trust follows the GMC established protocols for the transfer of information between Responsible Officers. RO to RO calls are arranged promptly where concerns are raised to share relevant information. Regular RO meetings are held with local Trusts to ensure information can be shared between organisations as appropriate. All new starters have an MPIT or TOI form completed and uploaded onto the appraisal system. Exceptions are doctors who transfer from HEE where the ARCP outcome is used for this process. Any concerns are flagged to the Deputy RO directly.
Action for next year:	Nil identified

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	None identified
Comments:	The Trust has a strong equality and diversity ethos and policies covering bias and discrimination
Action for next year:	None identified

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	None identified
Comments:	The Trust governance structure takes note of national reports and recommendations. Relevant teams review processes for assurance to ensure robust systems are in place. Eg. PAs were added to the Trust medical appraisal framework when GMC registration was proposed (2021/22), recent GMC PA guidance for GMP and professional standards, and recommendations included in the Leng Review.
Action for next year:	None identified

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	None identified

Comments:	Professional Standards are reviewed and updated as necessary in line with Trust and NHS policies and cover healthcare scientists and PAs, as well as medical and dental staff.
Action for next year:	None identified

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	None identified
Comments:	Full pre-employment background checks are undertaken by the HR team. We were able to review and confirm the robustness of this process during COVID when we were able to supply this information to support emergency the placement of doctors to other organisations.
Action for next year:	None identified

1F – **Organisational Culture**

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	Nil
Comments:	UHBW works closely with the University of Bristol on many fields of research and clinical practice. Several departments are led by internationally recognised clinicians with strong academic profiles. The Trust supports collaborative leadership and organisational values. In addition, activities to drive improvements promoting equity and inclusion, positive leadership, and a safe, open and honest learning culture are part of the current management development programme.
Action for next year:	None identified

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Schedule EDI audit for every 3-5 years
Comments:	Our last EDI audit looked at the characteristics of our appraisers in comparison to our medical cohort as well as our deferrals and FTP referrals. This data was reassuring in that we did not identify any major areas of concern, though will need regular monitoring. Next audit scheduled for spring 2026
Action for next year:	EDI audit Spring 2026

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of

whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	None identified
Comments:	Key performance indicators comprise: - Speaking Up concerns raised. The outline of all concerns will be recorded, and outcomes monitored by the Board and People Committee to identify any key themes or issues patterns/similarities to maintain a safe learning culture within the Trust. - National staff survey indicators relating to staff feeling secure about raising concerns about unsafe clinical practice and having confidence in the organisation to address the concern. -UHBW quarterly Staff Survey - A programme of workshops promoting awareness around discrimination and bias have been rolled out by staff appointed to review provision in the Trust, in conjunction with the launch of Trustwide inclusion and diversity networks.
Action for next year:	None identified

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	None identified
Comments:	Feedback is requested and shared for learning and quality improvement as part of Trust professional standards procedures
Action for next year:	None identified

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	Schedule EDI Audit every 3-5 years
Comments:	In 2022/3 we completed an EDI audit looking at the characteristics of our appraisers in comparison to our medical cohort, as well as our deferrals and FtP referrals. This data was reassuring in that we did not identify any major areas of concern, and will be monitored with regular audits every 3-5 years.
Action for next year:	EDI Audit for assurance scheduled for spring 2026

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Formalise peer review dates
Comments:	The RO and Deputy ROs attend RO network meetings and discuss issues with affiliated organisations to ensure appropriate alignment. Regular meetings are held with local organisations and peer reviews have been held with UH Dorset and NBT, another is planned for autumn 2025 with Sirona. The UHBW MD Team administrator has also set up a national medical appraisal and revalidation support team network with a collaborative

	working site on NHS Futures which is accessed regularly by nearly 100 members to communicate, share and compare processes across the UK.
Action for next year:	Continue to invite peer reviews with other Trusts

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	1262
Total number of appraisals completed	1018
Total number of appraisals approved missed	38
Total number of unapproved missed	104
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	291
Total number of late recommendations	0
Total number of positive recommendations	211
Total number of deferrals made	79
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	79
Total number of trained case investigators *Specifically relates to MHPS trained, though the Trust does have staff groups and bank staff who have undergone investigation training.	25 *
Total number of trained case managers	25*
Total number of concerns received by the Responsible Officer[2]	4 MHPS 3 GMC
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	168 days
Median duration of concerns processes closed (working days)[3]	n/a
Total number of doctors excluded/suspended during the period	1

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of doctors referred to GMC	5
Total number of appeals against the designated body's professional standards processes made by doctors	1
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	520
Total number of new employment checks completed before commencement of employment	485
Total number claims made to employment tribunals by doctors * 1 ET dismissed no hearing, 1 withdrew settled, 1 one still in process	3*
Total number of these claims that were not upheld[4]	1

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Peer reviews completed. Next EDI Audit scheduled. Issue Rev 6 notices for non-engagement now standard procedure.
Actions still outstanding
Peer review to be scheduled with Sirona.
Current issues
Alignment of processes with NBT to move to explore integration following the plan to merge both Trusts. Previous reviews to align processes should hopefully mean minimal impact for our Drs.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Procurement for the re-tendering process of a joint online portfolio will recommence in the autumn. This was paused of this whilst our current portfolio provider was acquired by another company.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Update roles as appropriate • Explore alignment of policies and possible integration of processes with NBT • Joint UHBW/NBT Medical Appraisal and Revalidation policy to be drafted. • Work with NBT on joint provision of training and quality assurance activities. • Continue to ensure that appraisal capacity is maintained. • Continue to use Rev 6 Notices • Continue to develop and refine QA process • Ensure alignment of processes with NBT over merger period. • Continue to invite peer reviews with other Trusts • Complete Peer Review with Sirona • Complete EDI Audit
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
There will be many challenges as the merger progresses to integrate processes but the aspiration will always be that improvements for our clinicians are enabled as a result.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	University Hospitals Bristol and Weston NHS Foundation Trust

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	9 September 2025		
Report Title:	Integrated Governance Report		
Report Author:	Mark Pender, Head of Corporate Governance Richard Gwinnell, Deputy Trust Secretary		
Report Sponsor:	Xavier Bell, Group Chief of Staff		
Purpose of the report:	**Approval**	**Discussion**	**Information**
			X
	To present the integrated governance report, which brings together the Committee Chairs' upwards reports, the registers of seals for UHBW and NBT, and other governance related items.		

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

Attached are the following items for the Board's information:

Committee Chairs' Reports from the July 2025 meetings:
Audit Committee in Common (Appendix A)
Digital Committee in Common (Appendix B)
Finance & Estates Committee in Common (Appendix C)
People Committee in Common (Appendix D)
NBT Quality and Outcomes Committee (Appendix E)
UHBW Quality and Outcomes Committee (Appendix F)

Register of Seals – July to September 2025 (Appendix G)

Strategic and Group Model Alignment

These documents directly support the Board's ambition to form a Group, and these documents support the new governance model being implemented.

Risks and Opportunities

None.

Recommendation

This report is for **Information.**

The Boards are asked to note the documents attached to this report.

History of the paper (details of where paper has previously been received)	
N/A	
Appendices:	Audit Committee in Common Chair's Report (Appendix A) Digital Committee in Common Chair's Report (Appendix B) Finance & Estates Committee in Common Chair's Report (Appendix C)

	People Committee in Common Chair's Report (Appendix D) NBT Quality and Outcomes Committee Chair's Report (Appendix E) UHBW Quality and Outcomes Committee Chair's Report (Appendix F) Register of Seals (Appendix G)

Meeting of Group Board of Directors of NBT and UHBW held in Public
9 September 2025

Reporting Committee	**Audit Committee in Common – July 2025 meeting**
Chaired By	**Shawn Smith, NBT Non-Executive Director**
Executive Lead	**Neil Kemsley, Group Chief Finance & Estates Officer**

For Information

1. This was the first meeting of the Audit Committee held in common between NBT and UHBW, which was a welcome step in the formation of the Bristol NHS Group.

2. The committee reviewed the Board Assurance Framework (BAF) for quarter two, which contained the Trust's principal risks. A discussion took place on whether a risk of power outage should be included on the BAF given the power outage at UHBW last year, and it was agreed that this would be looked at. The Committee also discussed how risks were escalated to the BAF, and where mitigations were recorded. It was noted that risk management at both trusts would be subject to a joint internal audit review during the current financial year.

3. The committee received the following internal audit final review reports:
   - UHBW Risk Management / BAF– Satisfactory
   - UHBW Financial Recovery (CIP)– Satisfactory
   - UHBW Theatre Safety – Satisfactory

   It was reported that there was a total of eight overdue recommendations for UHBW and nine for NBT, which was a much-improved position.

   An update on progress on the planning of reviews for 2025/26 was also provided and minor amendments to the UHBW audit plan were approved.

4. The Counter Fraud Progress Reports and Annual Reports for each trust were received, and the positive work in this area was welcomed.

5. The committee reviewed the Losses and Special Payments reports for both trusts, and the losses at UHBW associated with high-cost drugs were noted. A discussion also took place on how each trust understood losses and special payments to ensure that the information being presented was aligned, and it was reported that work was on-gong to ensure there was an agreed interpretation of these terms.

6. A report on Single Tender Actions at both trusts was received, and the alignment between the two trusts and the extra layer of reporting provided in the report was welcomed.

For Board Awareness, Action or Response

7. The Committee considered its terms of references and suggested a number of amendments for approval by the Board.
Key Decisions and Actions
N/A
Additional Chair Comments
There were no matters that the committee wished to bring to the attention of the Board. However, there are some areas that are still being worked on in view of the ongoing transition to a group committee model, particularly in relation to the BAF and hope this will be consistent in recording the risks for each trust. Going forward, this will be monitored by the committee.
Update from ICB Committee
N/A

Date of next meeting:	**28 October 2025**

Meeting of Group Board of Directors of NBT and UHBW held in Public
9 September 2025

Reporting Committee	**Digital Committee**
Chaired By	**Richard Gaunt, Non-Executive Director**
Executive Lead	**Neil Darvill, Joint Chief Digital Information Officer**

For Information

The Committee met on 22 July 2025 and received the following reports:

1. **Risks, Weaknesses and Opportunities at UHBW/NBT -** The Committee held a wide-ranging discussion on the strategic direction of digital transformation across both Trusts, particularly in the context of the Group. The Committee acknowledged the ongoing challenges created by financial pressures, workforce capacity, and competing organisational priorities. At the same time, the Committee recognised the significant opportunities to align digital transformation more closely with clinical strategies and organisational ambitions.

   The Committee reaffirmed the importance of prioritisation, transparent communication, and a focus on core infrastructure and workforce development in order to deliver meaningful benefits. It was agreed that these issues must be articulated clearly at Board level to ensure consistent alignment across the organisation.

   Overall, the Committee was assured that digital transformation priorities are being aligned with strategic objectives but emphasised the need for continued Board-level prioritisation and clarity.

2. **Digital Risk Report -** The Committee received the consolidated Digital Risk Report, which highlighted progress in harmonising the Board Assurance Frameworks of UHBW and NBT. While there was no change to the overarching principal digital risk, a number of individual risks had been closed following successful mitigation. Updates were also provided regarding prescribing systems and infrastructure vulnerabilities.

   The Committee discussed terminology and risk categorisation, the alignment of controls across both organisations, and the development of maturity assessments. It was noted that greater consistency of reporting will further support oversight of risk.

   The Committee was assured that digital risks are being actively managed, and that harmonisation work is underway to strengthen consistency and alignment of controls across the Group.

3. **Terms of Reference Review -** The Committee reviewed its Terms of Reference and endorsed the proposed changes to Executive membership and agreed minor amendments to the Non-Executive Director membership for submission to the Board.

4. **Internal Audit Update - Cyber Security Vulnerability Patch & Change Management -** The Committee received the outcomes of the internal audit on cyber security patching and change management, which had resulted in a limited assurance rating at NBT. The Committee was informed that while the audit highlighted issues with outdated software and patching processes, an action plan was in place and considered achievable. Members noted the importance of transparency and welcomed assurance that mitigations were progressing.

   The Committee also discussed the governance of cyber resilience and business continuity, acknowledging the layered defence approach in place but agreeing that a deeper review of cyber security preparedness should be scheduled.

   The Committee was assured that the issues identified are being addressed and confirmed that further scrutiny will be undertaken through a dedicated deep dive session.

5. **Joint Digital Systems, Policy and Operational Performance Update -** The Committee received a report which outlined key updates across digital services, including technology infrastructure, clinical systems, programme management, and information governance. Progress was reported in several areas, including:
   - the completion of backup and secure email projects,
   - the phased removal of legacy servers,
   - contract consolidation with System C to support future EPR development,
   - digitisation of health records,
   - improvements in system integration, and
   - continued progress in information governance and business intelligence, particularly in data quality and clinical coding.

   The Committee noted the scale of investment that would be required for a future Electronic Patient Record (EPR) business case and discussed the importance of realistic planning, clear prioritisation, and sustained engagement with clinical teams.

   The Committee was assured that significant progress is being made across digital systems and governance. It was agreed, however, that further clarity on timelines and prioritisation will be required as strategic planning develops.

6. **Digital Strategy and Operational Business -** The Committee considered the ongoing development of the Hospital Group's Digital Strategy. The Committee noted the engagement work already undertaken with clinical teams and system partners, and endorsed the ambition to publish the strategy by early 2026. The Committee also received an update on financial performance, cost improvement initiatives, and the development of a Single Managed Service model, which is already demonstrating positive outcomes in pilot areas.

Infrastructure risks were also reviewed, with assurance provided that mitigation plans are in place to manage upcoming technical works.

The Committee was assured that the strategy is progressing to plan, with alignment to the joint clinical strategy continuing to develop.

The Committee also received and reviewed its workplan and suggested updates on cyber security, prioritisation verses capacity and EPR at a future meeting.

For Board Awareness, Action or Response (including risks)

The Committee took assurance from all the above items, on behalf of the Board.

The Committee highlighted two areas for Board awareness:

- Cyber security resilience: A dedicated deep dive will be undertaken to provide further assurance on preparedness and business continuity, particularly in light of resource challenges.
- Future Electronic Patient Record (EPR) business case: Initial work has commenced to develop a group-wide business case. The scale of investment required is expected to be substantial and will require Board consideration in due course.

Key Decisions and Actions

- Endorsed the revised Terms of Reference for Board approval, subject to minor amendments.
- Agreed to schedule deep dives on cyber security, CareFlow Medicines Management rollout, EPR planning, CareFlow digitisation, and enterprise infrastructure.

Additional Chair Comments

A new combined EPR system across group will be required by 2029 with a hard stop at this point. Although the timeframe seems some time away, it is not long in an IT sense, particularly as there is no guarantee that existing supplier will be chosen. Future deep dives on cyber security and IT project prioritisation in light of capacity issues will be commissioned.

Date of next meeting:	Thursday 18 September 2025

Meeting of Group Board of Directors of NBT and UHBW held in Public
9 September 2025

Reporting Committee	**Finance & Estates Committee in Common - July 2025 meeting**
Chaired By	**Richard Gaunt, NBT Non-Executive Director**
Executive Lead	**Neil Kemsley, Group Chief Finance & Estates Officer**

For Information

1. This was the first meeting of the Finance & Estates Committee held in common between NBT and UHBW, which was a welcome step in the formation of the Bristol NHS Group.

2. The committee received the finance reports for both trust for Quarter 1. It was noted that finances were following their planned trajectories, although non-recurring funding had been used to achieve the planned deficit. Therefore, as Neil Kemsley, Group Chief Finance and Estates Officer, had flagged, a re-forecast might be necessary. A discussion also took place on how UHBW could evaluate the effect a reduction in NCTR would have on the budget, as this would help to inform the Trust's external discussions. He added that an NCTR valuation was included in NBT's financial performance report. It was reported that there had been very constructive discussion about the NCTR recovery plan with system partners, and a timeline had been proposed for projected recovery of 15% NCTR by the end of March 2026. Progress against this target would need to be closely monitored so that any deviation could be picked up at the earliest opportunity.

3. A report on the approach to financial forecasting was considered, and it was agreed that this would be the subject of further discussion at an extraordinary meeting of the committee at the beginning of September.

4. Neil Kemsley, Group Chief Finance and Estates Officer, introduced a discussion about the Hospital Group's approach to the Medium-Term Financial Plan and the Financial Strategy. It was reported that draft guidance from NHSE would be issued in July and full guidance in September accompanied by three- and four-year allocations for revenue and capital. This level of detail would be unprecedented and would facilitate planning on a longer-term basis.

5. The Committee considered the Group Board Assurance Framework (BAF) for Quarter 2. The new format of the BAF was welcomed, and it was suggested that the Committee periodically scrutinised areas of concern to ensure the risks were properly understood. It was also suggested that the committee could compare the risks in the System's five-year capital plan with those in the Group BAF to determine if the risks were appropriate.

6. The committee discussed how it wished to deal with estates reporting in the future, given that there were currently a number of differences between the

approaches taken by NBT and UHBW. It was agreed that the committee needed to take a risk-based approach and prioritise the most important issues for its attention. The fire risk at UHBW was of particular concern to the UHBW Board and would need particular attention.

For Board Awareness, Action or Response
7. An additional meeting of the Finance & Estates Committee in Comon will take place on 2nd September 2025 to consider the financial forecasts for the current financial year. 8. The Committee considered its terms of references and suggested a number of amendments for approval by the Board.
Key Decisions and Actions
N/A
Additional Chair Comments
N/A
Update from ICB Committee
N/A

Date of next meeting:	**30 September 2025.**

Meeting of Group Board of Directors of NBT and UHBW held in Public
9 September 2025

Reporting Committee	**People Committee – July 2025 meeting**
Chaired By	**Linda Kennedy, Non-Executive Director**
Executive Lead	

For Information

July's People Committee was the first meeting in common of the Bristol Hospital Group and had a focus on group development and establishing ways of working. With the appointment of a Group CPO and development of a group People Strategy, future reports will be aligned to strategic themes.

Group Development

There is currently a focus on developing new ways of working across the hospital group, sharing the group benefits business case and opportunities to improve efficiency, reduce duplication and improve staff experience. This includes shared workforce planning, development of group recruitment and controls, and alignment of systems (e.g. e-rostering), developing a Group People strategy and Learning & Workforce Development strategy. It also includes education and training, including developing a single corporate service, using automation and AI, aligning resident doctor induction and training alongside wider talent and development opportunities.

Many risks are shared across UHBW and NBT, including industrial action, shortages of medical staff, and violence and aggression towards staff. Other risks, such as changes to employment rights legislation and the impact of group development on BAU, have been identified by UHBW, and will be aligned across both Trusts.

Strategic Update

A joint strategic update covered shared challenges, opportunities and activities in the group. These include:

- Appointment of leadership teams, and development of the future target operating model is in progress,
- Financial challenges are necessitating difficult decisions, including additional workforce and recruitment controls, operating a MARS voluntary resignation programme, and considering whether to include Agenda for Change bank workers in the annual pay award,
- Industrial action, including a mandate received by the BMA for resident doctors, and potential action taken by the RCN and other Trade Unions,
- Incorporating recommendations from the NHS 10-Year workforce plan,
- Contributing to a national Target Operating Model for People Services being developed by KPMG,
- Anticipating changes in immigration and employment law due to come into force in the next two years,

- Recognition of the work of a team of F2 doctors on quality improvement in workforce development, including a nomination for the HSJ awards.

Performance

Key metrics for both Trusts were shared, noting that metrics are currently measured differently, and work is underway to align this:

- Below target turnover rates at both Trusts: NBT at 10.8% (target 11.3%) and UHBW at 9.9% (target 11.1%). NBT turnover is higher as includes fixed term contracts, UHBW does not.
- Vacancy rates—NBT reported 6.5% (above its 5.1% target), driven by maternity leave and additional staffing gaps for the Bristol Surgical Centre, as well as pro-active steps to control vacancies to improve finances. UHBW reported a low 2.6% (below its 4.0% target).
- Sickness absence at NBT remained at rolling 4.6% vs. 4.4% target, while UHBW showed improvement at in-month 3.9% vs. 4.5% target. Note NBT report rolling sickness, UHBW report in-month. NBT in-month sickness is 3.9%.
- Essential training compliance was 83.2% at NBT (below the 85% target) and 90.6% at UHBW (above the 90% target), with Oliver McGowan Level 2 training rollout cited as a key factor in NBT's decline. UHBW do not report on Oliver McGowan Level 2 training currently. This will be aligned moving forward.

Safe working

Reports from the Guardians of Safe Working were shared.

Bristol Sites (Nov 2024 – Jan 2025)

- **Compliance**: Bristol sites are compliant with NHS employer contract rules.
- **Exception Reporting**: An electronic system (Allocate) is in place. Exception reports continue to highlight recurring issues in specific specialties, though the number of concerning specialties has decreased.
- **Staffing Data**: Work is ongoing with Medical HR to better understand this.
- Updates include resolution of the oncology non-resident on-call rota, some shortages in medical staff, and improved attendance at resident doctor forum meetings.

Weston Sites (Feb – Apr 2025)

- **Compliance**: WGH is compliant with NHS contract rules.
- **Exception Reports**: 14 reports were submitted, all related to excess hours or missed breaks. Most came from Acute Medicine and Gastroenterology.
- **Staffing**: Heavy reliance on agency and bank doctors—estimated equivalent to 26 full-time posts.

Inclusion and Belonging

Both Trusts reported on the Workforce Race Equality, (WRES), Workforce Disability Equality scheme (WDES) and Gender Pay Gap (GDP).
Gender Pay gap – The mean GPG is currently 16.47% in favour of male employees at UHBW and 17.23% in favour of male employees at NBT. The mean nonmedical pay gap is 3.7% in favour of female employees at UHBW and 4.12% in favour of female employees at NBT. Strong pay controls are in place at both Trusts.
WRES and WDES – Both Trusts have adopted an antiracist framework, with shared activities. In light of the WRES and WDES, other areas of focus will be addressing cultures of ableism across both Trusts, career progression of minoritised colleagues, and aligning organisational reporting styles.

For Board Awareness, Action or Response

Key Decisions and Actions

- As the first People Committee in Common, Terms of Reference will be reviewed, and the workplan will remain in draft until the launch of the Group People Strategy,
- For the September meeting, an aligned position on risks will be presented,
- Actions were taken on compliance with Oliver McGowan training, and communication with patients about appropriate language and behaviour towards staff.

Additional Chair Comments

Happy to see increasing progress on developing closer working and alignment under our group model, particularly in key areas such as planning and inclusion. This will become closer, and increasingly aligned, as the Committee in Common continues to meet.

Update from ICB Committee

Jo Hicks shared plans for the new regional model ICB, as well as convening a discussion about the impact of industrial action in the region.

Date of next meeting:	**22 September 2025**

Meeting of Group Board of Directors of NBT and UHBW held in Public
9 September 2025

Reporting Committee	**NBT Quality and Outcomes Committee (QOC)**
Chaired By	**Professor Sarah Purdy, Non-Executive Director**
Executive Lead	**Professor Steve Hams, Group Chief Nursing and Improvement Officer** **Sanjoy Shah, Trust Medical Director (deputising for Tim Whittlestone, Group Chief Medical and Innovation Officer)**

For Information

The Committee met on 31 July 2025 and received the following reports:

1. **Performance Report:** This report updated the committee on the latest Trust performance against a range of key national metrics. The committee was informed of and discussed performance in diagnostics, cancer, urgent and emergency care (UEC) and referral to treatment (RTT). The committee discussed challenges with no criteria to reside, UEC and cancer performance in various specialties in particular. Urology was identified as a priority area due to its broad impact across quality domains, with a deep dive into the specialty recommended, to be undertaken by the new Committee in Common.

2. **Biannual Nursing Safe Staffing Report:** The report highlighted (pending a further report to be submitted to the Group Board in November) that the Trust remained broadly aligned with national staffing standards, despite increased patient acuity. The committee discussed several risks as well as good progress being made with Allied Health Professional staffing standards and was assured by the mitigations in place. QOC on behalf of the Board:
   - Noted the completion of the February 2025 data collection and the associated review for adult inpatient areas, providing assurance to the Board and therefore complying with the National Quality Board requirements for safe staffing.
   - Noted that a data collection was undertaken in June 2025 in the Emergency Department using the national ED SNCT. The paper arising from this would be shared with committee members in due course.
   - Noted the sustained increase in additional patients who are being cared for in our departments but who are not funded in the budgeted numbers, therefore leading to an increase in the use of temporary workforce.
   - Noted the patient acuity and dependency change that had occurred on the February 2025 data collection – this should be monitored through the next data collection to understand if this is a seasonal variance or a sustained change as part of the patient classification.
   - Noted the implication in the difference in headroom of 1% from the national standard to NBT budgeted. This influences the outputs of the tool and therefore must be manual adjusted.
   - Supported the plans for funding of the overall establishment adjustments.

- Noted that Equality and Impact Assessments will need to be undertaken for all wards subject to establishment adjustments. Discussed and approved the Bi-Annual Nursing Safe Staffing Report.
- Supported the increased requests within the paper totalling £1,155,254.
- Endorsed the data collection for the next six-monthly update paper scheduled for September 2025.

3. **Medical Examiner (ME) Service - Annual Report 2024/25 and Update:** The committee received the first statutory ME report following the service becoming a legal requirement on 9 September 2024. The service, one of the largest nationally, now reviews all non-suspicious deaths. While the average time from death to registration had increased slightly, digital solutions were being implemented to improve efficiency, and the year had been a positive one, with very few complaints about the service, strong engagement with families and learning from deaths work progressing well across both Trusts. The committee discussed the service's independence in escalating concerns and its role in high-profile cases.

4. **Needlestick Injury (NSI) Rates**: The report was provided to QOC due to the rise in NSIs, particularly during suturing procedures in neurosurgery and spinal surgery. The committee was assured by mitigation efforts, which included monitoring incidents, supporting the individuals involved, reviewing clinical techniques, and exploring system improvements including training. The committee discussed triangulating findings with Health and Safety and Education teams and the value of learning notices. The Control of Infection Committee would continue to monitor NSI rates, with further escalation to QOC if no improvement was observed.

5. **Maternity report:** The committee received the report, which provided the May 2025 Perinatal Quality Surveillance Matrix (PQSM) data, a six-month update on Avoiding Term Admissions into Neonatal Units (ATAIN) data and a Perinatal Mortality Review Tool (PMRT) quarterly update, all of which provided assurance about the quality of maternity and neonatal services at NBT. The committee discussed a retained swab never event, the need for clearer oversight of never events and the abandoned triage telephone calls rate. The committee was informed that the division had officially commenced the process to decamp NICU and gynaecology services to facilitate essential works. The committee also received an update from NBT's Maternity Safety Champion, who highlighted that work was underway to clarify the role of the NED Maternity Champion and the importance of meeting the Maternity Incentive Scheme standards.

6. **Community Partnership Group (CPG) Update**: The CPG update highlighted its inclusive recruitment, strong engagement across diverse communities, and collaboration with partner organisations. The first formal meeting of the group had been rescheduled to September. The committee welcomed the extensive engagement with people from diverse communities and the collaboration with partner organisations and UHBW.

7. **Healthcare Legal Report:** The report provided a quarterly update on the Trust's Healthcare Legal activity, noting the 558 clinical negligence claims and over 100 active inquests. Key themes from concluded claims included missed diagnoses and

consent issues, with in-house legal support contributing to significant cost avoidance and helping learn from and therefore prevent future incidents and claims.

8. **Clinical Policy Update:** The report provided an update on Trust-wide clinical policies and procedures. Performance in July was below expectations, but support was ongoing to improve policy review rates. The transition to LINK 2.0 was underway, with a future move to the MyStaff app proposed.

9. **Sub-committee upward reports**: The Committee received and was assured by upward reports from the:
   - Drugs and Therapeutics Committee
   - Clinical Effectiveness and Outcomes Group
   - Control of Infection Committee including C.Diff data
   - Patient Safety Group.

For Board Awareness, Action or Response (including risks)

The Board's attention is drawn to the committee's consideration of the:
- Nursing Safe Staffing report
- Medical Examiner report
- Healthcare Legal report.

Key Decisions and Actions

The Board is recommended to note this report and note the activities undertaken by the Quality and Outcomes Committee on behalf of the Board, for assurance purposes.

Additional Chair Comments

The Chair noted this was the final meeting of the NBT QOC and thanked committee members and the secretariat for their contributions to the work of the committee.

Date of next Quality and Outcomes Committee meeting:	Tuesday 30 September 2025 (QOC in Common with UHBW)

Meeting of Group Board of Directors of NBT and UHBW held in Public
9 September 2025

Reporting Committee	**UHBW Quality and Outcomes Committee – July 2025 meeting**
Chaired By	**Sue Balcombe, Non-Executive Director**
Executive Lead	**Stuart Walker, Hospital Managing Director**

For Information

1. The committee invited the Executive Directors to update them on any strategic emerging risks or areas of concern:

   - Following the publication of the Fuller Inquiry Report the executive team had been reviewing the recommendations and a response will be provided in the form of a report to a future Trust Board meeting.

   - Planning for the proposed resident doctors industrial action commencing the 25 July was well underway and currently no appointments had been cancelled.

   - In response to the Leng Review, the Trust has confirmed that there were currently 22 Physician Assistants employed. The executive team are awaiting formal guidance but in the interim the job descriptions and job roles of those affected were being reviewed in partnership with NBT. The Trust Medical Director was due to meet the clinicians who were said to be feeling unhappy and undervalued and the committee was assured that all necessary support would be provided.

2. The committee reviewed performance as detailed in the IQPR and noted that:

   - Complaints response times were still not good enough but noted that the agreed improvement plan was being implemented.

   - The new total waiting list size metric had been triggered due to issues with capacity in ENT, Paediatric Cardiology, and Maxillofacial and Oral Surgery. Additional capacity is being secured.

   - Lack of progress with reducing No Criteria to Reside continued. Concerns regarding the effective commissioning of appropriate bed capacity at system level were discussed.

3. The committee received the Quarter One Legal Report and noted the continuing high levels of complex cases being managed by the in-house legal team.

4. The committee received The Experience of Care Strategy Year One Review and noted the excellent progress which had contributed to the Trust being shortlisted for a national Patient Experience award. It was noted that:

- over 70% of inpatient wards are now using “What Matters to You” with excellent results
- the new contract for interpretation services has led to an interpretation fulfilment rate of 96%.

- issues with recording a patients’ communication needs on the Care Flow Alert System were causing concern and impacting patient care.

5. The Maternity Spotlight report focussed on the 2023 Neonatal Mortality data. It was noted that the risk adjusted mortality rates had been consistently better than the comparator group for the last four years. The Trust also performed consistently well on the number of neonatal deaths despite a higher risk population.

6. The committee received the MHRA Annual Report which demonstrated compliance in relation to blood transfusion, medical devices and medication.

7. The committee received the Bristol Acute Trusts Clinical Ethics Advisory Groups Annual Report and noted progress made.

8. The Safer Staffing report demonstrated a fill rate of 107% although escalation areas were still being used and require staffing. A higher level of Health Care Support Worker shifts had been used due to an increased need for Enhanced Care Observations. The six-monthly Safe Staffing review has been completed.

For Board Awareness, Action or Response
N/A
Key Decisions and Actions
The committee approved The Interim UHBW Patient Safety Incident Response Plan pending a full review in partnership with NBT in November to include situational analysis.
Additional Chair Comments
N/A
Update from ICB Committee
N/A

Date of next meeting:	**30 September 2025**

NBT Register of Seals

July to September 2025

No sealings have taken place since the last report.

UHBW Register of Seals

July 2025 to September 2025

Reference Number	Document	Date Signed
929	JCT Intermediate Building Contract for the Replacement of four lifts (designated as evacuation lifts) at St Michael's Hospital between UHBW and Hoistway Ltd.	06/08/2025
930	JCT Intermediate Building for CICU pendant replacement between UHBW and Stepnell Ltd.	06/08/2025

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	9 September 2025		
Report Title:	Group Scheme of Delegation and Standing Financial Instructions		
Report Author:	Catherine Cookson – Head of Finance, Financial Services and Assurance (UHBW) Patrick O'Brien, Assistant Director of Finance, Financial Services (NBT)		
Report Sponsor:	Neil Kemsley – Group Chief Finance and Estates Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	✓		
	Develop an aligned Group Scheme of Delegation to support the aligned Standing Financial Instructions approved at the Trust Board meeting in Common in April 2025.		

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

The draft Scheme of Delegation (SoD) has been developed using the current approved documents at each Trust. Where delegations were not previously noted within the individual SoDs these have now been included in the group model. Most of the group SoD is aligned between both trusts, where there are differences, these are highlighted in green (UHBW) and yellow (NBT). Key changes to the document relate to;

- Contract signing and threshold levels in income, fees and charges
- Contract signing and threshold levels in procurement tendering and contract procedures to reflect the approval thresholds for business cases, authority to procure and tender requirements, and to recognise the changes in the procurement regulations
- Threshold limits for orders and the approval of invoice within the management of non pay expenditure
- Areas not explicitly noted in current approved documents.

The aligned Standing Financial Instructions (SFIs) were approved at Board in April. Minor updates are required to reflect Group Executive titles and to align to the SoD (highlighted green is inserted text and red/strikethrough is deleted text).

Strategic and Group Model Alignment

This report is directly linked to the Patient First objective 'making the most of our resources'. The financial governance framework provides clarity on responsibilities for supporting the delivery of a break-even position and a capital programme which enables us to continue to support the Trust's strategic ambitions.

Risks and Opportunities
Risks • No Scheme of Delegation to support the Standing Financial Instructions • Lack of clarity on delegated responsibilities and governance requirements **Opportunities** • Provide clarity and training to all staff which will support the delivery of the financial position • Align financial governance across both Trusts ahead of Corporate Services Transformation and merger

Recommendation
This report is for **Approval** Under the Standing Financial Instructions, the Scheme of Delegation must be formally approved by the Trust Board in Common. The Boards in Common are asked to • **approve** the Scheme of Delegation and Standing Financial Instructions for onward approval by the Board in Common on 09 September, and • **note** the next steps regarding publication on the website and within the Trust, training to key stakeholders, consider the impact of the Corporate Services Transformation programme, and annual reviews.

History of the paper (details of where paper has <u>previously</u> been received)	
Trust Management Teams (UHBW and NBT)	27/08/2025
Finance and Estates Committee in Common	02/09/2025
Appendices:	Appendix 1 – Scheme of Delegation Appendix 2 – Updated Standing Financial Instructions

1. Objective

To develop an aligned Group Scheme of Delegation (SoD) to support the aligned Standing Financial Instructions (SFIs) approved at the Trust Board meeting in common in April 2025. The Group SoD will primarily be aligned for both Trusts with small variances for specific Trust related item and job titles.

2. Scope and Method of Review

The draft SoD (appendix 1) has been developed using the current approved documents at each Trust.

- North Bristol Trust's (NBT) SoD was used as the baseline document as NBT's SFIs were the base model for the aligned group model
- Compare with University Hospitals Bristol and Weston's (UHBW) SoD and update where more detail was included
- Compare against the Group SFIs, approved in April, to include the SFI reference and ensure all delegated items are included in the SoD
- Discuss with key stakeholders e.g. procurement, research and development
- Joint review and agreement of by the Trusts' Directors of Finance
- The delegated authority is the officer/group/committee who has been delegated the authority by the responsible officer noted in the SFIs. E.g. where the SFIs state the responsibility is with the Group Chief Finance and Estates Officer delegation would be assigned to the Trust Director of Finance.

The read through of the SFIs to the draft SoD has also identified where changes are required to the SFIs (appendix 2), including the confirmed titles of Group and Trust posts.

3. Key Areas to Note

The draft SoD reflect the current approved documents. Where delegations were not previously noted within the individual SoDs these have now been included in the group model. No changes have been made which significantly impact previous threshold arrangements, for most changes the delegation arrangements have been strengthened.
Most of the group SoD is aligned between both trusts, where there are differences, these are highlighted in green (UHBW) and yellow (NBT) and primarily relate to titles of roles and groups, administration of funds held on trust, and business case processes. Due to differing governance structures the business case processes for each Trust have remained however, as part of the Corporate Services Transformation Programme and the merger the business case processes will be reviewed and aligned.

Other key areas to note are

- Income, including contracts for the provision of healthcare, fees and charges
    - Contract signing delegation now explicitly included for NBT
    - Threshold level for Research and Development income (both)

- Procurement tendering and contracting procedures and contracts and purchasing
    - Contract signing delegation, now explicitly included for NBT

    - Estates based capital contract, the signing thresholds updated to recognise approvals process at business case, authority to procure, and tender stage (both trusts)
    - Specific section on procurement of Healthcare and non-Healthcare services to reflect the change to procurement regulations as noted in appendix 3 (both trusts)
    - Authority to seek competitive tenders, thresholds increased to reflect procurement regulation and the inclusion of zero commitment/contingent fee procurement
    - Thresholds amended on authorisation of estates-based capital tender evaluation reports to recognise approval process at business case and authority to procure stage (both trusts).

- Management of non-pay expenditure
    - Order limits aligned at £5,000 (from £10,000 UHBW and £2,500 NBT) with an additional delegation for reducing thresholds levels where operational priorities/financial recovery arrangements are implemented.
    - Invoice processing for non-SAP orders, threshold levels included for UHBW and updated for both to reflect the procurement thresholds.

- Not explicitly noted in the current delegation
    - Retention of records
    - Digital and data security
    - Risk Management
    - Audit
    - Acceptance of gifts and other standards of business control
    - Other delegated items not specifically referenced in the SFIs

4. Recommendations

Under the Standing Financial Instructions, the Scheme of Delegation must be formally approved by the Trust Board.

Finance and Estates Committee are asked to

- **approve** the new aligned Scheme of Delegation and updated Standing Financial Instructions for onward approval by Board in common on 09th September, and

- **note** the next steps regarding publication on the website and within the Trust, training to key stakeholders, consider the impact of the Corporate Services Transformation programme, and annual reviews.
    - Publish in each Trust (separate documents where yellow / green removed) and develop intranet friendly and delegated officer versions.
    - Where appropriate add additional notes to allow the document to be more easily understood by the end user.
    - Present SFIs and SoD to Divisional Finance Committees, or similar
    - Review at each corporate services transformation developed to assess impact
    - Annual update for 01 April for review by the Audit Committee in common before formal approval by Trust Board in common. The timing of the review will incorporate procurement thresholds and be available for the new financial year.

NHS
Bristol
NHS Group
Bristol | Weston

Appendix 1

Group
Scheme of Delegation

University Hospitals Bristol and Weston NHS Foundation Trust

North Bristol Trust

NHS Bristol NHS Group Bristol | Weston

Contents

Scheme of Delegation

Trust policies and procedural guidance

Delegated matters

(2.6) Compliance with the Standing Financial Instructions
Authority delegated to **All Staff, including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Trust**.

(2.7) Notify the Trust Director of Finance of any conflicts between local guidance and the Standing Financial Instructions
Authority delegated to **All Staff**.

(2.8) Disclose any failure to comply with the Standing Financial Instructions to the Trust Director of Finance Officer
Authority delegated to **All Staff**.

(2.8) Full details of non-compliance with the Standing Financial Instructions, including an assessment of potential impact and mitigating factors reported to the Audit Committee (2.8)
Authority delegated to **Trust Director of Finance**.

(2.9) Annual review of the Standing Financial Instructions and Scheme of Delegation
Authority delegated to **Audit Committee**.

(2.9) Annual approval of the Standing Financial Instructions and Scheme of Delegation
Authority delegated to **Trust Board**.

(2.11) Schedule of Decisions Reserved to Trust
Authority delegated to **Trust Board**.

(2.6/2.14) Approve all detailed financial procedures
Authority delegated to **Trust Director of Finance or nominated deputy**.

(2.15) Responsibility for:

- *Security of property of the Trust*
- *Avoiding loss*
- *Achieving economy and efficiency in use of resources*

Authority delegated to **All Staff**.

(2.17) The temporary suspension of the Standing Financial Instructions in exceptional circumstances where the circumstance is:

- *A Trust-wide problem rather than a directorate-specific issue*
- *If sufficient scale that failure to act quickly and decisively would put the Trust at significant financial and reputational risk*
- *Unforeseen and rapidly developing*
- *Such that following normal procedures would hinder the recovery of the situation.*

Authority delegated to **Trust Board**.

Financial framework

(3.1) Advising the Board on the financial framework within which the Trust operates
Authority delegated to **Group Chief Finance and Estates Officer**.

Business and budget plans

Delegated matters

(4.1 & 5.7) Submission of strategic and operational plans for the Trust including an annual financial plan
Authority delegated to **Group Chief Executive**.

(4.1) Development of strategic and operational plans for the Trust
Authority delegated to all **Group Executive Directors**.

(5.7 & 5.8) Preparation of annual (and longer term) financial plan and budget for the Trust
Authority delegated to **Group Chief Finance and Estates Officers**.
(4.3 & 5.9 & 5.10) Contribute to the preparation of annual financial plan, budget and other plans
Authority delegated to **all Group Executive Directors and Delegated Managers**.

Management of financial resource

Delegated matters

(5.1) Delegated budget managers

- *at individual cost-centre level*
  Authority delegated to **Budget Manager or nominated deputy**.

- *At department level*
  Authority delegated to **Departmental Manager or nominated deputy**.

- *Division/corporate services level*
  Authority delegated to **Clinical Chair/ Clinical Director/ Divisional Directors/ Corporate Director**
  May also include members of the Division /Corporate Services Management Team as authorised by the Clinical Chair/ Clinical Director / Divisional Director / Corporate Director.

- *Executive Director level*
  Authority delegated to **Group Executive Director or nominated deputy**.

(5.5) Virement of revenue and capital budgets
(Virements must be supported by appropriate paperwork and be agreed in principle by Management Accounts before onward delegated approval.)

- *Within a cost centre*
  Authority delegated to **Budget manager plus department manager**.

- *Within a department or specialty; between cost centres*
  Authority delegated to **Department manager**.

- *Within a division; between departments and specialities*
  Authority delegated to **Divisional Director**.

- *Between divisions, up to £5,000*
  Authority delegated to **Deputy Director of both divisions**.
- *Between divisions, over £5,000*
  Authority delegated to **Director of both divisions**.

- *Capital to revenue (and vice versa)*
  Authority delegated to **Capital Programme Steering Group or Capital Planning Group with express agreement of the Trust Director of Finance**.

(5.12) Design and delivery of adequate systems of financial budgetary control
Authority delegated to **Trust Director of Finance**

(5.13) Establishing monitoring and reporting systems for workforce, service delivery and quality, service capacity and activity, and efficiency planning to enable budget holders to deliver an integrated analysis of their service performance
Authority delegated to **All Executive Directors**.

(5.14) Compliance of all established monitoring and reporting systems
Authority delegated to **Delegated budget managers**.

(5.16) Monitor and analyse the integrated financial performance of the delegated service during the year. This shall include assessment of:

- *Progress towards delivering the required financial positions for the budget area*
- *The impact of resources used, including workforce, progress of service delivery and achievement of efficiency plans*
- *Trends and projections*
- *Where relevant, plans and proposals to recover adverse performance.*

Authority delegated to **Delegated budget managers**.

(5.20 & 5.17) Issue of timely, accurate, and comprehensive reports covering the delegated services and provision of budget manager training on an ongoing basis
Authority delegated to **Trust Director of Finance**.

(5.19) Inform the Trust Board of:

- *Significant in-year variance from the business plan and advise the Board on actions to be taken to address the variance*
- *Financial consequences of changes in Trust policy*
- *Financial implications of external determinations, such as national pay awards and changes to the pricing of clinical services.*

Authority delegated to **Group Chief Finance and Estates Officer and Trust Directors of Finance**.

Annual Accounts, reports and returns

Delegated matters

(6.1.1 & 6.4) Preparation of annual financial accounts and associated financial returns for Board approval
Authority delegated to **Trust Director of Finance**.

Preparation of Annual Report (or equivalent) for Board approval
Authority delegated to: **Group Director of Corporate Governance**

(6.1.2 & 6.1.3) Preparation of and submission financial returns to NHSE
Authority delegated to **Trust Director of Finance or nominated deputy**.

(6.4) Approval of the Annual Report and Accounts on behalf of the Trust Board
Authority delegated to **Trust Board**.

(not specified in Standing Financial Instructions) Preparation of Quality Report for Board approval
Authority delegated to **Group Chief Nursing and Improvement Officer**.

Income, including contracts for the provision of healthcare, fees and charges

Delegated matters

(7.1) Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due and the prompt banking of all monies received
Authority delegated to **Trust Director of Finance**.

(7.7) Inform Trust Director of Finance of money due to the Trust from initiated transactions
Authority delegated to **All Staff**.

(7.3) Setting policy and price structure (fees and charges) for the provision of works, goods and/or services

- *Private patients*
  Authority delegated to **Trust Director of Finance or nominated deputy**.

- *Overseas visitors*
  Authority delegated to **Trust Director of Finance or nominated deputy**.

- *Property rental, including residencies, based on professional assessment*
  Authority delegated to **Director of Estates and Facilities and Trust Director of Finance or nominated deputy**.

- *Trading services*
  Authority delegated to **Divisional / Corporate Director or nominated deputy and Trust Director of Finance or nominated deputy**.

- *Other income generation*
  Authority delegated to **Divisional / Corporate Director or nominated deputy and Trust Director of Finance or nominated deputy**.

(7.2) Approval, signing and execution[1] of contracts for all income due for the provision of works, goods and/or services

- *Hosting arrangements*
  Authority delegated to **Trust Director of Finance or nominated deputy**.

[1] In line with the Trust's Standing Orders for signing and sealing, where appropriate

- *The letting of premises and space to third parties based on professional assessment, excluding residencies (including leases, tenancy agreements and licences in conjunction with the accommodation policy).*

    - *<£5,000*
      Authority delegated to **Department Manager**.

    - *>£5,000 to <£100,000*
      Authority delegated to **Director of Estates and Facilities or nominated deputy**.

    - *>£100,000*
      Authority delegated to **Trust Director Finance or nominated deputy**

- *(7.15) Concession agreements*
  Authority delegated to **Trust Director of Finance**.

- *(7.13) All research projects, contracts, grant applications, approvals to apply for research funding, site agreements, sub-contracts with participating organisations, contract variations and amendments, and clinical trials, once considered by the Research and Development Committee, where applicable.*

    - *£50,000 or below*
      Authority delegated to ***Director of Research and Development or nominated deputy***.

    - *In excess of £50,000*
      Authority delegated to **Trust Director of Finance**

- *(7.13) The South West Central Research Delivery Network (SWCRDN) Decision to provide additional funding to an NHS partner of the SWCRDN following a request for financial support:*

    - *£50,000 or below*
      Authority delegated to ***South West Central Research Delivery Network***.

    - *In excess of £50,000*
      Authority delegated to **Executive Governance Group (which includes the Trust Medical Director) of the *South West Central Research Delivery Network***

- *Staff secondments*
  Authority delegated to **Divisional Management Team**.

- *(26.1) Sponsorship deals*
  Approve and execute agreements to receive sponsorship from third parties (including staff and loan of equipment):

    - *<£15,000*
      Authority delegated to **Divisional Operations Director**.

    - *£15,000 to £50,000*
      Authority delegated to **Trust Finance Director**.

    - *>£50,000*
      Authority delegated to **Hospital Managing Director**.

- *Trading services*:

    - *<£25,000*
      Authority delegated to **Department Manager**.

    - *£25,000 to <£250,000*
      Authority delegated to **Divisional/Corporate Director**.

    - *>£250,000*
      Authority delegated to **Trust Director of Finance or nominated deputy**.

- *Peripheral clinics and provider to provider arrangements*

    - *<£25,000*
      Authority delegated to **Department Manager**.

    - *£25,000 to <£250,000*
      Authority delegated to **Divisional/Corporate Director**.

    - *>£250,000*
      Authority delegated to **Trust Director of Finance or nominated deputy**.

- *Other income generation*

    - *<£25,000*
      Authority delegated to **department manager**.

    - *£25,000 to <£250,000*
      Authority delegated to **Divisional/Corporate Director**.

- *>£250,000*
  Authority delegated to **Trust Director of Finance or nominated deputy**.

- Contract management, monitoring and reporting
  Authority delegated in line with the approval, signing and execution delegation noted above.

- *Terminate lease and rental arrangements early at cost to the Trust*
  Authority delegated to **Trust Director of Finance**.

NHS service agreements for the provision of healthcare services:

- *(7.8) Entering suitable commissioning contracts with services commissioners for the provision of NHS services to patients*
  Authority delegated to **Trust Director of Business Development Strategy and Transformation** or **Trust Director of Finance**.
- *(7.9) Provision of up-to-date advice on:*
  - *Standard NHS contractual terms and conditions, issued by NHS England*
  - Costing and pricing of services
  - Payment terms and conditions
  - Amendments to contracts, SLAs and extra-contractual arrangements.

  Authority delegated to **Trust Director of Business Development Strategy and Transformation** or **Trust Director of Finance**.

- *(7.10) Ensure SLAs and other contractual and extra-contractual arrangements:*
  - Are devised so as to limit the risk to the Trust whilst enabling opportunities to generate income
  - Are financially sound and that any contractual arrangement pricing at marginal cost is approved by the **Chief Financial Officer** and reported to the **Trust Board**.

  Authority delegated to **Trust Director of Business Development Strategy and Transformation** or **Trust Director of Finance**.

- *(7.8) Agree and execute[1] NHS contracts for the provision of healthcare services / service level agreements in accordance with NHS standard commissioning contract terms:*

- *< or equal to £2 million*
  Authority delegated to **Trust Director of Finance**.

- *>£2 million*
  Authority delegated to **Hospital Managing Director and Trust Director of Finance**.

- *(7.8) Agreeing changes and developments within existing contracts for healthcare services*
  Authority delegated to **Hospital Managing Director and Trust Director of Finance**.

- *(7.11) Ensure systems and processes are in place to record patient activity, raise invoices and collect monies due under the agreements for the provision of healthcare services*
  Authority delegated to **Trust Director of Finance**.

- *Contract management, monitoring and reporting*
  Authority delegated to **Trust Director of Business Development Strategy and Transformation or Trust Director of Finance, or their nominated deputies**.

- *(7.12) Understand and use the contract monitoring information for the financial management of service areas*
  Authority delegated to **Budget Managers**.

Procurement tendering and contracting procedures & Contracts and Purchasing

Delegated matters

(8.3 & 8.2 & 8.10.3) Establish arrangements for the purchase of goods and services, including the provision of a procurement service provider who maintains up to date procedural guidance

Authority delegated to **Group Chief Finance and Estates Officer**.

*(8.1 & 9.2 & 9.4) Approval, signing and where applicable the execution of **Contracts /Agreements** to procure good/services on behalf of the Trust following procurement processes described in the Standing Financial Instructions and Scheme of Delegation, delivers value for money and is in line with tenders, quotations and evaluation reports*

- *Contracts and agreements following tendering process **unless** specifically referred to below:*
  - *<£250,000*

    Authority delegated to **Divisional/Corporate Director**.
  - *>£250,000*

    Authority delegated to **Trust Chief Operating Officer or Director of Finance**.

- *Purchase of healthcare:*
  - *<£100,000*

    Authority delegated to **Divisional Director**.
  - *>£100,000*

    Authority delegated to **Trust Director of Business Development, Strategy and Transformation or Trust Director of Finance**.

- *Zero commitment / contingent fee contracts*

  Authority delegated to **Divisional/Corporate Director**.

- *Property leases*

  Authority delegated to **Trust Director of Finance**.

- *Leases – non-property*

  Authority delegated to **Trust Director of Finance**.

- *Outsourcing services*
  - *<£100,000*
    Authority delegated to **Divisional/Corporate Director**.
  - *>£100,000*
    Authority delegated to **Trust Director of Business Development, Strategy and Transformation and Director of Finance**.

- *Facilities contracts*
  Authority delegated to **Director of Estates and Facilities or nominated deputy**.

- *Estates maintenance contracts*
  Authority delegated to **Director of Estates and Facilities or nominated deputy**.

- *Estates-based capital contracts*
  The contract **must not** be signed by the same officer who authorised the Capital tender report.

  - *<£250,000*
    Authority delegated to **Associate Director of Capital Estates**.

  - *>£250,000 to <£1m*
    Authority delegated to **Deputy Director of Estates and Facilities or nominated deputy**.

  - *>£1m to <£5m*
    Authority delegated to **Director of Estates and Facilities or nominated deputy**.

  - *>£5m*
    Authority delegated to **Trust Director of Finance**.

- *Terminate lease and rental arrangements early at cost to the Trust*
  Authority delegated to **Trust Director of Finance**.

See Standing Financial Instruction section 10.17 for variation and extension to contracts.

(8.2 & 9.3) Contract management, monitoring and reporting
Authority delegated **in line with the approval, signing and execution delegation noted above**.

(8.4 & 8.6 & 8.7 & 8.12 & 8.13) Authority to seek competitive tenders, or quotations, in conjunction the Procurement department and in line with thresholds required by procurement law (appendix 3).

- *Healthcare services*

  *All procurements **must** be undertaken in consultation with the Procurement department to ensure compliance with the Provider Selection Regime which has no upper or lower limits (all values reflect the life of the contract)*

  - *<£100,000*

    Authority delegated to **Divisional/Corporate Director and Director of Procurement or nominated deputy**

  - *£100,000 to <£500,000*

    Authority delegated to **Director of Business Development Strategy and Transformation or Trust Director of Finance and Director of Procurement or nominated deputy**

  - *£500,000 to <£1m*

    Authority delegated to **Trust Management Team and Director of Procurement or nominated deputy**

  - *>£1m*

    Authority delegated to **Trust Board**

- *Non-Healthcare*

  To be read in conjunction with appendix 1 (Procurement Governance framework) and the Business Case approval process. Where the procurement follows a business case the approval thresholds of that process will be used.

  All values include VAT and reflect the life of the contract

  - *Zero Commitment/contingent fee procurements*

    Authority delegated to **Divisional / Corporate Directors**

  - *>£12,000 (best value demonstrated)*

    Authority delegated to **Budget Manager**

  - *£12,000 to <£25,000*

    Authority delegated to **Deputy Divisional/Corporate Director who advise the Director of Procurement or their nominated deputy**.

- *£25,000 - £139,000*

  Authority delegated to **Deputy Divisional/Corporate Director and the Director of Procurement or their nominated deputy**

- *£139,000 - £500,000*

  Authority delegated to **Divisional/Corporate Director and Director of Procurement or nominated deputy**

- *£500,000 - £1m*

  Authority delegated to **Trust Management Team and Director of Procurement or nominated deputy**

- *>£1m*

  Authority delegated to **Trust Board**

(8.9) Single tender action and exception reports, reported to Audit Committee on a quarterly basis

- *<£25,000*
  Authority delegated to **Director of Procurement**.

- *£25,000 to <£500,000*
  Authority delegated **as above and Trust Director of Finance**.

- *£500,000 to >£1m*
  Authority delegated **as above and Hospital Managing Director**.

- *>£1m*
  Authority delegated **as above and Trust Board**.

(8.11.6) Authorisation of revenue and non-estates capital procurement award report (including VAT):

- *<£139,000*
  Authority delegated to **Director of Procurement and Divisional Finance Manager and Divisional / Corporate Director.**

- *£139,000 to <£1m*
  Authority delegated **as above and Trust Director of Finance**.

- *£1m to <£2.5m*
  Authority delegated **as above and Hospital Managing Director**.

- *>£2.5m*
  Authority delegated **as above and recommendation to Trust Board**.

(8.11.6/13.8.3) Authorisation of estates based capital tender evaluation reports

The delegated officer who signs the tender evaluation report **must not** sign the contract.

- *>£10,000 to <£250,000*
  Authority delegated to **Associate Director of Capital Estates**.

- *£250,000 to <£1m*
  Authority delegated to **Deputy Director of Estates and Facilities or nominated deputy**.

- *£1m to <£5m*
  Authority delegated to **Director of Estates and Facilities or nominated deputy**.

- *>£5m*
  Authority delegated to **Group Chief Finance and Estates Officer and recommendation to Trust Board**.

(8.14) Identify specific procedures for a recognised event of exceptional circumstance

Authority delegated to **Group Chief Finance and Estates Officer**.

Approval of Business Cases

Delegated matters

(10.15/13.3/13.5) Approval route in line with the Investment Policy (see table in appendix x)

UHBW

Revenue

- *<£100,000 - funding source or not*

  Authority delegated to **Divisional Management Team**.

- *>£100,000 – no funding source identified*

  Authority delegated to **Divisional Management team and Business Development Group and Planning and Delivery Board and Trust Management Team or decision through annual planning as default**.

- *<£1m – direct funding source identified*

  Authority delegated to **Divisional Management team and Business Development Group**.

- *£1m to <£3m - funding source identified*

  Authority delegated to **Divisional Management team and Business Development Group and Planning and Delivery Board**.

- *£3m to <£10 m – funding source identified*

  Authority delegated to **Divisional Management team and Business Development Group and Planning and Delivery Board and Trust Management Team**.

- *>£10m - funding source identified*

  Authority delegated to **Divisional Management team and Business Development Group and Planning and Delivery Board and Trust Management Team and Finance and Estates Committee and Trust Board**.

Capital

- *<£2m*

  Authority delegated to **Annual Capital Prioritisation and Trust Board**.

- *£2m to <£5m*

  Authority delegated to **Business Development Group and Capital Programme Steering Group**.

- *£5m to <£10m*

  Authority delegated to **Business Development Group and Capital Programme Steering Group and Trust Management Team**.

- *£10m to <£25m*

  Authority delegated to **Business Development Group and Capital Programme Steering Group and Trust Management Team and Finance and Estates Committee and Trust Board with Board of Governors support**.

- *£25m to <£50m*

  Authority delegated to **Business Development Group and Capital Programme Steering Group and Trust Management Team and Finance and Estates Committee and Trust Board with Board of Governors Potential onward approval at NHSE and HMT**.

- *>£50m*

  Authority delegated to **Business Development Group and Capital Programme Steering Group and Trust Management Team and Finance and Estates Committee and Trust Board with Board of Governors and onward approval at NHSE and HMT**.

- *Digital - <£25m or <£30m whole-life cost*

  Authority delegated to **Business Development Group, relevant Executive Committee sub-group and Capital Programme Steering Group and Trust Management Team and Finance and Estates Committee and Trust Board with Board of Governors' support.**

- *Digital - >£25m or >£30m whole-life cost*

  Authority delegated to **Business Development Group and DH Programme Board Capital and Capital Programme Steering Group and Trust Management Team and Finance and Estates Committee and Trust Board with Board of Governors and onward approval at NHSE and HMT**.

NBT (IN APPENDIX 3)

Management of non-pay expenditure

Delegated matters

(10.4/10.5) Maintain adequate systems and procedures for the ordering of goods and services

Authority delegated to **Trust Director of Finance and Director of Procurement**.

(10.2) Maintain records of officers who are authorised to place requisitions and orders, and the maximum value of orders that they have authority to place

Authority delegated to **Trust Director of Finance or nominated deputy**.

(10.5) Orders to be placed using the Trust's approved ordering systems and procedures. Orders must not be split to circumvent authorisation and delegation limits

Authority delegated to **All Staff**.

(10.5.5) Goods and equipment accepted on trial or loan, where there is an associated risk or commitment of future expenditure

Authority delegated to **Director of Procurement and Divisional Finance Manager / Finance Business Partner**.

(10.1/10.3/10.4/10.5) Maximum ordering limits (incl. VAT) subject to compliance with procurement, tendering and contract requirements within the Standing Financial Instructions and confirmation that sufficient budget exists to pay for the item.

- *<£5,000*
  Authority delegated to **SAP Authoriser**.

- *>£5,000*
  Authority delegated to **SAP Vetter**.

- *Reduce the threshold to reflect operational priorities*
  Authority delegated to **Trust Director of Finance or Divisional/Corporate Director**

(10.8/10.10) Maintain adequate systems and procedures for the verification, recording, and payment of all payable amounts ensuring the prompt payment of accounts and claims in accordance with contract terms and national guidance.

Authority delegated to **Trust Director of Finance**.

(10.8) Invoice Processing outside of SAP Ariba – where invoice price equals order/quote:

- *<£12,000*
  Authority delegated to **delegated budget manager for cost centre**.

- *£12,000 to <£139,000*
  Authority delegated to **Deputy Divisional/Corporate Director**.

- *£139,000 to <£500,000*
  Authority delegated to **Divisional/Corporate Director**.

- £500,000 to £1m
  Authority delegated to **Trust Management Team member or nominated deputy**

- >£1m
  Authority delegated to **Trust Management Team member and Trust Director of Finance**

Invoice Processing – where invoice price does not equal order/quote:

- *Invoice price exceeds order by lesser of 10% or £5,000*
  Authority delegated to **Budget Manager**.

- *Invoice price exceeds order over 10% or between £5,000 and £25,000*
  Authority delegated to **Divisional/Corporate Director**.

- *Where invoice price exceeds order over 10% and £25,000*
  Authority delegated to **Trust Director of Finance**.

Agreeing compromise arrangements with suppliers:

- *<£5,000*
  Authority delegated to **Divisional/Corporate Director**.

- *£5,000 to <£50,000*
  Authority delegated to **Trust Director of Finance**.

- *>£50,000*
  Authority delegated to **Hospital Managing Director**.

Process high value pre-approved invoices and payments, e.g. public dividend capital, loan repayments, etc.

- *<£1m*
  Authority delegated to **Head of Financial Accounts**.

- *£1m to <£10m*
  Authority delegated to **Head of Finance / Assistant Director of Finance**.

- *>£10m*
  Authority delegated to **Trust Director of Finance**.

(10.11) Prepayments and commitments covering future financial periods
Authority delegated to **Trust Director of Finance or nominated deputy**.

(10.12) Confirm goods and services due under a prepayment arrangement are received satisfactorily and in accordance with the contract
Authority delegated to **Budget Manager**.

(10.13/13.6) Maintain adequate procedures for interim payments made on account in contracts for building and engineering works
Authority delegated to **Trust Director of Finance and Deputy Director of Estates and Facilities**.

(10.14/13.6) Approve the final payments for building and engineering works following confirmation of the completeness and accuracy of the final account and that contract terms have been followed
Authority delegated to **Deputy Director of Estates and Facilities or nominated deputy**.

(10.17/10.18/13.6) Approve a variation which leads to increase in total contract cost subject to confirmation that the contract allows for a variation and complies with the procurement regulation (see appendix 3)

- *Revenue and non-estates capital contracts:*
  - *<£100,000*
    Authority delegated to **Divisional Director**

  - *£100,000 - <£500,000*
    Authority delegated to **Trust Management Team**.

  - *£500,000 to <£1m*
    Authority delegated to **Group Executive Meeting**.

- *>£1m*
  Authority delegated to **Finance and Estates Committee for onward approval by Trust Board**.

- *Estates capital contracts:*
  - *<£500,000*
    Authority delegated to **Capital Programme Steering Group / Capital Planning Group**.

  - *£500,000 to <£1m*
    Authority delegated to **Trust Management Team**.

  - *>£1m*
    Authority delegated to **Finance and Estates Committee for onward approval by Trust Board**.

(10.19) Approve an emergency material variation of a contract, which will be confirmed and authorised using the relevant contract procedure on the next working day, or otherwise as soon as possible

Authority delegated to **Trust Director of Finance**.

(10.20) Approve an extension to a contract which exceeds the maximum term of the contract

Authority delegated to **Director of Procurement and Trust Director of Finance**.

(10.21) Maintain adequate procedures for joint finance arrangements and the payments to associated parties

Authority delegated to **Trust Director of Finance**.

Terms of service and payment of members of the Trust Board and employees

Delegated matters

(11.1/11.2) Appointment, remuneration of, and performance of directors and senior staff in accordance with the Standing Orders and national guidance

Authority delegated to **Renumeration and Nomination Committee**.

(11.3) Remuneration and allowances of Chair and Non-Executive Directors, in accordance with instructions issued by DHSC

Authority delegated to **Council of Governors for Foundation Trusts and NHS England for Trusts.**

(11.4/11.6/11.10) Approve proposals for setting of remuneration and conditions of service for those employees not covered by the Remuneration and Nomination Committee through the implementation of national pay directives and local variations

Authority delegated to **Group Chief People and Culture Officer or nominated deputies**.

Approval of non-payroll rewards to staff

Authority delegated to **Group Chief People and Culture Officer and Group Chief Finance and Estates Officer or nominated deputies**.

(11.8/11.9) Maintain adequate systems and procedures for the delivery of the Trust's payroll function

Authority delegated to **Trust Director of Finance or nominated deputy**.

(11.11) Authorise timesheets and other positive reporting forms which will affect the amount of salary to be paid, e.g. starters, leavers, change of condition forms, attendance at work, sickness and absence records, maternity, paternity, parental and special leave, overtime, unsocial hours, bank shifts, etc.

Authority delegated to **Budget Manager**.

(11.12) Authorise travel and subsistence claims (only through e-expenses).

Authority delegated to **Budget Manager**.

(11.7) Appointment of permanent staff (subject to any vacancy control process in place) or extension of fixed term contract:

- *To funded establishment post*
  Authority delegated to **Department Manager and Divisional Finance Manager/Finance Business Partner and HR Business Partner**
- *To post not within funded establishment (with funding source)*
  Authority delegated **as above and to Divisional/Corporate Director**

- *To post not within funded establishment (with no funding source)*
  Authority delegated **as above, with Trust Director of Finance**.

- *All senior medical appointments*
  Authority delegated to **Trust Medical Director**

(11.7) Bank, agency and locum staff, subject to any vacancy control process in place

- *Nursing and clerical support services*
  - *Within establishment*
    - *Within cost centre budget*
      Authority delegated to **Budget Manager**.

    - *With no budget*
      Authority delegated to **appropriate Trust Management Team director and Trust Director of Finance or Hospital Managing Director**.

  - *Outside of establishment*
    - *Within cost centre budget*
      Authority delegated to **Divisional Director**.

    - *With no budget*
      Authority delegated to **Appropriate Trust Management Team Director and Trust Director of Finance or Hospital Managing Director**.

- *Medical*
  - *Within establishment*
    - *Within cost centre budget*
      Authority delegated to **Department Manager**.

        - *With no budget*
          Authority delegated to **Appropriate Trust Management Team Director <u>and</u> Trust Director of Finance or Hospital Managing Director**.

    - *Outside of establishment*
        - *Within cost centre budget*
          Authority delegated to **divisional director**.
        - *With no budget*
          Authority delegated to **Appropriate Trust Management Team Director <u>and</u> Trust Director of Finance or Hospital Managing Director**.

- *Non-framework agency*
    - *Within establishment*
        - *Within cost centre budget*
          Authority delegated **as Medical within establishment (above) <u>and</u> appropriate Trust Management Team director**.

        - *With no budget*
          Authority delegated to **appropriate Trust Management Team Director <u>and</u> Trust Director of Finance or Hospital Managing Director**.

    - *Outside of establishment*
        - *Within cost centre budget*
          Authority delegated **as Medical outside of establishment (above) <u>and</u> appropriate Trust Management Team director**.

        - *With no budget*
          Authority delegated to **appropriate Trust Management Team director <u>and</u> Trust Director of Finance or Hospital Managing Director**.

(11.13/11.14/11.15) Appointment of self-employed, limited company or umbrella professional services agency:

- *Group Executive*
  Authority delegated to **Group Chief Executive Officer**.
- *Trust Management Team, Divisional Board, or those with significant financial responsibility*
  Authority delegated to **Hospital Managing Director**.

- *Other posts over £220 per day and/or over 6 months*
  Authority delegated to **Trust Director of People**.

- *Other posts below £220 per day and less than 6 months*
  Authority delegated to **HR Business Partner**.

(11.6/11.10) Submission of banding of new posts or re-banding of existing posts
Delegated authority: **Divisional/Corporate Director for approval at Trust Review Panel**.

(11.6/11.10) Approve departure under compromise agreement (excluding mutually agreed resignation scheme (MARS) arrangements):

- *Directors and very senior managers*
  Authority delegated to **Remuneration Committee and Group Chief People and Culture Officer and Group Chief Finance and Estates Officer**.

- *Other staff*
  Authority delegated to **Group Chief People and Culture Officer and Group Chief Finance and Estates Officer or nominated deputies**.

(11.6/11.10) Approve redundancy (and mutually agreed resignation schemes, or similar arrangements) in line with appropriate NHSE and HMT guidance (link):

- *Payment up to £100,000*
  Authority delegated to **Trust Director of Finance and Trust Director of People**

- *Payment over £100,000*
  Authority delegated to **Remuneration Committee**.

- *Contractual*
  Authority delegated to **Trust Director of Finance and Trust Director of People**

- *Non-contractual*
  Authority delegated to **Group Chief People and Culture Officer for onward submission to HM Treasury via NHS England**.

- *Executive Director*
  Authority delegated to **Remuneration Committee for onward submission to HM Treasury via NHS England**

(11.6/11.10) Early retirement in furtherance of efficiency or on ill health grounds
Authority delegated to **Trust Director of Finance and Trust Director of People**.

(11.4/11.9) Authorisation of relocation expenses

- *Payment up to £5,000*
  Authority delegated to **Divisional Vacancy Control/Review Panels**

- *Payment > £5,000*
  Authority delegated to **Trust Director of Finance and Trust Director of People, or nominated deputies**

(11.6/11.10) Approve annual leave applications and carry forward to next financial year:

- *Within national or Trust approved limits*
  Authority delegated to **Line Manager**.

- *Outside of the limits*
  Authority delegated to **Divisional/Corporate Director**.

Insurance, including risk pooling

Delegated matters

(12.1 and 12.4) Ensure and approve adequate insurance cover:

- *Schemes administered by NHS Resolution*
  Authority delegated to **Trust Director of Finance or nominated deputy**.

- *Other insurance arrangements*
  Authority delegated to **Trust Director of Finance or nominated deputy**.

Capital investment, private financing, fixed asset register and security of assets

Delegated matters

(13.1/13.2/4.1/5.18/10/15) Compile and submit for Board approval an annual capital plan with progress of delivery reported to Board during the year
Authority delegated to **Trust Director of Finance**.

(13.6/10.13/10.14) Maintain adequate systems and procedures for the delivery of approved capital schemes
Authority delegated to **Trust Director of Finance or nominated deputies**.

(13.8.1) Authority to commit expenditure to an approved capital scheme
Authority delegated to **Capital Programme Steering Group** / **Capital Planning Group**

(13.8.2) Authority to proceed to tender
Authority delegated **in line with the business case approval thresholds**

(13.8.3 / 8.11.6) Approve a successful tender of an approved capital scheme
*The delegated officer who signs the tender evaluation report **must not** sign the contract*.

- *>£10,000 to <£250,000*
  Authority delegated to **Associate Director of Capital Estates**.

- *£250,000 to <£1m*
  Authority delegated to **Deputy Director of Estates and Facilities or nominated deputy**.

- *£1m to <£5m*
  Authority delegated to **Director of Estates and Facilities or nominated deputy**.

- *>£5m*
  Authority delegated to **Group Chief Finance and Estates Officer and recommendation to Trust Board**.

(10.17) Approve a variation which leads to increase in total contract cost subject to confirmation that the contract allows for a variation and complies with the procurement regulation (see appendix 3)

- *<£500,000*
  Authority delegated to **Capital Programme Steering Group** / **Capital Planning Group**.

- *£500,000 to £1m*
  Authority delegated to **Trust Management Team**.

- *>£1m*
  Authority delegated to **Finance and Estates Committee for onward approval by Trust Board**.

Funding capital investments through Private Finance Initiative:

- *Assess comparative merit of progressing scheme through PFI*
  Authority delegated to **Finance and Estates Committee as advised by Group Chief Financial and Estates Officer**.

- *Authorise payment of the sums identified in the schedule of the unitary payment (being the annual service payment defined in Schedule 18 of the Project Agreement) to be made to the PFI partner over the lifetime of the scheme (project term).*
  Authority delegated to **Trust Board**.

- *Authorise annual Retail Price Index (all items) adjustment, in accordance with the PFI Project Agreement*
  Authority delegated to **Trust Board**.

- *Oversee delivery of the PFI contract terms, ensuring appropriate delivery and monitoring of the PFI contract, and including agreement of fee adjustments resulting from facilities management service and performance issues, to verify the invoice total*
  Authority delegated to **Group Chief Finance and Estates Officer**.

- *Approve decision to withhold or delay payment of all or part of an invoice submitted by the PFI partner, at risk of incurring penalties and late payment charges*
  Authority delegated to **Head of Finance (Financial Services)** / **Assistant Director of Finance (Financial services)** **or nominated deputy**.

- *Process payment of monthly account to the PFI partner in accordance with the Trust Board authorisation*
  Authority delegated to **Head of Finance (Financial Services)** / **Assistant Director of Finance (Financial services)**.

(13.9/13.10/13.11/13.12) Maintain adequate asset register systems and procedures including verification of additions and disposals, revaluations, calculation of annual capital charges, and reconciliations
Authority delegated to **Trust Director of Finance or nominated deputy**.

(13.13/13.15/13.16/13.17) Maintain adequate systems and procedures for controlling the security of assets, including markings, verification, disposals, market value and condemnations
Authority delegated to **Trust Director of Finance or nominated deputy**.

(13.14) Ensure the security of property of the Trust and reporting breaches in accordance with agreed procedures
Authority delegated to **All Staff**

Bank and cash and investments

Delegated matters

(14.2) Compile and submit for Board approval a Treasury Management Policy statement, where appropriate
Authority delegated to **Trust Director of Finance**.

(14.5) Opening, operating and controlling all bank accounts, referencing the Trust's name or Trust address
Authority delegated to **Trust Director of Finance**.

(14.4/14.6) Maintain adequate systems and procedures for the management and reporting, including compliance, of commercial and Government Banking Service accounts
Authority delegated to **Trust Director of Finance or nominated deputy**.

(14.7) Day to day operation of bank accounts

[redacted].

[redacted].

- *Approval to pay*
  Authority delegated to **Head of Finance (Financial Services)** / **Assistant Director of Finance (Financial services)**.

- *Approval of direct debits of standing order arrangements*
  Authority delegated to **Head of Finance (Financial Services)** / [redacted].

Outsourced banking arrangements

- *Maintain list of approved signatories*
  Authority delegated to **Shared Business Services (SBS) under terms of contract with the Trust**

- *Approval to pay*
  Authority delegated to **SBS following confirmation of availability of cash required by Head of Financial Control**.

(14.8/14.9) Determine when to subject commercial banking service supplier to competitive tendering and report results to Board
Authority delegated to **Trust Director of Finance**.

(14.11/14.14) Maintain adequate systems and procedures for the security of cash, cheques and other negotiable instruments
Authority delegated to **Head of Finance (Financial Services)** / **Assistant Director of Finance (Financial services)**.

(14.10) Approve the use of Trust credit cards (in the name of the Trust only)
Authority delegated to **Head of Finance (Financial Services)** / **.**

(15.1) Investment of funds

- *Surplus exchequer funds*
  Authority delegated to **Trust Director of Finance**.

- *Charitable fund cash balances, where applicable*
  Authority delegated to **Investment advisors appointed by the Charity Committee**.

Stores and receipt of goods

Delegated matter

(17.1) Maintain adequate systems and procedures for the management of stocks and stores, including safe stock levels, issue, return, losses and stock take
Authority delegated to **Trust Director of Finance or nominated deputy**.

(17.2) Management, monitoring and reporting of stores, including reporting any negligence or malpractice to the Trust Director of Finance:

- *Pharmaceutical stores*
  Authority delegated to **Director of Pharmacy**.

- *Medical equipment management*
  Authority delegated to **Head of Clinical Engineering**.

- *Divisional/clinical ward stores*
  Authority delegated to **Divisional Director or nominated deputy**.

- *Estates and Facilities stores*
  Authority delegated to **Director of Estates and Facilities or nominated deputy**.

- *Digital stores*
  Authority delegated to **Group Chief Digital Officer or nominated deputy**.

(17.3.2) Condemn and arrange for disposal of all other goods and equipment, i.e. items that are obsolete, redundant, irreparable or cannot be repaired cost effectively:

- *With a current or estimated purchase price up to £1,000*
  Authority delegated to **Budget Manager**.

- *With a current purchase price of £1,000-£5,000*
  Authority delegated to **Divisional/Corporate Director**.

- *With a current purchase price of over £5,000*
  Authority delegated to **Trust Director of Finance**.

(17.3.2) Disposal of mechanical engineering plant with replacement value estimated at:

- *Up to £10,000*
  Authority delegated to **Head of Estate Maintenance**.

- *£10,000 to £100,000*
  Authority delegated to **Director of Operational Estates and Facilities**.

- *Over £100,000*
  Authority delegated to **Trust Director of Finance**.

(17.3.2/13.11/13/13) Approve sale or transfer (e.g. donation) of equipment assets to another organisation for continued use:

- *Clinical equipment*
  Authority delegated to **Chief Medical Officer**.

- *IT equipment*
  Authority delegated to **Trust Director of Finance and Group Chief Digital Officer**.

- *Other equipment*
  Authority delegated to **Trust Director of Finance and relevant Trust Management Team Director**.

External borrowing and Public Dividend Capital

Delegated matter

(18.3) Maintain adequate systems and procedures for the application of loans, including reporting any short-term borrowings to the next Board meeting
Authority delegated to **Trust Director of Finance**.

(18.2/18.3/18.4) Approve all borrowing including temporary borrowing, commercial loans and PDC
Authority delegated to **Trust Director of Finance and Finance and Estates Committee**.

(18.2) Application for borrowing on behalf of the Trust
Authority delegated to **Trust Director of Finance or nominated deputy**.

Losses and special payments

Delegated matters

(19.1) Maintain adequate systems and procedures for maintaining and accounting for a register of losses and special payments
Authority delegated to **Trust Director of Finance or nominated deputy**.

(19.1/19/4) Approve losses, write-offs and compensation payments due to/made under:

- *Theft, fraud, corruption, criminal activity, overpayment of third parties, and ex-gratia payments to patients and staff for loss of personal effects:*
    - *<£1,000*
      Authority delegated to **Trust Director of Finance or nominated deputy**.
    - *£1,000 up to <£50,000*
      Authority delegated to **Hospital Managing Director**.
    - *>£50,000*
      Authority delegated to **Audit Committee**.

- *Fruitless payments including abandoned capital schemes; bad debts and claims abandoned, including in respect of private patients, overseas visitors and other third parties; overpayment of salaries; damage to buildings, fittings, furniture, equipment, and property in stores and in use due to culpable cause (e.g. fraud, theft, arson); and additional payments made to third parties in connection with or arising out of contractual liabilities, including sums payable under agreed settlements and court judgments:*

    - *<£10,000*
      Authority delegated to **Trust Director of Finance or nominated deputy**.

    - *£10,000 up to <£100,000*
      Authority delegated to **Hospital Managing Director**.

    - *>£100,000*
      Authority delegated to **Audit Committee**.

- *Public liability claims:*

    - *<£3,000*
      Authority delegated to **Divisional/Corporate Director, without legal advice**

    - *>£3,000*
      Authority delegated to **Divisional/Corporate Director and Trust Director of Finance, without NHS Resolution**.

- *Personal injury claims involving negligence (legal advice must be obtained and guidance applied):*

    - *<£10,000*
      Authority delegated to **Trust Director of Finance or Trust Director of People**, **with legal advice**.

    - *>£10,000*
      Authority delegated to **Trust Director of Finance or Trust Director of People**, **with NHS Resolution**.

- *Compensation (no limit) payments made under legal obligation:*
  Authority delegated to **Hospital Managing Director and Trust Director of Finance**.

- *Maladministration and distress payments where there was no financial loss by the claimant:*

    - *Remedy up to £1,000*
      Authority delegated to **Trust Director of Finance or nominated deputy**.

    - *Remedy between the value of £1,001 and £50,000*
      Authority delegated to **Hospital Managing Director**.

    - *Remedy over the value of £50,000*
      Authority delegated to **Trust Board**.

All areas to be reported to the Audit Committee (19.5).

(19.3) Reporting any loss or suspected loss to department manager and Trust Director of Finance
Authority delegated to **All Staff**.

(19.2.2/25.5.5) Report incidents to the Police:

- *General*
  Authority delegated to **Department Manager (inform Divisional/Corporate director as soon as possible and also inform Local Security Management Specialist**.)

- *Where a fraud is involved*
  Authority delegated to **Trust Director of Finance or Local Counter Fraud Specialist**.

Patients' property

Delegated matters

(20.2/20.3/20.4) Maintain adequate systems and procedures for informing patients that the Trust will not take responsibility or liability for property brought onto Trust premises. Where property is brought in, maintain adequate systems and procedures for safe custody of property, including disposal

Authority delegated to **Trust Director of Finance and Trust Director of Nursing or nominated deputies**.

(20.5) Inform staff of responsibilities and duties for the administration of patient property
Authority delegated to **Department Manager**.

Funds held on Trust

Delegated matters

Administration of the Trust's charitable funds
Authority delegated to **Bristol and Weston Hospitals Charity**. Trust lead is Director of Business Development, Strategy and Transformation.

Authority Delegated to **Southmead Hospital Charity.** Trust lead is the Trust Director of Finance

(21.6) Acceptance of donations of goods or cash from charitable bodies relating to capital defined expenditure
Authority delegated to **Capital Programme Steering Group** / **Capital Planning Group**.

(21.6) Approve expenditure from charitable funds, where required:

- *<£1,000*
  Authority delegated to **one fund signatory**.

- *£1,000 to <£10,000*
  Authority delegated to **two fund signatories**.

- *£10,000 to <£25,000*
  Authority delegated **as above plus Director of Communications**.

- *£25,000 to £50,000*
  Authority delegated to **two fund signatories plus Trust Director of Finance**.

- *>£50,000*
  Authority delegated to **two fund signatories plus Charity Committee**.

(21.6) Spending plans will be submitted to the Charity Committee for approval in March each year. Approval is delegated to approve additional spending plans that arise during the year as follows:

- *<£10,000*
  Authority delegated to **Assistant Chief Finance Officer (Financial Services) or nominated deputy in their absence**.

- *£10,000 to <£25,000*
  Authority delegated to **Director of Communication**.

- *£25,000 to >£50,000*
  Authority delegated to **Trust Director of Finance or nominated deputy**.

- *>£50,000*
  Authority delegated to **Charity Committee**.

Retention of records

Delegated matter

(22.1) Maintain adequate systems and procedures for managing all NHS records, ensuring compliance with current DHSC best practice on record management
Authority delegated to **Group Chief Digital and Information Officer**.

Digital and data security

Delegated matters

(23.1) Maintain adequate systems and procedures for the accuracy and security of the date of the Trust
Authority delegated to **Group Chief Digital Information Officer**.

(23.1) Approval of the implementation of upgrades or changes to general computer systems
Authority delegated to **Group Chief Digital Information Officer and Digital Committee**.

(23.2) New systems and amendments which impact on corporate financial systems are developed in a controlled manner and thoroughly tested prior to implementation
Authority delegated to **Trust Director of Finance and Deputy Chief Digital Information Officer**.

(23.3, Freedom of Information Policy) Maintain a Freedom of Information publication scheme
Authority delegated to **Group Director of Corporate Governance**.

(23.4) Ensure that any contract for computer services for financial applications shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage
Authority delegated to **Trust Director of Finance**.

(23.6) Ensure that risks to the Trust arising from the use of digital technology are effectively identified and considered; and appropriate action is taken to mitigate or control risk
Authority delegated to **Group Chief Digital Information Officer**.

Risk Management

Delegated matters

(24.1) Maintain adequate systems and procedures for managing risk and meeting current DHSC requirements for assurance frameworks
Authority delegated to **Group Director of Corporate Governance**.

(24.1) Governance and assurance systems:

- *Corporate Risk Register*
  Authority delegated to **relevant Executive Directors**.

- *Divisional Risk Registers*
  Authority delegated to **Divisional Directors and Divisional Managers**.

- *Quarterly review of Risk Registers*
  Authority delegated to **Trust Management Team**.

- *Reports on the Risk Registers quarterly*
  Authority delegated to **Trust Management Team**.

- *Maintenance of the Assurance Framework*
  Authority delegated to **Group Director of Corporate Governance**.

- *Quarterly review of Assurance Framework*
  Authority delegated to **Trust Management Team**.

- *Exception Reports on the Assurance Framework*
  Authority delegated to **Audit Committee**.

(24.3) Ensure that the existence, integration and evaluation of the risk management system is used to inform the Annual Governance Statement within the Annual Report and Accounts as required by current DHSC guidance
Authority delegated to **Group Director of Corporate Governance**.

Audit

Delegated matters

(25.3/25.5) Ensure the provision of an internal audit service which meets the NHS internal audit standards
Authority delegated to **Trust Director of Finance**.

(25.15/25.17) Appointment of External Auditors and determination of the term of the contract
Authority delegated to **Council of Governors for NHS Foundation Trusts and Auditor Panel Trusts**.

(25.6/25.7/25.18) Implementation of agreed internal and external audit recommendations
Authority delegated to **Trust Management Team and nominated deputies**.

(25.20.1) Develop the Trust's Counter Fraud and Bribery Policy for approval at Audit Committee
Authority delegated to **Trust Director of Finance**.

(25.20.2) Appointment of an NHS accredited Local Counter Fraud Specialist in accordance with the NHS Counter Fraud Authority Standards
Authority delegated to **Trust Director of Finance**.

(25.23) Compliance with the Trust's Counter Fraud and Bribery Policy, including reporting any suspicions to the Local Counter Fraud Specialist, and/or the Chief Financial Officer
Authority delegated to **All Staff**.

(25.26) Appointment of a Local Security Management Specialist to provide security management services to the Trust, in accordance with the requirements of the DHSC and NHS England
Authority delegated to **Trust Director of Finance**.

Acceptance of gifts by staff and other business standards of control

Delegated matters

(26.2) Maintain adequate systems, policies and procedures for the acceptance of gifts and hospitality and the register of interest across the Trust
Authority delegated to **Group Director of Corporate Governance**.

(26.1) Maintain a register of gifts, hospitality and sponsorship
Authority delegated to **Group Director of Corporate Governance**.

(26) Compliance with the gifts, hospitality, and sponsorship policy
Authority delegated to **All Staff**.

(26.3-26.5) Acceptance of gifts, excluding cash or vouchers

- *Business articles less than £50 per gift*
  Receiving member of staff may accept with no requirement to register.

- *Gifts over £50 or several small gifts of a value over £100 from same source over a 12-month period*
  Receiving member of staff may accept if declared and registered.

- *Gifts over £50 per gift*
  Receiving member of staff should decline or seek Trust Secretary advice.

(26.6) Decline gifts of cash or vouchers, regardless of value
Authority delegated to **All Staff**.

(26.9) Acceptance of hospitality:

- *Modest hospitality if normal and reasonable in the circumstances*
  Receiving member of staff may accept but should refer to line manager or relevant Director if in doubt.

- *Inappropriate hospitality offers*
  Member of staff should notify Group Director of Corporate Governance.

(26.11) Acceptance of sponsorship:

- *Commercial sponsorship for attendance at conference, where does not compromise current or future purchasing decisions*
  Approval from line manager with advice from Director of Procurement, where appropriate.

- *Sponsorship of Trust events by existing suppliers*
  Approval by Group Director of Corporate Governance for recording in the register with contractual agreement signed by the Trust Director of Finance.

- *Sponsorship of Trust events where the sponsor does not have a contract with the Trust*
  As above and the Director of Procurement.

(26.11) Approve and execute agreements to receive sponsorship from third parties (including funding of staff and loan of equipment):

- *<£15,000*
  Authority delegated to **Divisional Operations Director**.

- *£15,000 to £50,000*
  Authority delegated to **Trust Director of Finance**.

- *>£50,000*
  Authority delegated to **Hospital Managing Director**.

Other delegations not specifically referenced in the Standing Financial Instructions

Delegated matters

Affix Trust Seal to documentation:

- *Where there is a legal requirement for a physical seal (e.g. by the Land Registry or HMRC) as advised by internal or external legal*
  Authority delegated to **Chair of Trust and Group Chief Executive**.

- *Executive documentation as a Deed including Agreements, Leases and Licences, provided there is not legal requirement for a physical seal (as above).*
  Authority delegated as per **Income, including contracts for the provision of healthcare, fees and charges (7.2) in the physical presence of an attesting witness for each signature**.

Legal Services

- *Authority to engage with legal advisors*
  Authority delegated to **Group Chief Executive** or **Trust Secretary**.
- *Maintenance of framework arrangements with approved legal advisors*
  Authority delegated to **Trust Secretary**.
- *Approval of call-off of services*
  Authority delegated to **Trust Secretary** (**delegated to Commercial and Legal Services Manager**).

Grievance procedure/appeals board procedures
Authority delegated to **Group Chief People and Culture Officer**.

Authorisation of new drugs or significant change of use of existing drugs
Authority delegated to **Medicines Advisory Group – see specific guidelines and terms of reference for this Group.**

- *Request for new drugs requiring authorisation before purchase*
  Authority delegated to **Senior Pharmacy Manager**.

- *Orders placed to suppliers over £5,000 to be signed*
  Authority delegated to **Director of Pharmacy or Pharmacy Purchasing Manager**.

- *Pharmacy Payment Lists to be authorised*

Authority delegated to **Director of Pharmacy**, **Purchasing Manager or Senior Pharmacy Clerical Officer**.

- *Copy invoices over £10,000 and invoices from NHS bodies to be sent with the Payments Lists to Creditor Payments*
  Authority delegated to **Director of Pharmacy**, **Purchasing Manager or Senior Pharmacy Clerical Officer**.

- *Pricing agreements and quotations should be authorised*
  Authority delegated to **Director of Pharmacy or Pharmacy Purchasing Manager**.

- *Authorisation of coding slips for invoices and credits requiring payment to be carried out*
  Authority delegated to **Senior Clerical Officer**.

Patients' and relatives' complaints:

- *Overall responsibility for ensuring that all complaints are dealt with effectively*
  Authority delegated to **Chief Nursing and Improvement Officer**.

- *Responsibility for ensuring complaints relating to a division are investigated*
  Authority delegated to **Divisional Director and Head of Nursing**.

- *Legal complaints – coordination of their management*
  Authority delegated to **Trust solicitor**.

Relationship with the media
Authority delegated to **Group Director of Communications**, **who reports to the Group Chief Executive**.

Infection prevention and control

- *Corporate policy*
  Authority delegated to **Director of Infection Prevention and Control/Chief Nursing and Improvement Officer/ Clinical Chairs / Clinical Directors**.

- *Divisional and clinical delivery*
  Authority delegated to **Director of Infection Prevention and Control/Chief Nursing and Improvement Officer/ Clinical Chairs / Clinical Directors**.

All proposed changes in bed allocation
Authority delegated to **Hospital Managing Director or nominated deputy**

Review of Fire Precautions
Authority delegated to **Fire Safety Manager**.

Review of all statutory compliance: legislation and health and safety requirements including Control of Substances Hazardous to Health Regulations
Authority delegated to **Director of Estates and Facilities/Health and Safety Advisor**.

Review of compliance with environmental regulations, for example those relating to clean air and waste disposal
Authority delegated to **Director of Estates and Facilities**.

Review of Trust's compliance with Data Protection Act
Authority delegated to **Group Chief Digital and Information Officer**.

Review the Trust's compliance with the Access to Health Records Act
Authority delegated to **Group Chief Digital and Information Officer**.

Clinical audit
Authority delegated to **Group Chief Medical and Innovation Officer**.

Human Rights Act compliance
Authority delegated to **Trust solicitor**.

Equality and diversity schemes
Authority delegated to **Group Chief People and Culture Officer**.

Child protection
Authority delegated to **Group Chief Nursing and Improvement Officer**.

In case of a major incident

Delegated matter

Commitment of resource in the event of a major incident
Authority delegated to **Trust Management Team Director on call**.

Scheme of Delegation

Appendices

Appendix 1

Procurement Governance Mechanisms

For values between £10k and £25k (including VAT) (the "Medium value process")

Procedure	Outcome detail	Governance mechanism
Quotation process	3 or more valid quotes provided	PO progressed
Quotation process	Fewer than 3 valid quotes	STA and PO progressed
Framework agreement (internal, external)	Compliant direct award	PO progressed

For values between £25k and £139k (including VAT) (the "high value process")

Procedure	Outcome detail	Governance mechanism
Tender process (local quote, framework tender, Find a Tender Service (FTS))	2 or more competitively priced bids received, provided that a minimum of 3 quotes or tenders were requested	Recommendation Report
Tender process (local quote, framework tender, FTS)	2 or fewer competitively priced bids received, where fewer than 3 quotes or tenders were requested	Recommendation Report incorporating an STA
Tender process (local quote, framework tender, FTS)	Contract not awarded to process winner	Exception Report, followed by STA if exception awarded
Framework agreement (external, internal)	Compliant direct award	Short-form Recommendation Report
Framework agreement (external, internal)	Non-compliant direct award	Exception Report, followed by STA if exception awarded
Compliant call from approved framework/call-off agreement	None required	PO Progressed
Contract modification	Contract variation/extension (in scope)	Short-form Recommendation Report
Contract modification	Contract variation/extension (out of scope)	Exception Report
No tender progress	Non-compliant direct award	Exception Report incorporating an STA

For values above £139k (the "very high value process")

Procedure	Outcome detail	Governance mechanism
Procurement strategy creation	Requirement for spend above £100k	Procurement Strategy Report
Tender process (local quote, framework tender, FTS)	2 or more competitively priced bids received, provided that a minimum of 3 quotes or tenders were requested	Recommendation Report
Tender process (local quote, framework tender, FTS)	2 or fewer competitively priced bids received, provided that a minimum of 3 quotes or tenders were requested	Recommendation Report incorporating an STA
Tender process (local quote, framework tender, FTS)	Contract not awarded to process winner	Exception Report followed by STA if exception awarded
Framework agreement (external, internal)	Compliant direct award	Recommendation Report
Framework agreement (external, internal)	Non-compliant direct award	Exception Report followed by STA if exception awarded
Contract modification	Contract variation/ extension (in scope)	Recommendation Report
Contract modification	Contract variation/ extension (out of scope)	Exception Report
No tender process	Non-compliant direct award	Exception report incorporating an STA

Appendix 2

A **public contract** typically only applies to purchases that are above the threshold set out in the regulations. However, there are requirements in terms of notification that are required to be published and guidance to be followed for contracts below the threshold but above the lower limits. There are, however, currently 3 main sets of regulations in play for NHS Trusts (PCR2015, PA23 and PSR) each with varying applicable values. The table below shows the lower limits and main thresholds for NHS trusts.

	PCR 2015 (incl. VAT)	PCR inc. VAT	PCR
Threshold goods and services	139,688	139,688	No upper or lower limit to when these regulations exist
Below threshold lower limit	30,000	12,500	No upper or lower limit to when these regulations exist
Works	5,372,609	5,372,609	
Light-touch regime	663,540	663,540	
Concession contracts	5,372,609	5,372,609	

PCR 2015	Public Contract Regulations: old regulations but remain valid for all purchases and contracts made under any framework that was awarded under these regulations.
PA23	Procurement Act 2023: new regulations in place since February 2025. Applies to any procurement run directly by the Trust since February 2025 or under a framework that has been run and awarded under these Regulations.
PSR	Provider Selection Regime: introduced January 2024 and covers purchases of healthcare services, e.g. insourcing or outsourcing of clinical services.

Appendix 3

UHBW

Business Case Approval Route – Revenue

Value	Divisional Level	Business Development Group	Planning and Delivery Board	Executive Committee	FDEC and Trust Board	Decision through Annual Planning as default
<£100k funding source or not	Yes					
>£100k no funding source identified	Yes	Yes	Yes	Yes		Yes
<£1m direct funding source identified	Yes	Yes				
£1m to <£3m funding source identified	Yes	Yes	Yes			
£3m to <£10m Funding source identified	Yes	Yes	Yes	Yes		
£10m+ Funding source identified	Yes	Yes	Yes	Yes	Yes	

Business Case Approval Route – Capital

Value (capital_	Approval Route	Ultimate Approver
Annual Capital Plan Individual items <£2m	Annual capital prioritisation 1. Prioritisation using standard template 2. Trust Capital Group, Exceptional CC/DD Review, CPSG, FDEC and Trust Board as part of Trust Annual Plan	Trust Board
£2m to <£5m	Business Development Group (BDG), Capital Programme Steering Group	CPSG
£5m to <£10m	BDG, CPSG, Executive Committee	Executive Committee
£10m to <£25m	BDG, CPSG, Executive Committee, FDEC, Trust Board, (Board of Governors support),	Trust Board
£25m to <£50m	BDG, CPSG, Executive Committee, FDEC Trust Board (Board of Governors support), *Recommend adopt NHSE and HMT approval at this stage – but discretion to be applied if meets criteria for internal approval only.*	Trust Board/ NHSE and HMT – *to be agreed at PID stage and with CFO*
£50m+	BDG, SEDPB, CPSG, Executive Committee, FDEC Trust Board (Board of Governors support), NHSE, HMT	HMT
Digital <£25m or <£30m whole life cost	BDG, Relevant Executive Committee Sub-group, CPSG, Executive Committee, FDEC, Trust Board (Board of Governors support),	Trust Board
Digital £25m+ or £30m+ whole life cost	BDG, DHPB, CPSG, Executive Committee, FDEC, Trust Board, ICB, NHSE and HMT	HMT

NBT Business Case Approval Route

Before any case can progress through the approval processes detailed below, divisional and corporate support is needed for both capital and revenue cases as follows:

Divisional support	Prior to any scheme advancing, the Divisional Management Board should consider and approve the case

Business Case Review Group	The Business Case Review Group is a sub-committee of the Trust Management Team. The purpose of the Committee is to:
	• Review all capital and revenue business cases of value greater than £100k (defined as annual cost for recurring commitments or over life-time of contractual commitments, combined capital and revenue values):
	  ○ To ensure trust-wide impacts have been understood within the case
	  ○ To maintain consistent quality standard for cases going through for approval
	• Provide an approval recommendation to the Chief Finance Officer or Chief Executive on finalised business cases
	• Test and confirm procurement strategy
	• Monitor development and delivery of business case pipeline
	• Provide a report to Trust Management Team and Finance & Performance Committee listing all business cases that it has reviewed, and which have subsequently been approved in accordance with the SoDA.

The business case process outlined below applies to all contract renewals and extensions as well as new revenue, capital, or combined spend

Full life cost of new expenditure - Revenue, Capital or Combined (for recurring revenue commitments - annual costs)	<£1m	≥£1m, <£2.5m	≥£2.5m, <£25m	≥£25m
Business Case Review Group	Review and provide approval recommendation			
Executive Team	Review and approve cases >£100k (only where the business case relates to any item that has not already been identified and agreed as an investment priority as part of annual business planning)			
Trust Director of Finance	Approval	Approval	Approval	Approval
Chief Executive or Hospital Managing Director		Approval	Approval	Approval
Chief Executive			Approval	Approval
Finance & Estates Committee			Approval	Approval
Trust Board			Approval	Approval
NHS England				Approval

This approval process shall also apply to any business case of lesser value, or no monetary value, where, in the considered opinion of the Chief Finance Officer, it carries a significant reputational risk or requires strategic input. The Chief Finance Officer shall determine the relevant approvals based on the level of risk / input identified (note also Schedule of Decisions Reserved to the Trust Board 3.2).

Value	<£100k	≥£100k, <£2.5m	≥£2.5m, <£25m	≥ £25m
Business Case type required	**CFO business case**	**Single-stage Business Case**	**OBC and FBC**	**SOC, OBC and FBC**

Appendix 2

Standing Financial Instructions

V2 – updated from April 2025

Green - insertions

~~Red – deletions~~

NHS
Bristol
NHS Group
Bristol | Weston

STANDING FINANCIAL INSTRUCTIONS

Notes:

Numbering is aligned in both Trust SFIs. Trust-specific additions to each SFIs appear at the end of sections so as to preserve alignment, or via addition of 'A' after the relevant number.

1 Interpretation

1.1 The **Group Chair** of the Trust is the final authority in the interpretation of Standing Orders on which the **Group Chief Executive** and **Group Director of Corporate Governance** shall advise them. In the case of the Standing Financial Instructions, they will be advised by the **Group Chief Finance and Estates Officer**.

1.2 The definitions applied to the Standing Orders apply also for these Standing Financial Instructions. The following additional definitions apply:

Legislation definitions:

No additional legislation

Other definitions:

1.2.1 **Budget manager** is the director or employee with delegated authority to manage the finances (Income and Expenditure including in relation to capital) and resources for a specific area of the Trust.

1.2.2 **Commissioning** is the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.3 **Contracting and procuring** is the process of obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.4 **Group** means the hospital group established by North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust.

1.2.5 **Procurement Service provider** is the group that manages the Trust's procurement strategy and processes. The current service provider: Bristol and Weston NHS Purchasing Consortium (BWPC) is hosted by the Trust.

1.2.6 **Shared Business Service (SBS)** is the NHS Shared Business Services, which provides support services to North Bristol NHS Trust, or any equivalent replacement provider.

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

2 Introduction

2.1 These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of the Trust, its directors and officers in relation to all financial matters with which they are concerned.

2.2 The SFIs explain the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

2.3 They identify the financial responsibilities which apply to everyone working for the Trust; and shall be used in conjunction with the Schedule of Decisions Reserved to the Board **in common** (Appendix 1) and the Scheme of Delegation (Appendix 3).

2.4 Detailed procedural advice, which shows how the SFIs should be applied, is maintained in departmental and financial procedure notes.

2.5 These SFIs do not refer to all legislation or regulations and advice issued by the Department of Health and Social Care or NHS England applicable to the Trust. Any uncertainty regarding the application of these SFIs should be discussed with the **Group Chief Finance and Estates Officer**, prior to action.

2.6 The SFIs apply to **all staff**, including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Trust. Failure to comply with the SFIs could lead to disciplinary action, up to and including dismissal. The SFIs do not provide detailed procedural advice and should be read in conjunction with the relevant departmental guidance and the financial procedure notes (available on the intranet or via the Finance Department). The **Group Chief Finance and Estates Officer** must approve all detailed financial procedures.

Compliance with these SFIs

2.7 These SFIs prevail over any division and service guidance or procedural documents in the event of any conflicts between the SFIs and any such guidance. They also prevail over any guidance or instruction issued by other organisations conducting business with the Trust. **All staff** should notify the **Group Chief Finance and Estates Officer** of any conflicts between the local guidance and instruction and the SFIs, if the conflict cannot be resolved satisfactorily locally.

2.8 **All staff** have a duty to disclose, as soon as possible, to the **Group Chief Finance and Estates Officer**, any failure to comply with these SFIs. Full details of the non-compliance including an assessment of the potential impact; and any mitigating factors shall be reported by the **Group Chief Finance and Estates Officer** to the next formal meeting of the Audit Committee **in common** for referring action or ratification.

Responsibilities and delegations

2.9 These SFIs have been compiled under the authority of the **Trust Board in common**. They are reviewed by the **Audit Committee in common** annually and approved by the **Trust Board in common**.

2.10 The **Trust Board in common** exercises financial supervision and control by:

2.10.1 approving the financial strategy.

2.10.2 requiring the submission and approval of budgets that deliver the financial targets set for the Trust within approved allocations and overall income.

2.10.3 approving specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation.

2.10.4 approving the method of providing financial services.

2.11 The **Board in common** has resolved that certain powers and decisions may only be exercised by the **Board in common** in formal session. These are set out in the Schedule of Decisions Reserved to Trust (Appendix 1). All other powers have been delegated to the Board's appointed committees, and the directors and officers of the Trust.

2.12 **The Group Chief Executive** is the Accounting Officer of the Trust and:

2.12.1 is legally accountable to the Secretary of State for Health and Social Care and NHS England for all of the actions of the Trust.

2.12.2 is accountable to the **Trust Board in common** for ensuring that the **Board of Directors** meets its obligation to perform the Trust's functions within the available financial resources and holds overall executive responsibility for the Trust's activities

2.12.3 is responsible to the **Board in common** for ensuring that its financial obligations and targets are met.

2.12.4 is responsible overall for the maintenance of the Trust's systems of internal control.

2.12.5 is responsible for ensuring that all members and staff of the Trust are aware of and understand their responsibilities within these SFIs.

2.13 Save for the decisions and actions reserved to the **Trust Board in common**, the **Group Chief Executive** has full operational authority to approve the financial transactions of the Trust and to delegate such powers to post-holders within the Trust management. The **Group Chief Executive** will, as far as possible, delegate detailed responsibilities, as described in these SFIs and, in more detail in the Scheme of Delegation (Appendix 3).

2.14 **The Group Chief Finance and Estates Officer** is responsible for:

2.14.1 maintaining and implementing the Trust's financial policies.

2.14.2 maintaining an effective system of internal financial control including ensuring that adequate and effective financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained

2.14.3 ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time

2.15 **All staff**, including Board members are responsible for:

2.15.1 the security of the property of the Trust.

2.15.2 avoiding loss.

2.15.3 achieving economy and efficiency in the use of resources.

Hosting Arrangements

2.16 Where the Trust hosts an organisation with a separate management board, the financial transactions supporting the day-to-day business of the organisation shall be strictly in accordance with the Trust's Standing Financial Instructions, policies, and procedures. Responsibility for decision making, planning, and reporting will be delegated in accordance with the hosting agreement or as specified in the Scheme of Delegation.

Temporary suspension of procedures in exceptional circumstances

2.17 The **Trust Board in common** shall allow the SFIs to be suspended temporarily in exceptional circumstances, where the circumstance is:

2.17.1 a Trust wide problem, rather than a directorate specific issue.

2.17.2 of sufficient scale that failure to act quickly and decisively would put the Trust at significant financial and reputational risk.

2.17.3 unforeseen and rapidly developing.

2.17.4 such that following normal procedures would hinder the recovery of the situation.

3 Financial framework

3.1 The **Group Chief Finance and Estates Officer** shall ensure that members of the Board **in common** are aware of the financial aspects of NHS England's applicable oversight framework, within which the Trust is required to operate.

4 Business and budget plans

4.1 The **Group Chief Executive** shall submit to the **Board in common** and external regulators as required, strategic and operational plans, as suggested by relevant guidance, to meet the needs of the Board **in common**. These plans will be developed by the **Group Chief Finance and Estates Officer** and **other Executive Directors** and will include:

4.1.1 An annual financial plan, which takes into account financial targets and forecast limits of available resources, in accordance with the requirements of NHS England and for submission to NHS England.

4.1.2 An annual budget and supporting operational plans (including capital plans as applicable, in accordance with section 13 of these SFIs).

4.2 The plans will be approved before the start of each financial year.

4.3 **All staff who have been given delegated authority** to manage and administer budgets shall be expected to contribute to the preparation of the annual financial plan, budget and other plans.

5 Management of the financial resource

5.1 The **Group Chief Executive** shall require directors and **delegated authorised budget managers** to seek to deliver the financial outturn targets set by the **Trust Board in common** within the approved annual budget plan and the adjustments to those targets reflected in the re-forecasts performed during the year.

5.2 The **Group Chief Executive** may change the financial outturn targets of any divisions, or services.

5.3 **Directors** and **delegated authorised budget managers** shall seek to deliver their service responsibilities within the limits of the financial outturn targets set for them. ~~Financial and other resources shall only be used for the purposes for which they are provided, as approved by the **Chief Executive** and the **Board**~~. (duplicated in 5.5 below)

5.4 Delegation and associated responsibilities must be clearly communicated. Control of budgets shall be exercised in accordance with these Standing Financial Instructions and supplementary guidance issued by the **Group Chief Finance and Estates Officer**.

5.5 Except where otherwise approved by the **Group Chief Executive**, taking account of advice of the **Group Chief Finance and Estates Officer**, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purposes shall transfer to the Trust's reserves, unless covered by the delegated powers of virement.

5.6 Expenditure for which there is no provision in an approved budget and is not subject to funding under the delegated powers of virement, or approved procedures for new funding obtained during the year, may only be incurred if authorised by the **Group Chief Executive**.

Setting the annual financial plan

5.7 The **Group Chief Executive** shall be responsible for providing the **Trust Board in common** with the annual financial plan, taking into account financial targets and forecast income and service developments as developed by the **Group Chief Finance and Estates Officer** in accordance with Standing Financial Instructions 4.1. The plan will identify the significant assumptions on which it is based; and provide details of significant changes to service and workforce plans and how these will impact on the Trust's financial targets. The plan will identify how the Trust will achieve the annual efficiency savings set by the Department of Health and Social Care.

5.8 The **Group Chief Finance and Estates Officer** shall be responsible overall for the design and delivery of the annual integrated financial budget plan.

5.9 All **Executive Directors** shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

5.10 **Budget holders** shall provide all financial, statistical and other relevant information, including service, capacity, workforce and efficiency plans, as required by the **Group Chief Finance and Estates Officer** to enable budgets to be compiled.

5.11 **All budget managers** should sign up to their allocated budgets at the start of each financial year.

Managing and reporting the financial position during the year

5.12 The **Group Chief Finance and Estates Officer** shall be responsible overall for the design and delivery of adequate systems of financial budgetary control. These systems will include processes for:

5.12.1 identifying the level of earned income directly attributable to each budget area.

5.12.2 identifying the target (gross or net) allowable expenditure for each budget area, that will enable each budget holder to deliver their annual financial target contribution to the overall Trust target.

5.12.3 updating the forecast income and allowable expenditure, during the year, to reflect changes in contracted income, service capacity and delivery.

5.12.4 monitoring and reporting financial performance against plans and forecasts.

5.12.5 delivering monthly integrated financial reports to meet the requirements of the Project Management Office, Finance and ~~Performance~~ Estates Committee and the **Trust Board in common** in a form approved by the **Board in common**.

5.13 All **Executive Directors** shall be responsible for establishing monitoring and reporting systems for workforce, service delivery and quality, service capacity and activity, and efficiency planning to enable budget holders to deliver an integrated analysis of their service performance.

5.14 **All staff to whom responsibility is delegated** to incur expenditure or generate income shall comply with the requirements of those systems.

5.15 Designated **budget holders** shall be responsible for maintaining expenditure within the limits of earned available income.

5.16 Designated **budget holders** shall monitor and analyse the integrated financial performance of their service during the year. This shall include assessment of:

5.16.1 progress towards delivering the required financial position for the budget area.

5.16.2 the impact of resources used, including workforce, progress of service delivery and achievement of efficiency plans.

5.16.3 trends and projections.

5.16.4 where relevant, plans and proposals to recover adverse performance.

5.17 The **Group Chief Finance and Estates Officer** shall ensure that budget holders are provided with training on an ongoing basis, advice and support from suitably qualified finance staff, to enable them to perform their budget management role adequately.

5.18 The **Group Chief Finance and Estates Officer** shall be required to compile and submit to the **Trust Board in common** such financial estimates and forecasts, on both revenue and capital account, as may be required.

5.19 The **Group Chief Finance and Estates Officer** shall keep the **Trust Board in common** informed of:

5.19.1 significant in-year variance from the business plan and advise the Board **in common** on actions to be taken to address the variance.

5.19.2 financial consequences of changes in Trust policy.

5.19.3 financial implications of external determinations, such as national pay awards and changes to the pricing of clinical services.

5.20 The **Group Chief Finance and Estates Officer** shall issue timely, accurate and comprehensible advice and financial reports to each budget manager, covering the areas for which they are responsible

6 Annual accounts, reports and returns

6.1 The **Group Chief Finance and Estates Officer** shall:

6.1.1 prepare financial returns in accordance with the accounting policies and guidance provided by the Department of Health (DHSC), NHS England and the Treasury, the

Trust's accounting policies, and accounting standards and practice as determined and applicable by the accounting bodies in the UK.

6.1.2 prepare and submit annual financial returns and reports to the DHSC and NHS England as required and certified in accordance with current guidelines.

6.1.3 submit periodic monitoring and financial returns to external organisations, such as NHS England, in accordance with the timetables set by those organisations.

6.2 The Trust's annual accounts must be audited by an auditor appointed by the Trust. The Trust's audited annual accounts shall be presented to a public meeting and made available to the public, within the timescales set by the DHSC and NHS England.

6.3 The **Group Chief Executive** shall publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the current DHSC and NHS England requirements and guidance.

6.4 The Trust's annual report and statutory accounts must be presented to the **Trust Board in common** for approval.

6.5 The annual report and accounts and the auditor's report must be presented at a meeting of the **Council of Governors** in accordance with the NHS England's timetable.

7 Income, including contracts for the provision of healthcare, fees and charges

7.1 The **Group Chief Finance and Estates Officer** is responsible for:

7.1.1 designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.1.2 the prompt banking of all monies received.

7.2 A contract or agreement must be in place for all income due to the Trust for the provision of goods or services to a third party. The nature of the contract or agreement will depend on the goods or services being provided. The **Group Chief Finance and Estates Officer** is responsible for signing all contracts and agreements with delegated responsibilities given within the Scheme of Delegation.

7.3 Employees responsible for agreeing the prices of goods and services provided by the Trust should ensure that they cover all costs, including overheads. Support should be sought from the finance department as required. Appropriate, independent professional advice shall be taken on matters of valuation. Prices and charges shall be reviewed at least annually. This paragraph applies equally to:

- the sale of goods and services
- support to commercial research trials and projects
- pricing of non-patient care service agreements with other bodies.

7.4 Where such income matters are dealt with by the Shared Business Service, such arrangements will be incorporated in a Service Level Agreement with the Shared Business Service.

~~**Fees and charges for the provision of healthcare**~~

7.5 The **Group Chief Finance and Estates Officer** shall:

7.5.1 follow the up-to-date DHSC's guidance and regulations for setting prices for providing NHS services.

7.5.2 approve and regularly review the level of all fees and charges set, other than those determined by the DHSC or by statutory regulation.

7.5.3 take independent professional advice on matters of valuation, as necessary.

7.6 The **Group Chief Finance and Estates Officer** shall approve all property and non-clinical equipment leases, property rentals and tenancy agreements. The **Director of Estates and Facilities** shall advise on these arrangements.

7.7 **All employees** shall inform the **Group Chief Finance and Estates Officer** promptly of money due to the Trust arising from transactions which they initiate, or deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

NHS service agreements for the provision of services

7.8 The **Group Chief Executive** is responsible for ensuring that the Trust enters into suitable Commissioning Contracts with service commissioners for the provision of NHS services to patients, in accordance with the business plans; and for establishing the arrangements for providing extra-contractual services. Where the Trust makes arrangements for the provision of services by non-NHS providers, the **Group Chief Executive** is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided.

7.9 The **Group Chief Finance and Estates Officer** shall provide up to date advice on:

7.9.1 Standard NHS contractual terms and conditions, issued by NHS England.

7.9.2 costing and pricing of services.

7.9.3 payment terms and conditions.

7.9.4 amendments to contracts, SLAs and extra-contractual arrangements.

7.10 The **Group Chief Finance and Estates Officer** shall ensure that SLAs and other contractual and extra- contractual arrangements:

7.10.1 are devised so as to limit the risk to the Trust, whilst enabling opportunities to generate income

7.10.2 are financially sound; and that any contractual arrangement pricing at marginal cost are approved by the ~~**Chief Financial Officer**~~ and reported to the **Trust Board in common**.

7.11 The **Group Chief Finance and Estates Officer** is responsible for ensuring that systems and processes are in place to record patient activity, raise invoices and collect monies due under the agreements for the provision of healthcare services.

7.12 **Budget holders** with responsibilities for managing delivery against service agreements must ensure they understand and use the contract monitoring information for the financial management of their service areas.

Research and development

7.13 All applications for research funding shall be considered and approved by the research Department. This applies to applications to NHS institutions such as grant requests to the National Institute for Health Research, and non-NHS organisations, including commercial sponsorship organisations, charitable bodies and research councils**.**

7.14 The agreement covering any undertaking of research shall recognise the Trust's policies governing Intellectual Property rights. Where there is any lack of clarity this shall be resolved prior to undertaking the relevant research project.

Concession agreements

7.15 The **Group Chief Finance and Estates Officer**, advised by the **Director of Estates and Facilities** or another individual with appropriate expertise within the Estates & Facilities division shall review and propose plans for all concession agreements proposed for the Trust, including arrangements that do not incur an immediate direct cost for the Trust, but can expose it indirectly to significant liability. The **Group Chief Finance and Estates Officer** shall authorise all concession agreements entered into by the Trust.

8 Procurement, tendering and contracting procedure

8.1 The Trust is permitted to enter into contracts within the statutory powers delegated to it. The procedure for setting contracts shall comply with those powers and these SFIs, in particular this section 8 and sections 9 and 10, all of which should be read together. Delegated powers of authorisation are granted to Trust officers according to the Scheme of Delegation. A contractual arrangement must be in place for all goods and services procured by the Trust. The nature of the contract or agreement will depend on the goods, services or works being provided. The **Group Chief Finance and Estates Officer** is responsible for signing all contracts and agreements with delegated responsibilities given within the Scheme of Delegation.

8.2 All contracts made shall ensure best value for money using the Trust's procurement service provider and processes established by the **Group Chief Finance and Estates Officer.** For each contract a **Trust Officer who is a delegated budget holder** shall be nominated and hence responsible for overseeing and managing the contract on behalf of the Trust.

8.3 The **Group Chief Finance and Estates Officer** is responsible for making arrangements for the purchase of goods and services:

8.3.1 On a non-contracted basis in accordance with the requisitions processes set out in section 10 of these Standing Financial Instructions and the delegated authorities set out in the Scheme of Delegation, and

8.3.2 On a contracted based in accordance with this section 8 of these Standing Financial Instructions and the delegated authorities set out in the Scheme of Delegation.

Legislation and guidance regarding public procurement

8.4 The Trust shall comply with all relevant procurement legislation and guidance, including any advertising and award requirements.

8.5 The Trust shall comply as far as is practicable with all guidance and advice issued by the Department of Health for Social Care and NHS England in respect of procurement, capital investment, estate and property transactions and management consultancy contracts.

Competitive tendering

8.6 The **Group Chief Finance and Estates Officer** shall be responsible for ensuring compliance with applicable procurement law and guidance, and for advising the **Board in common** regarding matters in relation to which discretion is permitted or required including for the setting of thresholds in addition to those prescribed by procurement law. Additional detail relating to the Trust's procedures for complying with procurement law and discretionary matters shall be incorporated in these Standing Orders through the Scheme of Delegation; and shall be reviewed at least annually.

8.7 The **Trust Board** **in common** shall ensure that competitive tenders, or quotations are invited, in line with the thresholds required by procurement law and as set out in the Scheme of Delegation, for:

8.7.1 the supply of goods, materials and manufactured articles.

8.7.2 services, including management consultancy services from non-NHS organisations.

8.7.3 design, construction and maintenance of building and engineering works, including construction and maintenance of grounds and gardens.

8.8 The **Trust Board** **in common** shall allow for exceptions to the requirement for formal tendering procedures in accordance with procurement law.

8.9 Subject to compliance with procurement law, the **Trust Board** **in common** shall allow for the requirement for formal tendering procedures to be waived in certain circumstances, for example where:

- the **Group** **Chief Executive** decides that formal tendering procedures would not be practicable
- available timescales due to unforeseen circumstances genuinely mean that competitive tendering is not a realistic option, in accordance with procurement law requirements. Failure to plan the work properly should not be regarded as a justification for waiving tendering procedures
- specialist expertise, goods and services are required and are genuinely available from only one source, in accordance with procurement law requirements. Evidence of the unique status will be required to support any exemption
- the task is essential to complete the project, and arises as a direct and genuine consequence of an existing or recently completed assignment; and engaging different suppliers for the new task would be counter-productive, in accordance with procurement law requirements
- there is a clear benefit to be gained from maintaining continuity with an earlier supply in accordance with procurement law requirements. In such cases, the benefits of such continuity must outweigh any potential advantage to be gained from competitive tendering

Note that section 8.4 takes precedence over the above list of exemptions to competitive tendering. The Trust should take the advice of BWPC when enacting any of the aforementioned exemptions. Approval of any exemptions should be carried out with reference to the Scheme of Delegation and reported to Audit Committee in common on a quarterly basis.

8.10 The **Group** **Chief Finance** **and Estates** **Officer** shall ensure that:

8.10.1 any fees paid to an organisation to administer the competitive tendering exercise are reasonable and within commonly accepted rates for such work.

8.10.2 waivers to competitive tendering procedures are not used to avoid competition, for administrative convenience.

8.10.3 that procedural guidance from BWPC is kept up to date. The guidance will include the rules, requirements and records to be maintained for each key stage of the tendering process. These procedures shall include, but not be limited to, requirements for:

- record of issue of invitations to tender
- submission, storage and audit trail for receipt of tenders

- process and record of opening tenders
- evaluation of tenders (inc. completeness, accuracy, compliance with prescribed format etc)
- admissibility of tenders, including treatment of tenders received after the deadline but prior to other bids being "opened"
- reasons behind decision to award the contract

8.11 The procurement service provider shall ensure that:

8.11.1 Tenders are fair, transparent, competitive and at all times compliant with all relevant procurement legislation and guidance, and in accordance with the Scheme of Delegation (Appendix 3).

8.11.2 Tenders and quotations expressly state suppliers' obligations to comply with all relevant legislation.

8.11.3 Tender processes and rules are in accordance with up-to-date and relevant specialist guidance, including government procurement policy notes.

8.11.4 It maintains a record of competitive tenders and subsequent contract awards.

8.11.5 Award notices are published for all contracts where required by procurement law.

8.11.6 Procurement Strategy reports are created for all contracts with a total value as set by the **Chief Financial Officer** in accordance with the Scheme of Delegation

Quotations: competitive and non-competitive

8.12 The **Trust Board** **in common** shall approve the value range whereby formal tendering procedures are not adopted, but quotations will be required.

8.13 The **Group** **Chief Finance** **and Estates** **Officer** shall determine the procedures to be followed in respect of competitive and non-competitive quotations. These will include:

8.13.1 Procedures for expenditure that is less than the thresholds set under SFI 8.12 (in accordance with the Scheme of Delegation).

8.13.2 types of service or supply to be sought through quotations.

8.13.3 minimum number of competitive quotes to seek, currently set at three.

8.13.4 requirement for written quotations.

8.13.5 retention of records.

8.13.6 confidentiality across the process.

8.13.7 recording the decision to go to contract.

8.14 The **Group** **Chief Finance** **and Estates** **Officer** shall identify specific procedures to be followed in the instance of a recognised event of exceptional circumstance and report to the Finance and Estates Committee in common.

9 Contracts and purchasing

9.1 The **Trust Board** **in common** shall only enter into contracts on behalf of the Trust that are within the statutory powers delegated to it by the Secretary of State and shall comply with:

9.1.1 the Trust's Standing Orders and Standing Financial Instructions (including in particular SFI 8).

9.1.2 UK procurement legislation and guidance,.

9.1.3 any relevant directions issued, or recognised by, the DHSC and NHS England.

9.2 In all contracts made by the Trust, the **Trust Board in common** shall:

9.2.1 seek to obtain best value for money.

9.2.2 for contracts subjected to tendering or quotation, ensure that the contracts contain the same terms and conditions of contract as was the basis on which tenders or quotations were invited (unless otherwise permitted by the selected procurement process).

9.3 The **Group Chief Executive** and **Executive Directors** shall nominate managers to oversee and manage and arrange for execution of each contract on behalf of the Trust

Longer term commitments

9.4 All contracts, leases, tenancy agreements and other commitments, which might result in a long-term liability, must be notified to and authorised, in accordance with the limits set out in the Scheme of Delegation, in advance of any commitment being made.

Healthcare Service Agreements

9.5 The **Group Chief Finance and Estates Officer** shall ensure that SLAs and extra-contractual arrangements agreed with other NHS trusts, for provision of services to the Trust, are agreed in accordance with procurement law.

In-house services

9.6 The **Trust Board in common** shall determine which in-house services should be market tested by competitive tendering; and the frequency with which this should be done. In instances where competitive tendering is required, the **Board in common** shall nominate suitably qualified staff to administer the process and ensure that procurement law and guidance are applied correctly, including:

9.6.1 setting clearly defined specifications for the service.

9.6.2 clear separation between the in-house service provider tender team and the Trust's commissioning team.

9.6.3 independent evaluation process.

9.7 The **Group Chief Executive** shall ensure that best value for money can be demonstrated for all services provided on an in-house basis and shall nominate officers to oversee and manage the contract on behalf of the Trust, separate from those that are providing the service.

10 Management of non-pay expenditure

10.1 Requisitions and orders are subject to the delegations and limits set out in SFI 8 and SFI 9.

10.2 The **Group Chief Finance and Estates Officer** shall:

10.2.1 maintain the list of managers who are authorised to place requisitions and orders for the supply of goods and services.

10.2.2 set the maximum value of each requisition or order and the system for authorisation above that level.

10.2.3 set out procedures for seeking of professional advice regarding the supply of goods and services.

10.3 These delegation limits are maintained in the Scheme of Delegation.

Requisitioning and ordering goods and services

10.4 The **Group Chief Finance and Estates Officer** shall maintain adequate systems and procedures for the ordering (including requisitions) of goods and services. These shall include:

10.4.1 procedural instructions and guidance on the obtaining of goods, works and services incorporating the thresholds identified in the Scheme of Delegation.

10.4.2 recognition of the Trust's approved supply arrangements, including, but not limited to the following:

- recognised Trust wide procurement systems
- other recognised controlled ordering systems for specific service areas providing that they can evidence a secure audit trail
- framework agreements made by the Trust, or by BWPC, including approved suppliers of temporary, locum and interim staff placements; and contractual arrangements for on-going ad-hoc support from chosen service suppliers (eg emergency maintenance and repair services for medical equipment)

10.5 **Employees** responsible for placing requisitions and orders; and **managers** responsible for authorising the orders shall ensure that:

10.5.1 approval is obtained in advance from the **Group Chief Finance and Estates Officer** for any contractual arrangement that may involve taking on an ongoing obligation, or legal responsibility.

10.5.2 sufficient budget exists to pay for the item ordered, or if insufficient budget is available, the **Group Chief Finance and Estates Officer** has authorised the purchase.

10.5.3 a Purchase Order is raised on an approved electronic ordering system prior to the goods or services being received.

10.5.4 orders are not split or otherwise manipulated to circumvent authorisation and delegation limits.

10.5.5 goods and equipment are not accepted on trial, or on loan, where there is an associated risk or commitment to current or future expenditure, unless specifically approved by the **Group Chief Finance and Estates Officer** as advised by BWPC.

10.6 Employees shall use the Trust's approved supply arrangements.

10.7 Where the service is provided by or maintained by the Shared Business Service, the arrangements shall be set out in the SLA.

Receipt of goods and services and system of payment and payment verification

10.8 The **Group Chief Finance and Estates Officer** shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or with national guidance (such as the government's Fair Payment Code).

10.9 Where applicable, such requirements will be specified in any SLA with the Shared Business Service provider.

10.10 The **Group Chief Finance and Estates Officer** shall:

10.10.1 ensure the prompt payment of all properly authorised accounts and claims.

10.10.2 maintain an adequate system of verification, recording and payment of all amounts payable, including relevant thresholds.

10.10.3 identify procedures to follow for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.10.4 maintain instructions to employees regarding the handling and payment of accounts within the Finance Department.

Prepayments and payments on account

10.11 The **Group Chief Finance and Estates Officer** shall specify the circumstances under which goods and services can be paid in advance of receipt, through the use of prepayments. These circumstances will include instances where one or more of the following apply:

10.11.1 the **Group Chief Finance and Estates Officer** has approved that the pre-payment, in part, or in full, is specified in the agreed contractual arrangement.

10.11.2 the proposed arrangement is compliant with procurement law and guidance, where the contract is above a stipulated financial threshold.

10.11.3 the financial advantages are shown to outweigh the disadvantages and risks.

10.11.4 it is customary for the payment in advance for a service that is provided for a specific period of time (e.g., rates, rentals, service and maintenance contracts, insurance, utilities standing charges).

10.12 The **budget holder** shall confirm that the goods and services due under a prepayment arrangement are received satisfactorily and in accordance with the contractual arrangements.

Payments to contractors by instalments

10.13 The **Group Chief Finance and Estates Officer** shall identify adequate procedures to address interim payments made on-account in contracts for building and engineering works. These will include arrangements for receipt of independent and appropriate certificates and confirmations of work completed, to the required standards.

10.14 Final payments shall only be made after the Trust's nominated **contract manager** has certified the accuracy and completeness of the value of the final account submitted by the contractor; and has confirmed that the procedure set out in the contract terms has been followed properly.

Approvals for Business Cases

10.15 With reference to Appendix 3 (Scheme of Delegation) and where required by applicable investment policies, all planned (including Capital funded) procurements must have a signed off Options Appraisal and/or Business Case report for the procurement which is produced in conjunction with the Trust's procurement service provider.

10.16 All Options Appraisals, and ultimately procurement Business Cases must include Whole Life Cost estimates as well as identification of projected savings.

*A genuine pre-estimate of contract value must be ascertained and should not automatically be based on previous years' expenditure, but also based on an estimate of future demand, and

any additional value gained by the supplier. Contract durations should not be artificially curtailed to bring values below approval thresholds.

Variations and extensions to contracts

10.17 Contracts may be designed to allow for variations to the sum agreed, or the works, goods and/or services to be delivered. These variations shall be clearly identified and shall be approved in accordance with the relevant contract process.

10.18 Where a variation to contract (or the aggregate of several variations to contract) leads to an increase in total contract cost of an amount as specified in the Scheme of Delegation, (a cost overrun) then this shall be approved in accordance with the Scheme of Delegation.

10.19 Where new material variations are needed in an emergency, approval should be sought from a relevant **authorising officer** (which in most cases will be the **Group Chief Finance and Estates Officer**); and shall be confirmed and authorised, using the relevant contract procedure, on the next working day or otherwise as soon as possible.

10.20 Extensions to contracts which exceed the maximum term of the contract shall be confirmed in writing and authorised in accordance with the Scheme of Delegation and reported to Audit Committee in common. Contract Extensions should not exceed the maximum term permitted under the terms of the contract defined when the contract was let.

Joint finance arrangements with local authorities and voluntary bodies

10.21 Payments to local authorities and voluntary organisations shall comply with procedures laid down by the **Group Chief Finance and Estates Officer** which shall be in accordance
with current legislation.

11 Terms of service and payment of members of the Trust Board in common and employees

Board members, directors and specified senior managers

11.1 The **Trust Board in common** shall be accountable for taking decisions on the remuneration and terms of service of directors and senior managers not on Agenda for Change terms and conditions. The **Board in common** shall establish a Remuneration ~~and Nominations~~ Committee **in common** responsible for determining the remuneration of, and appointment of directors and senior staff in accordance with Standing Orders.

11.2 The Remuneration ~~and Nominations~~ Committee **in common** shall:

11.2.1 agree appropriate remuneration and terms of service for the **Group Chief Executive**, other directors and any staff remunerated via Very Senior Manager arrangements, (as described in the terms of reference of the Committee), employed by the Trust:

- all aspects of salary (including any performance-related elements and bonuses)
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms.

11.2.2 monitor and evaluate the performance of individual directors and other staff on Very Senior Manager arrangements

11.2.3 advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

11.3 The Trust shall pay allowances to the **Group Chair** and **Non-Executive Directors** of the Board **in common** in accordance with instructions issued by the DHSC.

11.3A The **Council of Governors** will decide the remuneration and allowances and other terms of office of the **Group Chair** and **Non-Executive Directors**.

Other employees

11.4 The **Group Chief People and Culture Officer** shall consider and approve proposals for the setting of remuneration and conditions of service for those employees not covered by the Remuneration ~~and Nominations~~ Committee **in common**.

Funded establishment and staff appointments

11.5 The staff establishment plans incorporated within the annual plans approved by the **Trust Board in common** shall be regarded as the funded establishment. The funded establishment of any department should reflect the Trust's approved workforce plans, which form part of the Trust's budget plans submitted to the NHS England.

11.6 The **Group Chief People and Culture Officer** shall ensure adherence to the Agenda for Change rules and approved policies and procedures and terms and conditions for employees paid on alternative contractual arrangements, including the consultant contract. These procedures shall address:

11.6.1 setting starting pay rates and conditions of service, for employees.

11.6.2 approving plans to engage, re-engage employees, either on a permanent or temporary nature, or hire agency staff.

11.6.3 agreeing to changes in any aspect of remuneration, including re-grading, within the Agenda for Change allowed rules.

11.6.4 ensuring that all employees are issued with a contract of employment in a form which complies with employment legislation.

11.7 The **Budget Holder** shall ensure that the cost of the appointment, or change in conditions can be met within the limit of their approved budget and funded establishment.

Processing payroll

11.8 The **Group Chief Finance and Estates Officer** shall maintain procedural instructions for delivery of the Trust's payroll function. These procedures shall be compliant with employment legislation, the Data Protection Act and HM Revenues and Customs regulations.

11.9 The **Group Chief Finance and Estates Officer** shall ensure that the arrangements for providing the payroll service are supported by:

11.9.1 adequate internal controls and audit review procedures

11.9.2 timetables for submission of properly authorised time records and other notifications

11.9.3 arrangements to make payment on agreed dates

11.9.4 arrangements for allowed methods of payment, and

11.9.5 that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

11.10 The **Group Chief People and Culture Officer** shall:

11.10.1 agree the final determination of pay and allowances.

11.10.2 agree appropriate (contracted) terms and conditions.

11.11 **Delegated authorised budget managers** shall ensure that the electronic staff record, including the approved staff establishment, is kept up to date. **Nominated managers** shall ensure that all staff are keeping their records complete, including requirements to:

11.11.1 submit time records, and other notifications in accordance with agreed timetables,

11.11.2 complete time records and other notifications in accordance with the **Group Chief Finance and Estates Officer's** instructions

11.11.3 submit forms notifying change in circumstances and termination of employment in the prescribed form, as soon as these changes are reported to them.

Travel and subsistence expenses

11.12 Reimbursement of expenses incurred by Trust staff shall be made by the Payroll Service in accordance with the Trust's relevant current policy and procedures, and subject to verification and authorisation of the claim by an officer with delegated authorisation for this purpose.

Use of self-employed management consultants and contractors

11.13 All senior staff must be on the payroll of the Trust or the other trust in the Group unless there are exceptional temporary circumstances, which will require the **Group Chief Executive's** approval. This includes all Trust Board **in common** members and staff with significant financial responsibility.

11.14 The **Group Chief People and Culture Officer** shall establish procedures to ensure that the Trust's interests are protected in the contractual arrangements entered into with self-employed consultants and contractors. These procedures shall ensure that the contractual arrangements do not contravene HM Revenues and Customs' requirements regarding the avoidance of tax and national insurance contributions through the use of intermediaries, such as service companies or partnerships, known as the off-payroll working rules.

11.15 All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.

12 Insurance, including risk pooling schemes administered by the NHS Resolution Litigation Authority

12.1 The **Trust Board in common** shall determine the Trust's arrangements for insurance cover, including the option to insure through the risk pooling schemes administered by the NHS Litigation Authority (under its operating name NHS Resolution); or to self-insure for some or all of the risks covered by the risk pooling schemes.

12.2 If the **Trust Board in common** decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers and third-party liability) covered by the scheme, this decision shall be reviewed annually.

12.3 The **Group Chief Finance and Estates Officer** shall ensure that:

12.3.1 documented procedures cover the Trust's insurance arrangements, including for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

12.3.2 the arrangements entered into are appropriate and complementary to the risk management programme.

12.3.3 the **Trust Board in common** is informed of the nature and extent of the risks that are self-insured in the event that the Board **in common** decides not to use the risk pooling schemes administered by the NHSR for one or other of the risks covered by the schemes.

12.4 The **Group Chief Finance and Estates Officer** shall determine the level of insurance cover to be held by the Trust.

13 Capital investment, private financing, fixed asset registers and security of assets

13.1 The **Group Chief Finance and Estates Officer** is responsible for compiling and submitting for Board **in common** approval an annual capital programme, which is affordable within available resources over the lifetime of the investment.

13.2 The **Group Chief Finance and Estates Officer** shall report to the **Board in common**, the progress of delivery of the capital programme, against plan, during the year.

13.3 The **Group Chief Executive** shall ensure that:

13.3.1 there is an adequate appraisal and approval process in place for determining capital expenditure priorities and supporting systems to identify and assess the financial effect of each proposal on business plans.

13.3.2 all stages of capital schemes are managed and controlled adequately; and that schemes are delivered on time and to cost.

13.3.3 capital investment is risk assessed against the declared commissioning strategic plans of significant commission organisations and is consistent with the Trust's long term strategic plans.

13.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

13.5 The **Group Chief Finance and Estates Officer** shall review the costs and revenue analysis, including revenue consequences included in the business case

13.6 For approved capital schemes, the **Group Chief Finance and Estates Officer** shall:

13.6.1 issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

13.6.2 agree arrangements for managing stage payments.

13.6.3 maintain procedures for monitoring and reporting on the progress of delivery of contracts; and capital expenditure and commitments against plans and against the Trust's capital programme.

13.7 Where appropriate, the Trust's **Procurement Service** shall advise the **Group Chief Finance and Estates Officer**, on the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.8 Authorisations issued to the manager(s) responsible for any scheme shall be made in accordance with the value limits set out in the Scheme of Delegation:

13.8.1 specific authority to commit expenditure.

13.8.2 authority to proceed to tender.

13.8.3 approval to accept a successful tender.

13.8.4 Authority to proceed with contract variations.

Asset Register

13.9 The **Group Chief Finance and Estates Officer** shall maintain registers of assets and shall maintain procedures for keeping the registers up to date, including provision for arranging for physical confirmation of the existence of assets against the asset register to be conducted every three years on a rolling basis for assets.

13.10 The **Group Chief Finance and Estates Officer** shall maintain procedures for verifying additions and amendments to the assets recorded in the asset register. These procedures and records will include:

13.10.1 additions to the fixed asset register clearly identified to an appropriate budget manager.

13.10.2 properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties.

13.10.3 records of costs incurred within the Trust, on stores, requisitions and labour including appropriate overheads.

13.10.4 lease agreements in respect of assets held under a finance leases.

13.11 The **Group Chief Finance and Estates Officer** shall maintain procedures for controlling the disposal of assets and updating of asset registers and financial records to reflect the event. These procedures will include the requirement for the authorisation and validation of the de-commissioning and disposal of the asset.

13.12 The **Group Chief Finance and Estates Officer** shall approve procedures for:

13.12.1 applying depreciation charges and indexation valuation adjustment to assets, using methods and rates as specified in the guidance issued by the DHSC.

13.12.2 reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

Security of assets

13.13 The **Group Chief Finance and Estates Officer** shall maintain procedures for controlling the security of assets, including fixed assets, cash, cheques and negotiable instruments. The procedures will include:

13.13.1 recording managerial responsibility for each asset

13.13.2 identification of additions and disposals

13.13.3 identification of all repairs and maintenance expenses

13.13.4 physical security of assets

13.13.5 periodic verification of the existence of, condition of, and title to, assets recorded

13.13.6 identification and reporting of all costs associated with the retention of an asset

13.13.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments

13.14 **All employees** are responsible for the security of property of the Trust and for following such routine security practices in relation to NHS property as may be determined by the **Board in common**. Any breach of agreed security practices, or damage and losses to Trust property shall be reported in accordance with agreed procedures.

13.15 Where practical, assets should be marked as Trust property. ~~Disposals and condemnations~~

13.16 The **Group Chief Finance and Estates Officer** shall prepare procedures for the disposal of assets including condemnations and ensure that these are notified to budget managers. The procedures will include arrangements to be followed for:

13.16.1 condemning and disposing of unserviceable and redundant assets.

13.16.2 maintaining records of assets disposed of, including confirmation of destruction of condemned assets.

13.16.3 specific processes to be followed in instances where assets are passed on for future use to another organisation.

13.16.4 the sale of assets, including through competitive bids and negotiated bids; and sales linked to larger contracts for work, such as assets arising from works of construction, demolition or site clearance.

13.17 The appropriate **asset management lead** responsible for the decision to dispose of an asset shall advise the **Group Chief Finance and Estates Officer** of the estimated market value of the asset, taking account of professional advice where appropriate.

14 Bank accounts and Government Banking Service accounts

14.1 The **Trust Board in common** shall approve the banking arrangements for the Trust.

14.2 Where applicable, the **Group Chief Finance and Estates Officer** is responsible for producing a Treasury Management Policy, in accordance with any relevant guidance from NHS England, for **Trust Board in common** approval.

14.3 The **Group Chief Finance and Estates Officer** is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of bank accounts. This advice will take into account guidance and Directions issued by the DHSC.

14.4 The **Group Chief Finance and Estates Officer** shall:

14.4.1 establish and maintain necessary commercial bank accounts and Government Banking Service (GBS) accounts.

14.4.2 advise the Trust's bankers, formally in writing, of the conditions under which each account will be operated (the bank mandate).

14.4.3 seek to limit the use of commercial bank accounts and the value of cash balances held within them.

14.4.4 conduct the Trust's main banking services and financial transactions using accounts provided by the GBS.

14.5 Only the **Group Chief Finance and Estates Officer** or their nominated representative, is authorised to open, operate and control a bank account, where monies owned by the Trust, including where applicable charitable funds, are received or expended. All such accounts must

be held in the name of the Trust. It is a disciplinary offence for any other officer of the Trust to establish and operate such an account.

14.6 The **Group Chief Finance and Estates Officer** shall:

14.6.1 ensure that payments made from bank or GBS accounts do not exceed the amount credited to the account.

14.6.2 monitor compliance with DHSC guidance on the level of cleared funds.

14.6.3 where such processes are undertaken by a Shared Business Service (SBS) these will be specified in a Service Level Agreement with the SBS.

Banking procedures

14.7 The **Group Chief Finance and Estates Officer** shall prepare detailed instructions on the operation of bank and GBS accounts which shall include:

14.7.1 the conditions under which each bank and GBS account is to be operated.

14.7.2 details of those authorised to sign cheques or other orders drawn on the Trust's accounts.

14.7.3 details of limits to delegated authority, including the number of authorised signatories required, and arrangements for authorising alternative mechanisms for 'signing' cheques and orders.

Tendering and review

14.8 The **Group Chief Finance and Estates Officer** shall review the commercial banking arrangements of the Trust at regular intervals to ensure they continue to reflect best practice and represent best value for money.

14.9 The **Group Chief Finance and Estates Officer** shall report the results of any tendering exercise to the **Board in common**. This review is not necessary for GBS accounts.

Trust credit cards

14.10 The **Group Chief Finance and Estates Officer** shall approve the allocation and operation of credit cards on behalf of the Trust; implement arrangements to monitor whether the credit cards are being used appropriately; and take action where inappropriate use is identified.

Security of cash, cheques and other negotiable instruments

14.11 The **Group Chief Finance and Estates Officer** shall:

14.11.1 approve the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

14.11.2 maintain adequate systems for ordering and securely controlling any such stationery.

14.11.3 provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, and procedure notes for the safe storage of keys, and for coin operated machines.

14.11.4 prescribe systems and procedures for handling cash and negotiable securities on behalf of the Trust.

14.12 Where such issues are undertaken by the Shared Business Service, detailed requirements will be specified in a Service Level Agreement with The Shared Business Service.

14.13 The Trust's money shall not under any circumstances be used for the encashment of private cheques or cheques for private purposes.

14.14 All cheques, postal orders, cash etc, shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the **Group Chief Finance and Estates Officer**.

14.15 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisations or individuals absolving the Trust from responsibility for any loss.

15 Investments

15.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State for Health and Social Care and authorised by the **Board in common** and in accordance with the Trust's Treasury Management Policy, where applicable.

16 Management of debtors

16.1 The **Group Chief Finance and Estates Officer** shall manage debts in accordance with the Trust's Treasury Management Policy, and where not applicable the **Group Chief Finance and Estates Officer** shall:

16.1.1 maintain effective processes for the appropriate recovery action on all outstanding debts.

16.1.2 deal with instances of income not received, in accordance with losses procedures.

16.1.3 maintain effective processes to prevent, or detect overpayments and initiate recovery when this occurs.

17 Stores and receipt of goods

17.1 The **Group Chief Finance and Estates Officer** shall determine procedures for the management stocks of resources, defined in terms of controlled stores and departmental stores. These will address the procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses; and include the principles that stocks are:

17.1.1 managed so that best value for money can be achieved whilst maintaining minimum safe stock levels.

17.1.2 subjected to annual stock take as a minimum, where rolling stock checks are not in place.

17.1.3 valued at the lower of cost and net realisable value.

17.2 The **Group Chief Finance and Estates Officer** shall:

17.2.1 delegate responsibility for the management of stores to relevant, suitably qualified departmental managers.

17.2.2 (taking expert advice where necessary) define the security arrangements and the custody of keys for any stores and locations in writing. Wherever practicable, stocks should be marked as health service property.

17.2.3 approve alternative arrangements for the management of stores where a complete system of stores control is not justified.

17.2.4 identify those authorised to requisition and accept goods supplied.

17.3 The **designated store manager** shall:

17.3.1 Maintain stocks in line with clearly defined local procedures that are consistent with the overall requirements set out by the Trust.

17.3.2 implement periodic review of slow moving and obsolete items; and for condemnation, disposal, and replacement of all unserviceable articles.

17.3.3 report to the **Group Chief Finance and Estates Officer** any evidence of significant overstocking and of any negligence or malpractice in the management and use of stocks

18 External borrowing and Public Dividend Capital

18.1 Where applicable, the **Group Chief Finance and Estates Officer** shall advise the **Board in common** on the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the DHSC and in accordance with the Trust's Treasury Management Policy. The **Group Chief Finance and Estates Officer** shall also provide periodic reports to the Board **in common** concerning the PDC debt and all loans as applicable.

18.2 The **Trust Board in common** shall agree the list of employees authorised to make short term borrowings on behalf of the Trust. This shall include the **Chief Executive** and the **Group Chief Finance and Estates Officer**.

18.3 The **Group Chief Finance and Estates Officer** shall prepare detailed procedural instructions concerning applications for loans and shall ensure that:

18.3.1 all short-term borrowings are kept to the minimum period of time possible, consistent with the Trust's overall cashflow position, represent good value for money, and comply with the latest guidance from the DHSC.

18.3.2 the **Trust Board in common** is made aware of all short term borrowings at the next meeting.

18.4 The **Finance and Estates Committee in common** shall ensure that all proposed long-term borrowing is consistent with the Trust's financial plans; and is approved by the **Trust Board in common**.

18.5 Where applicable for an NHS Foundation Trust, the Trust can obtain a working capital facility from the commercial banking sector. Short term borrowing should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, comply with the Trust's Treasury Management Policy and all guidance issued by NHS England.

19 Losses and special payments

19.1 The **Group Chief Finance and Estates Officer** shall prepare procedural instructions for maintaining a register of losses and special payments, including write-offs, condemnations and ex-gratia payments; and on the recording of and accounting for losses and special payments, including ex-gratia payments, as set out in the Scheme of Delegation. The records will include:

19.1.1 the nature, gross amount (or estimate if an accurate value is not available), and the cause of each loss.

19.1.2 the action taken, total recoveries and date of write-off where appropriate.

19.1.3 the category in which each loss is to be noted.

19.2 The **Group Chief Finance and Estates Officer** shall determine the nature and/or value of losses which must be reported immediately to the **Chief Financial Officer** ~~or~~ **Group Chief Executive**:

19.2.1 where fraud or bribery is suspected, this shall be reported to the **Local Counter Fraud Specialist**, in accordance with the Trust Counter Fraud and Bribery Policy.

19.2.2 where a criminal offence is suspected, the **Group Chief Finance and Estates Officer** must immediately inform the **Local Security Management Specialist** who may inform the police if theft or arson is involved.

19.2.3 where losses, other than those that are clearly trivial, are apparently caused by theft, arson, neglect of duty or gross carelessness, the **Group Chief Finance and Estates Officer** must immediately notify the external auditor and the **Trust Board in common**.

19.3 **Any employee** discovering or suspecting a loss of any kind shall immediately inform their head of department and ensure that the loss is recorded in accordance with the relevant policy.

19.4 The **Trust Board in common** shall approve a scheme of delegation for the approval and authorisation of the write off of losses, compensations and ex-gratia payments, within the limits delegated to it by the Department of Health and Social Care and NHS England. Write offs includes the abandonments of claims and the charging of fruitless payments.

19.5 The **Audit Committee in common** shall receive regular reports from the **Group Chief Finance and Estates Officer** of losses, compensations and ex-gratia payments made, with details of all cases for which the **Trust Board in common's** specific approval is required.

19.6 The **Group Chief Finance and Estates Officer** and where applicable the Shared Business Service shall be authorised to:

19.6.1 take any necessary steps to safeguard the Trust's interests in the event of bankruptcies and company liquidations.

19.6.2 investigate whether any insurance claim can be made.

20 Patients' property

20.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival in accordance with relevant law and guidance.

20.2 The **Group Chief Executive** shall ensure that patients or their guardians, as appropriate, are clearly and suitably informed before or on admission into hospital that the Trust will not accept responsibility or liability for patients' property brought into NHS premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

20.3 The **Group Chief Finance and Estates Officer** shall provide procedural instructions on the collection, custody, banking, recording, safekeeping, and disposal of patients' property. (including instructions on the disposal of the property of deceased patients and of patients

transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. These instructions will include arrangements for:

20.3.1 managing large amounts of money handed over by longer stay patients

20.3.2 restricting the use of patients' monies for purposes specified by the patient, or their guardian

20.4 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

20.5 **Departmental and senior managers** shall inform staff of their responsibilities and duties for the administration of the property of patients.

21 Funds held on Trust

21.1 Charitable funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the NHS, the objects of which are for the benefit of the NHS in England.

21.2 The charitable trusts associated with the University Hospitals Bristol and Weston NHS Foundation Trust are administered by the Trustees of Bristol & Weston Hospitals Charity (hereafter called the Trustees). The Trustees have their own systems of accounting and financial control and operate separate bank accounts to the Trust. Charitable funds should not be confused with those operated by the Trust.

21.3 All gifts, donations and proceeds of fund-raising activities which are intended for the Trust's benefit shall be handed to either the Trustees or to the Trust's cashier who will bank the money and transfer funds and donor's intention or area of benefit as appropriate. Any charitable funds paid in through the Trust's cashier must be clearly identified as such to ensure it is separated from the Trust's exchequer funds.

21.4 The **CFO** shall be required to advise the **Trust Board** **in common** on the financial implications of any proposal for fund-raising activities which the Trust may initiate, sponsor, or approve.

21.5 The Trustees will designate a fund advisor for each fund held who must comply with the written procedures issued by the charitable trusts regarding the use of these funds.

21.6 Expenditure of any funds held in trust shall be conditional upon:

21.6.1 the expenditure being within the terms of the appropriate fund

21.6.2 meeting the delegated limits in accordance with the Scheme of Delegation.

21.6.3 the prior approval of the Trust's Capital Programme Steering Group being obtained for items falling within the capital definition

21.6.4 being authorised by the fund advisor in writing, or by a person to whom the fund advisor has delegated authority having advised the Trustees in writing

22 Retention of records

22.1 The **Group** **Chief Executive** is responsible for managing all NHS records, regardless of how they are held; and shall require policy and procedures to be followed that ensure compliance

with the current DHSC best practice guidelines on records management. These procedures will include arrangements for:

22.1.1 managing archives of all records required to be retained in accordance with DHSC guidelines

22.1.2 records held in archives to be accessible for retrieval by authorised persons

22.1.3 destruction of records in accordance with relevant DHSC and NHS England guidelines.

22.2 Where documents are held by a Shared Business Service, detailed records storage requirements will be set out in a SLA with the Shared Business Service.

23 Digital and data security

23.1 The **Group Chief Digital and Information Officer** shall be responsible for the accuracy and security of the data of the Trust and shall devise and implement any necessary procedures to ensure:

23.1.1 computer assets and data programmes are protected from theft or damage

23.1.2 adequate and reasonable protection of the Trust's data from deletion or modification; accidental or intentional disclosure to unauthorised persons, having due regard for relevant data protection legislation.

23.1.3 adequate controls operate over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data.

23.1.4 controls exist such that the computer operation is separated from development, maintenance and amendment.

23.1.5 adequate audit trails exist through the computerised system; and that these are subjected to periodic reviews as the Director may consider necessary.

23.2 Where computer systems have an impact on corporate financial systems, the **Group Chief Finance and Estates Officer** shall ensure that new systems and amendments to existing financial systems are developed in a controlled manner and thoroughly tested prior to implementation. The **Group Chief Finance and Estates Officer** shall gain assurance that:

23.2.1 systems acquisition, development and maintenance are delivered in line with contractual agreements and Trust procedures.

23.2.2 new systems that have an impact on, or are replacing existing financial systems are developed in a controlled way and thoroughly tested before they are put into practice. External organisations providing this service will need to provide assurances that what they do is adequate.

23.2.3 data produced for use with financial systems is adequate, accurate, complete and timely, and that a management audit trail exists.

23.2.4 finance staff have the necessary levels of access to such data.

23.2.5 such computer audit reviews as are considered necessary are being carried out.

23.3 The **Group Chief Executive** shall maintain a Freedom of Information (FOI) Publication Scheme, consistent with models approved by the Information Commissioner.

Contracts for computer services with other health bodies or outside agencies

23.4 The **Group Chief Finance and Estates Officer** shall ensure that any contract for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract shall also ensure rights of access for audit purposes.

23.5 Where another health organisation or any other agency provides a computer service for financial applications, the **Group Chief Finance and Estates Officer** shall periodically seek assurances that adequate controls are in operation.

Risk assessment

23.6 The **Group Chief Digital and Information Officer** shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered; and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

24 Risk management

24.1 The **Group Chief Executive** shall ensure that the Trust has adequate procedures for managing risk and meeting current DHSC requirements for assurance frameworks, which shall be approved and monitored by the Trust Board **in common**.

24.2 The programme of risk management shall include:

24.2.1 arrangements for identifying and quantifying risks and potential liabilities

24.2.2 promotion, to all levels of staff, of a positive attitude towards the identification and management of risk

24.2.3 procedures to ensure all significant risks and potential liabilities are assessed and addressed, including through maintenance of effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk

24.2.4 contingency plans to offset the impact of adverse events

24.2.5 arrangements for reviewing the effectiveness of the risk management processes in place, including: internal audit; clinical audit; and health and safety review

24.2.6 arrangements for reviewing the risk management programme

24.3 The **Group Chief Executive** shall ensure that the existence, integration and evaluation of the risk management system is used to inform the Annual Governance Statement within the Annual Report and Accounts as required by current DHSC guidance.

25 Audit

25.1 In accordance with Standing Orders, the Board **in common** shall formally establish an **Audit Committee,** with clearly defined terms of reference. The Committee will seek assurance for the **Board in common** on the range of issues in accordance with guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

25.1.1 overseeing internal and external audit services.

25.1.2 reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments.

25.1.3 reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives.

25.1.4 monitoring compliance with Standing Orders, Standing Financial Instructions, delegations and reservations.

25.1.5 reviewing schedules of losses and compensations and advising the Board **in common** where necessary.

25.1.6 reviewing the arrangements in place to support the application of the Assurance Framework on behalf of the Board **in common** and advising the Board **in common** accordingly.

25.2 Where the Audit Committee **in common** considers there is evidence of *ultra vires* transactions, or improper acts, or if there are other important matters that the Committee wishes to raise, the **Chair of the Audit Committee** **in common** should raise the matter at a full meeting of the **Board**. Exceptionally, the matter may need to be referred to NHS England (to the **Group Chief Finance and Estates Officer** in the first instance).

25.3 It is the responsibility of the **Group Chief Finance and Estates Officer** to ensure an adequate internal audit service is provided. The Audit Committee **in common** shall be involved in the selection process when the internal audit service provision is subjected to market testing.

25.4 In the case of the Shared Business Service, the **Group Chief Finance and Estates Officer** shall ensure that maintenance of an adequate internal audit service is specified in any service level agreement and shall further specify assurance arrangements between the Trust's internal and external auditors and the Shared Business Service's auditors.

25.5 The **Group Chief Finance and Estates Officer** shall ensure that:

25.5.1 there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an independent and effective internal audit function.

25.5.2 the **Head of Internal Audit** is sufficiently qualified and experienced to perform that role; to facilitate the effective discussion of the results of internal audit work with senior management.

25.5.3 the internal audit service is adequate and meets the NHS internal audit standards as applicable from time to time.

25.5.4 the internal audit service provides the Audit Committee **in common** with an annual report of the coverage and results of the work of the service, as required by DHSC and NHSE.

25.5.5 the police are informed at the right time, in cases of misappropriation and other irregularities not involving fraud or bribery

25.5.6 there is effective liaison with the Trust's appointed Local Counter Fraud Specialist (LCFS), or NHS Counter Fraud Authority on all suspected cases of fraud and bribery and all anomalies which may indicate fraud or bribery

25.6 The **Group Chief Finance and Estates Officer** and designated auditors are entitled to require and receive, without necessarily giving prior notice, the following:

25.6.1 access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature.

25.6.2 access at all reasonable times to any land, premises or members of the **Board in common** or employees of the Trust

25.6.3 sight of any cash, stores or other property of the Trust under the control of any member of the **Board in common or Trust employee**

25.6.4 explanations concerning any matter under investigation

Internal Audit

25.7 The internal audit service shall:

25.7.1 provide an independent and objective assessment for the **Group Chief Executive**, **the Board in common** and the Audit Committee **in common** on the degree to which risk management, control and governance arrangements support the achievement of the Trust's objectives.

25.7.2 operate independently of the decisions made by the Trust and its employees; and of the activities which it audits. No member of the team providing the internal audit service will have executive responsibilities.

25.8 The **Head of Internal Audit** shall develop and maintain an Internal Audit Strategy for providing the **Group Chief Executive** with an objective evaluation of; and opinions on the effectiveness of the Trust's risk management, control and governance arrangements. The planned programme of work will inform the **Head of Internal Audit's** opinion. This will contribute to the framework of assurance that supports completion of the Annual Governance Statement, which forms part of the annual financial accounts.

25.9 The **Head of Internal Audit** shall ensure that the audit team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience needed to deliver the internal audit plan in line with NHS internal audit standards as applicable from time to time.

25.10 The **Head of Internal Audit** will normally attend Audit Committee **in common** meetings and has an independent right of access to all **Audit Committee members, the Group Chair and Group Chief Executive** of the Trust.

25.11 The **Head of Internal Audit** shall be accountable to the **Group Chief Finance and Estates Officer**. The reporting system for internal audit shall be agreed between the **Group Chief Finance and Estates Officer**, the Audit Committee **in common** and the **Head of Internal Audit**. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards.

25.12 The internal audit service will review, appraise and report upon such matters as required by DHSC and NHSE and the **Trust Board in common**.

25.13 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the **Group Chief Finance and Estates Officer** must be notified immediately.

25.14 In obtaining third party assurance from other auditors, the **Head of Internal Audit** should follow the Internal Auditors Practitioners Group (IAPG) assurance guidance.

External Audit

25.15 The External Auditor is appointed by the Council of Governors Representative at a general meeting of the Council of Member Representatives and paid for by the Trust. The Audit Committee **in common** must ensure a cost-efficient service. If there are any problems relating

to the service provided by the External Auditor, then this should be raised with the External Auditor and reported to the Audit Committee **in common** and Council of Governors Representatives.

25.16 The Trust will ensure that the external auditor complies with the Audit Code for NHS Foundation Trusts at the date of appointment and on and on-going basis throughout the term of appointments.

25.17 The **Council of Governors** shall determine the terms of the contract for the provision of the External Audit.

25.18 The Audit Committee **in common** will receive and agree the External Auditor's annual plan.

Counter Fraud and Bribery

25.19 In line with their responsibilities the Trust **Group Chief Executive** and **Group Chief Finance and Estates Officer** shall ensure compliance with relevant directions and guidance on countering fraud and corruption within the NHS;

25.20 The **Group Chief Finance and Estates Officer** shall ensure that:

25.20.1 the Trust's Counter Fraud and Bribery Policy is maintained and remains up to date;

25.20.2 an NHS accredited Local Counter Fraud Specialist is appointed to the Trust to deliver the requirements of the Policy in accordance with the NHS Counter Fraud Authority Standards.

25.21 The appointed **Local Counter Fraud Specialist** shall report to the **Group Chief Finance and Estates Officer** and shall work with staff in NHS Counter Fraud Authority, when required;

25.22 The Local Counter Fraud Specialist will provide a written report to the Audit Committee **in common**, on an annual basis at least, on the counter fraud work completed within the Trust;

25.23 In accordance with the Trust's Counter Fraud Policy, any suspicions involving financial crime must be reported to the **Local Counter Fraud Specialist**, and/or the **Group Chief Finance and Estates Officer** or via the NHS Fraud and Bribery Reporting Line.

25.24 All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010.

25.25 Where evidence of Fraud and/or is identified all available sanctions will be pursued against offenders. This may include internal and professional body disciplinary sanctions, criminal prosecution and civil action to recover identified losses.

Security Management

25.26 The **Group Chief Finance and Estates Officer** shall ensure that a qualified Local Security Management specialist is appointed to provide security management services to the Trust, in accordance with the requirements of the DHSC and NHS England.

25.27 The **Local Security Management Specialist** will provide a written report to the Audit Committee **in common**, on an annual basis at least, on the security management work completed within the Trust.

26 Acceptance of Gifts by Staff and Other Standards of Business Control

26.1 The **Group Chief Executive** shall ensure that a Register of Interests, Gifts and Hospitality is established to formally record declarations of interests, gifts and hospitality made by Trust staff, and as the **Accountable Officer** has ultimate responsibility for ensuring the Trust has appropriate policies in place in respect of conflicts of interest and the acceptance of gifts or other benefits in kind conferring an advantage to a member of staff. These policies should be consistent with the Standards of Business Conduct for NHS Staff.

26.2 The **Group Director of Corporate Governance** of the Trust is responsible for implementing the Trust's Register of Interests, Gifts and Hospitality Policy across Clinical Divisions and Trust Headquarters and ensuring all Trust employees are aware of these Trust policies and the restrictions in relation to accepting gifts, inducements, benefits in kind or other personal advantage that could be considered to be bribes under the Bribery Act 2010.

Gifts

26.3 Casual gifts offered by contractors or others may be construed to be connected with the performance of duties so as to constitute an offence under the Bribery Act 2010 and therefore all such gifts should be declined. Business articles with little intrinsic value (of less than £50 per gift) such as diaries, calendars, pens etc. need not be refused, nor small tokens of gratitude from patients or their relatives.

26.4 Any gift accepted of value greater than £50 should be declared in writing to the Trust Secretary via the Register of Interests, Gifts, and Hospitality. If several small gifts worth a total of over £100 are received by an individual from the same or closely related source in a twelve-month period, these should also be declared on the Register of Interests, Gifts, and Hospitality.

26.5 Gifts offered to an individual where the value exceeds £50 should be declined. In exceptional circumstances and with the agreement of the line manager, the matter may be referred to the Trust Secretary for a decision as to whether the gift can be accepted.

26.6 Under no circumstances may staff accept cash or vouchers, even below the £50.00 threshold. Gifts of cash made to a ward or department are deemed to be charitable donations and should be dealt with as described in section 21. No further declaration is required.

26.7 All gifts to staff must be accepted in line with the Trust's Register of Interests, Gifts and Hospitality Policy.

Hospitality

26.8 Suppliers must not attempt to influence business decision making by offering hospitality to trust staff. Modest hospitality provided it is normal and reasonable in the circumstances may be accepted (e.g., lunches in the course of a working visit). If in doubt, advice should be sought from the employee's line manager or relevant Director.

26.9 Any offers of inappropriate hospitality should be notified to the **Trust secretary** for appropriate action.

26.10 All hospitality to staff must be accepted in line with the Trust's Register of Interests, Gifts and Hospitality Policy.

Sponsorship

26.11 Acceptance by staff of commercial sponsorship for attendance at relevant conferences and courses is acceptable, but only where the employee seeks approval in advance from their line

manager. Approval must depend on whether acceptance will, or could be believed to, compromise current or future purchasing decisions in any way.

26.12 The sponsorship of Trust events by existing suppliers to the Trust is acceptable subject to informing the **Trust Board Secretary** of the agreement for recording the details in the Register of Gifts, Hospitality and Sponsorship. Where the sponsor does not have a contract for supplies or services with the Trust, the Procurement Department should be consulted. The Trust **Group Director of Corporate Governance** be informed. In all such cases there must be no favouritism shown to any one supplier in a way that could later be challenged by a competitor. Where this could be the case the same opportunity to sponsor events should be offered to the other interested parties.

26.13 Some suppliers offer training as a part of supplying equipment, and this should be fully reflected through the contract entered into with the relevant organisation. In such cases no disclosure to the Trust **Group Director of Corporate Governance** is necessary.

26.14 The Trust shall not enter into commercial or charitable sponsorship arrangements which link such sponsorship to the supply of goods or services from any particular source.

26.15 Employees must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the Trust. This does not apply to concessionary agreements negotiated with companies by the Trust, or the NHS, or by recognised staff interests, on behalf of all staff for example, staff benefit schemes.

ENDS

Report To:	Meeting of Group Board of Directors of NBT and UHBW held in Public		
Date of Meeting:	9 September 2025		
Report Title:	Committee Terms of Reference and Memberships		
Report Author:	Mark Pender, Head of Corporate Governance Richard Gwinnell, Deputy Trust Secretary		
Report Sponsor:	Maria Kane, Group Chief Executive		
Purpose of the report:	**Approval**	**Discussion**	**Information**
	X	**X**	
	To present proposed changes to Committee Terms of Reference and Committee memberships for approval.		

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

Further to the committee terms of reference and memberships agreed in principle by the Boards in Common on 8 April 2025, further review work and consultation with Group Non-Executive Directors and Executive Directors has been undertaken.

The proposed amended terms of reference are attached as follows:

Appendix A: Audit Committee in Common.
Appendix B: Digital Committee in Common.
Appendix C: Finance & Estates Committee in Common.
Appendix D: Quality and Outcomes Committee in Common.
Appendix E: People Committee in Common.

Following the appointment of Group Executive Directors and Group Non-Executive Directors, the membership of the Committees has also been reviewed, and the proposed membership is attached as Appendix F.

These documents are provided for the Boards' approval.

In the spirit of continuous improvement, the committee terms of reference and membership will be kept under regular review and any further proposed amendments will be submitted to the Boards to ensure they remain effective and up to date.

Strategic and Group Model Alignment

These documents directly support the Boards' ambition to form a Group, and these documents support the new governance model being implemented.

Risks and Opportunities

None.

Recommendation

This report is for **Approval.**

The Boards are asked to:

• Approve the revised terms of reference of committees set out in Appendices A to E to this report. • Approve the revised membership of committees set out in Appendix F to this report.	
History of the paper (details of where paper has <u>previously</u> been received)	
N/A	
Appendices:	Appendix A: Audit Committee in Common Terms of Reference. Appendix B: Digital Committee in Common Terms of Reference. Appendix C: Finance & Estates Committee in Common Terms of Reference. Appendix D: Quality and Outcomes Committee in Common Terms of Reference. Appendix E: People Committee in Common Terms of Reference. Appendix F: Revised Committee Memberships

Audit Committee

Terms of Reference

1. Constitution

1.1. The Audit Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The Audit Committee (hereafter referred to as "the Committee") operates as Committees in Common of both Boards.

1.2. The Committee has no executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within each Trust's Standing Orders.

~~1.2.~~1.3. Where necessary, the Committee will consider separate reports from each Trust whilst they remain sovereign organisations.

2. Purpose

2.1. The Committee is responsible for assuring the Board on matters concerning:

- Governance including financial governance, corporate governance and clinical and non-clinical audit
- The management of risks~~Risk management~~, and
- Internal control - seeking assurance from internal and external audit and counter fraud.

3. Duties

3.1. Governance, Risk Management and Internal Control

The Committee will;

- Seek assurance that the Trust's activities are efficient, effective and represent value for money – including reviewing the establishment and maintenance of an effective system of internal control that supports the achievement of the Trust's objectives
- Seeking assurance that the Trust complies with regulation and information is triangulated with independent sources prior to recommendation to the Board for approval.
- Test the effectiveness of the use of the Board Assurance Framework
- ~~Seek assurance that appropriate governance arrangements have been implemented to support the organisation operating in the emerging Integrated Care Systems and Integrated Care Partnerships~~

3.2. Internal Audit

The Committee will:

- Ensure there is an effective internal audit function that meets the relevant audit standards and provides appropriate independent assurance to the Committee, Group Chief Executive and Board.
- Receive and review the Head of Internal Audit Opinion, prior to Board approval

3.3. External Audit

The Committee will:

- In accordance with the Local Audit and Accountability Act 2014, establish an 'Auditor Panel' to advise on the appointment of external auditors (membership of the panel will be approved by the Board). For an NHS Trust, the Panel shall recommend the appointment of external auditors to

the Board. For an NHS Foundation Trust, the Panel shall make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the Trust's External Auditor.

- Review and monitor the work and findings of the external auditor and consider the implications and management's responses to their work.
- Consider of the provision of the external audit service - including the performance, cost, seeking assurance that the audit function remains independent, and of any questions of resignation and dismissal
- Agree the Letter of Representation before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management response
- Agree any non-audit services conducted – agreeing acceptable thresholds and safeguards. Any such work will be disclosed within the Annual Report

3.4. Financial Reporting

The Committee will

- Receive assurances from management on financial matters
- Monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance
- Ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board

3.5. Whistleblowing /Freedom to Speak Up

The Committee will, on a three yearly basis

- Review the effectiveness of the Trust's arrangements for its employees to raise concerns
- Ensure that arrangements allow proportionate and independent investigation of such matters and appropriate follow up action

3.6. Counter Fraud

The Committee will

- Satisfy itself that the Trust has adequate arrangements in place for countering fraud, bribery and corruption
- Review the outcomes of counter fraud work and investigations- seeking assurance that management are addressing any gaps in internal controls and are progressing actions to meet recommendations made
- Ensure that the Trust has appropriate policies and procedures for all work related to fraud, bribery and corruption

3.7. Other Assurance Functions

The Committee will:

- Review the findings of other significant assurance reviews, both internal and external to the Trust, and consider the implications for the governance of the Trust (e.g. from regulators /inspectors etc)
- ~~Receive updates on progress made towards the achievement of clinical audits and receive the Annual Clinical Audit Report and Annual Audit Plan~~
- ~~Receive the Trust's Charity Annual Accounts and Report~~

4. Membership

4.1. Members of the Committee shall be appointed by the Board and shall comprise;

- Non-Executive Director Chair
- At least one other ~~the~~ Non-Executive Director ~~Chairs of the Board's Committees~~

4.2. At least one of whom shall have recent and relevant financial experience.

4.3. The Chair of the Trust Board shall not be a member of the Committee.

4.4. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be:

- 2 Non-Executive Directors (including the Chair or their designated deputy)

5.2. The following officers will have an open invitation to each meeting, unless otherwise informed by the Committee Chair (or when the Committee meets privately):

- Group Chief Executive
- Group Chief Finance & Estates Officer
- The Hospital Managing Directors
- Trust Directors of Finance
- Representatives from Internal Audit, External Audit and Counter Fraud
- Group Chief ~~Director of~~ Corporate Governance Officer
- Independent Freedom to Speak Up Guardian (FTSU)

5.3. The Head of Internal Audit, representative of external audit, Counter Fraud Specialist and FTSU Guardian have a right of direct access to the Chair of the Committee.

6. Frequency

6.1. The Committee shall meet:

- At least on a quarterly basis at appropriate times in the reporting and audit cycle and otherwise as required.
- In private with external and internal audit representatives without any member of the executives present on at least one occasion each year

6.2. The Group Chief Executive, external auditors or internal auditors may request an additional meeting if they consider that one is necessary.

7. Authority

7.1. The Committee is authorised:

- to investigate any activity within its terms of reference
- to seek any information required from any employee of the Trust in order to perform its duties, and to direct all employees to cooperate with any requests made by the Committee
- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- to call any employee to be questioned at a meeting of the Committee as and when required
- to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

8. Meeting administration

8.1. The Trust Secretariat shall act as the secretary of the Committee

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members

9. Reporting

9.1. An exception report will be provided to the Board via the Committee chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

9.2. Following scrutiny, the Committee will recommend to the Board the approval of the Accounts, Annual Report, Annual Governance Statement, and the Letter of Representation. ~~, Quality Account and the Annual Clinical Audit report.~~

9.3. The Committee shall make necessary recommendations to the Board on areas relating to the appointment, re-appointment and removal of internal auditors and terms.

9.4. The Committee will conduct an annual review of its effectiveness.

Version XX

Date Approved: XX

Date of Next Review Date: XX

NHS North Bristol NHS Trust

NHS University Hospitals Bristol and Weston NHS Foundation Trust

Digital Committee

Terms of Reference

1. Constitution

1.1. The Digital Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The Digital Committee (hereafter referred to as "the Committee") operates as a Committee in Common of both Boards.

1.2. The Committee has no executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within the Trusts' respective Standing Orders.

2. Purpose

2.1. The Committee is responsible for assuring the Boards on matters concerning all aspects of, digital strategy, the operational delivery of digital services and delivery of the digital transformation programmes across both Trusts.

2.2. The scope of the Committee covers:

- Digital strategy and transformation, digital systems, policy and operational performance, cyber security, digital risks

3. Duties

3.1. Digital Strategy & Transformation

- Receive, scrutinise, shape and approve the trusts' digital strategy(s).
- Monitor delivery of the trusts' digital strategy(s), ensuring that the desired outcomes are achieved.
- Ensure that the trusts have appropriate digital plans which aligns with the trusts' broader business plan.
- To review and monitor strategic risks within the Committee's area of responsibility, as set out in the Group Board Assurance Framework.

3.2. Digital Systems, Policy and Operational Performance

- Ensure the trusts have robust and effective digital policies and processes in place, including cyber security, information governance and records management.
- Monitor key performance indicators relating to operational digital and IMT performance.

3.3. Business Cases and Capital Expenditure

- Receive, scrutinise, shape and approve significant digital capital/revenue business cases, in line with the delegated authorisations set out in the Trusts' respective Standing Financial Instructions and Schemes of Reservation and Delegation.
- Monitor key performance indicators and benefits realisation relating to significant digital capital/revenue investments.

3.4. In carrying out these duties, the Committee will:

- Work collaboratively with system partners to improve the alignment of digital systems and processes within BNSSG; and

- Liaise with other Committees to ensure coordinated and comprehensive oversight of cross-cutting themes.

4. Membership

4.1. Members of the Committee shall be appointed by the Board and shall comprise:

- Two Non-Executive Directors ~~from each Board~~, one of whom shall be appointed as the Committee ~~Co-~~Chair
- ~~At least two Executive Directors from each Board~~
- ~~-~~ Group Chief Digital information Officer
- Group Chief Finance and Estates Officer
- Group Chief Medical and Innovation Officer
- Group Formation Officer

4.2. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be:

- At least one Non-Executive Directors ~~from each Board~~
- At least two Executive Directors

5.2. The Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair.

5.3. Regular attendees of the Committee include:

- Deputy Joint Chief Digital Information Officer
- Joint Chief Systems and Product Officer
- Joint Chief Technology Officer
- Joint Chief Data & Analytics Officer
- Chief Clinical Information Officer: Nursing, Midwifery & AHPS (CCIO) UHBW
- Chief Clinical Informatics Officer (CCIO) NBT

~~5.1.~~5.4. Other Group Executive Directors may attend on an ad hoc basis.

6. Frequency

6.1. The Committee shall meet a minimum of 6 times per annum.

6.2. Additional meetings may be called at the request of the of the Chair.

7. Authority

7.1. The Committee is authorised:

- to investigate any activity within its terms of reference
- to seek any information required from any employee of the Trusts in order to perform its duties, and to direct all employees to cooperate with any requests made by the Committee
- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- to call any employee to be questioned at a meeting of the Committee as and when required

- to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary

8. Meeting administration

8.1. The Trust Secretariat shall act as the secretary of the Committee

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members

9. Reporting

9.1. An exception report will be provided to the Boards via the Committee Chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

9.2. The Committee will conduct an annual review of its effectiveness.

Version 1.1~~0~~

Date Approved: ~~08/04/2025~~ Reviewed by Digital Committee on 22 July 2025.

Date of Next Review Date: ~~08/04/2026~~

North Bristol NHS Trust

University Hospitals Bristol and Weston NHS Foundation Trust

Finance and Estates Committee

Terms of Reference

1. Constitution

1.1. The Finance and Estates Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The Finance and Estates Committee (hereafter referred to as "the Committee") operates as Committees in Common of both Boards.

1.2. The Committee has no executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within each Trust's Standing Orders.

2. Purpose

2.1. To seek and receive assurance on the stewardship of each Trust's finances and estates, including but not limited to financial planning, financial performance, investment decisions and benefits realisation, and development and implementation of an estate's strategy, to ensure the delivery of long-term financial sustainability.

2.2. The scope of the Committee covers:

- **Financial Strategy:** annual budget, financial performance, capital investment programme, financial risk, financial relationships, Board Assurance Framework document.
- **Investment:** financial performance benchmarks, Capital Investment Policy, compliance, Project Initiation Documents, capital investments and divestments, business cases.
- **Estates and Facilities:** estates strategy, estate risks, regulatory compliance.

3. Duties

3.1. Financial Strategy

To consider and examine on behalf of the Board of Directors:

- The annual budget;
- Key Trust and Divisional financial performance indicators;
- Progress to deliver the capital investment programme, in line with recommendations from the Capital Programme Steering Group;
- Risks associated with financial plans (finance risk);
- Financial relationships with the Trust's Commissioners;
- Financial performance and productivity metrics applied by NHS England;
- Financial performance forecasts;
- Financial aspects of the Board Assurance Framework document; and
- Business cases classed as 'major' or 'high' risk; making recommendations for approval or rejection to the Board.

3.2. Investment

- Set financial performance benchmarks and monitor the performance of investments;

- Review proposed revisions to the Capital Investment Policy for approval by the Trust Board of Directors each year;
- Seek and consider evidence of organisational compliance with the Capital Investment Policy;
- Review and approve business cases in accordance with the Trust's Standing Financial Instructions and Scheme of Delegation.
- Review the Annual Green Plan prior to its submission.

3.3. Estates and Facilities

- To support the development and implementation of an Estates Strategy, and be assured about its delivery;
- To be assured that the Trust is aware of and acting on estates risks, in particular those relating to fire safety;
- To receive assurances in relation to regulatory compliance; and

3.4. The Committee will also consider relevant high risk internal audit reports and seek updates on progress to close recommendations.

4. Membership

4.1. Members of the Committee shall be appointed by the Board and shall comprise:

- At least ~~Two~~ two Non-Executive Directors ~~from each Board~~, one of whom shall be appointed as ~~the Committee Co~~ Chair
- ~~At least two Executive Directors from each Board.~~The Group Chief Finance and Estates Officer
- The Group Chief People and Culture Officer
- The Hospital Managing Directors

4.2. Other Group Executive Directors may attend on an ad hoc basis.

~~4.2.~~4.3. If a member is unable to attend a meeting of the Committee, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and sufficient understanding of the issues under discussion. The deputy should be approved by the Chair in advance of the relevant meeting.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be;

- At least two Non-Executive Directors
- The The Group Chief Finance and Estates Officer ~~Chief Financial Officer~~ or nominated deputy
- At least one other Executive Director, or nominated deputy

5.2. The following individuals will attend (but are not members of) the Committee:

- ~~Director of Corporate Governance~~Group Chief Corporate Governance Officer
- Trust Directors of Finance

5.3. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues. Such additional representatives may include:

- Director of Operational Finance
- Director of Estates & Facilities

6. Frequency

6.1. The Committee shall meet a minimum of 6 times per annum.

6.2. Additional meetings may be called at the request of the Chair.

7. Authority

7.1. The Committee is authorised to:

- Review, monitor, and where appropriate, investigate any matter within its terms of reference, and seek such information from any employee of the Trust as it requires to facilitate this activity.
- Obtain whatever advice it requires, including external professional or legal advice if deemed necessary (as advised by the Director of Corporate Governance). In so doing, it may require directors and other officers, or independent specialists to attend meetings to provide such advice.

8. Meeting administration

8.1. The Trust Secretariat shall co-ordinate secretariat services to the Committee.

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members.

9. Reporting

9.1 The Chair of the Committee shall report to the Board of Directors on the activities of the Committee and shall make whatever recommendations the Committee deems appropriate (on any area within the Committee's remit where disclosure, action or improvement is considered necessary).

~~9.2 The Chair shall provide a report on the activities of the Committee at each meeting of the Audit Committee.~~

~~9.3~~9.2 The Committee shall prepare a statement for inclusion in the Annual Report about its activities.

~~9.4~~9.3 The Committee will conduct an annual review of its effectiveness.

Version XX

Date Approved: XX

Date of Next Review Date: XX

People Committee

Terms of Reference

1. Constitution

1.1. The People Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The People Committee (hereafter referred to as "the Committee") operates as Committees in Common of both Boards.

1.2. The Committee has no executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within the Trusts' Standing Orders.

2. Purpose

2.1. The Committee is responsible for assuring the Boards on matters concerning all aspects of delivery that relate to workforce supply, development and wellbeing and the delivery of education.

2.2. The scope of the Committee covers:

- **Workforce:** workforce strategy and planning; workforce supply (recruitment and retention); workforce health and wellbeing; learning and development; leadership development; culture and organisational development; HR systems, policies and processes; Equality, Diversity and Inclusion (EDI); workforce engagement; Freedom to Speak Up (FTSU); and workforce risk.
- **Education:** Group Learning and Workforce strategy and the delivery of thereof.

3. Duties

3.1. Workforce

- Receive, scrutinise, shape and approve the trusts' Group People Strategy.
- Ensure that the trusts have an appropriate annual workforce plan which aligns with the trusts' broader business plan.
- Receive and scrutinise updates relating to Our People Patient First priorities.
- Monitor delivery of the trusts' people strategy(s), ensuring that the desired outcomes are achieved.
- Monitor key performance indicators relating to workforce supply, development and wellbeing.
- Monitor and take assurance against the trusts' approach to Equality, Diversity and Inclusion (EDI), including reviewing the trusts' performance against nationally mandated standards and corresponding action plans.
- Ensure that cultural improvement is a priority for the trusts, and that the approach and initiatives connected to cultural improvement are effective.
- Ensure that the trusts continue to develop and embed an open and safe culture towards Speaking Up, including by receiving FTSU exception reports/ escalations.
- Receive ~~exception~~ reports and escalations from the Guardian of Safe Working Hours.
- Ensure that the trusts' approach and initiatives connected to the promotion of staff health and wellbeing are aligned to workforce needs and embody the culture and values of the trusts.
- Ensure there is a positive and open culture to staff engagement and that there are appropriate processes in place for engaging and communicating with staff at all levels.

- To receive and review the findings of the annual National NHS Staff Survey and ensure the implementation and effectiveness of resultant action plans.

3.2. Education

- Receive, scrutinise, shape and approve the trusts' Group Learning and Workforce Development Strategy.
- Monitor delivery of the trusts' education strategy(s), ensuring that the desired outcomes are achieved.
- Monitor key performance indicators relating to education.

3.3. Review and monitor strategic risks within the Committee's area of responsibility, as set out in the Board Assurance Framework (BAF).

3.4. The Committee shall collectively undertake the statutory duties of the Non-Executive Director Champion Role related to Security Management – Violence and Aggression

3.5. In carrying out these duties, the Committee will:

- Work collaboratively with the other Committees and on behalf of the Board to test and seek assurance from a range of perspectives on the key risks affecting the trusts to ensure coordinated and comprehensive oversight of cross-cutting themes; and
- Work collaboratively with system partners to improve the supply and development of the whole health and care workforce in BNSSG.

4. Membership

4.1. Members of the Committee shall be appointed by the Board and shall comprise:

- At least t~~T~~wo Non-Executive Directors ~~from each Board~~, one of whom shall be appointed as the Committee ~~Co~~ Chair
- ~~At least two Executive Directors from each Board.~~The Group Chief People and Culture Officer
- The Group Chief Digital Information Officer
- The Group Chief Nursing and Improvement Officer
- The Group Formation Officer
- Group Chief Medical & Innovation Officer

4.2. Other Group Executive Directors may attend on an ad hoc basis.

~~4.2.~~4.3. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be

- At least two Non-Executive Director
- At least two Executive Director

5.2. At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues

6. Frequency

6.1. The Committee shall meet a minimum of 6 times per annum.

6.2. Additional meetings may be called at the request of the Chair.

7. Authority

7.1. The Committee is authorised:

- to investigate any activity within its terms of reference
- to seek any information required from any employee of the Trusts in order to perform its duties, and to direct all employees to cooperate with any requests made by the Committee
- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference, and
- to call any employee to be questioned at a meeting of the Committee as and when required
- to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary

8. Meeting administration

8.1. The Trust Secretariat shall act as the secretary of the Committee

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members

9. Reporting

9.1. An exception report will be provided to the Boards via the Committee Chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

9.2. The Committee will conduct an annual review of its effectiveness.

Version XX

Date Approved: XX

Date of Next Review Date: XX

Quality and Outcomes Committee

Terms of Reference

1. Constitution

1.1. The Quality and Outcomes Committee is constituted as a standing Committee of each of the University Hospitals Bristol and Weston NHS Foundation Trust Board of Directors and the North Bristol NHS Trust Board of Directors (hereafter collectively referred to as "the Boards"). The Quality and Outcomes Committee (hereafter referred to as "the Committee") operates as Committees in Common of both Boards.

1.2. The Committee has no executive powers, other than those specifically delegated by the Boards in these Terms of Reference which are incorporated within each Trust's Standing Orders.

2. Purpose

2.1. The Committee is responsible for assuring the Boards on matters concerning all aspects of quality and ~~, safety, experience and~~ performance, to ensure the delivery of safe, ~~and~~ effective and timely treatment ~~care to patients~~ and that people have the best possible experience of being in our care.

2.2. The scope of the Committee covers:

- ~~**Quality and**~~ **Patient safety, Clinical Effectiveness and Outcomes:** quality strategy and reporting, quality improvement, quality ~~clinical~~ governance and escalation, clinical risk, clinical audit, clinical effectiveness, patient safety, safe staffing, Infection Prevention and Control (IPC), safeguarding, ~~clinical effectiveness~~, safe and effective prescribing and administration of medicines, health inequalities, NHS System Oversight Framework (SOF) – Quality of Care and Outcomes.
- ~~**Patient E**~~**experience of Care:** patient and public engagement, complaints ~~(and compliments), serious incidents and never events~~, local and national patient experience surveys and other feedback, Equality, Diversity and Inclusion (EDI - patient-focused).
- **Performance:** target setting and action planning, operational performance monitoring (e.g., against care access standards), activity recovery, performance benchmarking and reporting, learning mechanisms, Emergency Planning Resilience and Response (EPRR), NHS SOF – Access.

3. Duties

3.1. ~~Quality and~~Patient safety, Clinical Effectiveness and Outcomes

- ~~Receive, scrutinise, shape and approve the trusts' quality strategy(s)~~
- Monitor progress and achievement of the trusts' overall quality ~~strategy,~~ priorities and quality-related action plans, and provide an informed opinion to the Boards on the sustainability of objectives.
- Receive and scrutinise the trusts' annual quality accounts ~~reports~~ prior to submission to the trusts' Boards for approval.
- Support the trusts' objective to strive for continuous quality improvement and oversee the trusts' approach to quality improvement is robust and embedded across the trusts.
- Monitor the impact of the trusts' clinical strategy, transformation and cost improvement programmes on the quality and safety of patient care.
- Review the suitability and implementation of risk mitigation plans with regards to their potential impact on safety and care quality, utilising Quality and Equality Impact Assessment outputs.

- Receive and review details of ~~serious incidents and~~ never events, Coroner's Prevention of Future Deaths (Regulation 28) reports and any other significant patient safety investigations.~~.~~
- Oversee that the trusts have robust and effective quality ~~clinical~~ governance arrangements in place to support compliance with regulatory standards and external sources of assurance, including the receipt of draft and final reports, oversight of action plans and other statutory undertakings.
- Oversee compliance with all relevant healthcare standards, including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, NHS England and statutory regulators of healthcare professionals.
- Receive assurance on processes to ensure ~~Be assured of~~ safe and effective prescribing and administration of medicines.
- Receive, scrutinise and approve the clinical audit plan and receive assurance on progress against the plan and related programmes.
- Support the trusts' objective to reduce health inequalities amongst its patients and communities~~y~~.
- Oversight of the NHS System Oversight Framework themes of Quality of Care and Outcomes.
- Consider and examine activity models to ensure consistency and to provide assurance on critical assumptions.
- Consider and examine operational performance and its potential impact on our patients.
- Receive Safer Staffing reports and assure the Trust Board of the fitness for purpose of Nurses, Midwives and Allied Health Professionals staffing levels.

3.2. ~~Patient e~~Experience of Care

- Support the trusts to actively engage with patients, staff, carers, the public and other relevant stakeholders on care experiences, and take into account, as appropriate, views and information from these sources in guiding the trusts' quality ~~strategy(s) and~~ priorities and in developing co-production as our default approach.
- Receive and scrutinise reports on patient, family, carer and public feedback (complaints, surveys and engagement ~~and patient experience~~, identifying key themes, trends and learning. ~~s including oversight of actions plans arising from serious incidents, complaints and never events.~~
- Identify opportunities to improve outcomes and experiences for patients and carers through innovative practice and partnerships.
- Review the results and outcomes of local and national ~~patient~~ experience of care surveys.
- ~~Receive and review the Equality and Diversity Annual Report, with a particular focus on patient experience and quality of care.~~

3.3. Performance

- Oversight of target setting, as relates to quality, safety and experience KPIs, including ensuring a comprehensive suite of metrics is ~~are~~ in place bringing together key national and local targets, and that due consideration is given to relevant regional and national benchmarking statistics.
- Undertake additional scrutiny and deep dives into performance where there is consistent non-delivery against plans.

- Oversee the trusts' performance around Emergency Care and Elective Care and seek assurance that the risks to delivery are known, robust action plans are in place to address these issues and that the implementation of these plans are resulting in intended outcomes.
- Oversight of the NHS System Oversight Framework theme - Access.
- Seek assurance on the robustness of the trusts' Emergency Planning Resilience and Response (EPRR) framework, including receiving the annual NHS England assurance report, and testing compliance of business continuity arrangements across the trusts.
-

3.4. Review and monitor strategic risks within the Committee's area of responsibility, as set out in the Board Assurance Framework (BAF).

3.5. The Committee shall collectively undertake the statutory duties of the Non-Executive Director Champion Role related to:

- Hip Fracture, Falls and Dementia
- Learning from Deaths
- Safety and Risk
- Palliative Care and End of Life
- ~~Health and Safety~~
- Children and Young People
- Resuscitation
- Emergency Preparedness
- Safeguarding
- Maternity and Neonatal Care.

3.6. In carrying out these duties, the Committee will:

- Extend the Boards' monitoring and scrutiny of standards of ~~quality,~~patient safety, clinical effectiveness and outcomes. ~~safety,~~patient and carer experience and performance of services across both trusts, make recommendations to the Boards on opportunities for improvement and support these opportunities where identified;
- Seek sources of evidence from management groups at trust, divisional and sub-divisional level on which to base informed opinions regarding the standards detailed above;
- Work collaboratively with the other Committees and on behalf of the Board to test and seek assurance from a range of perspectives on the key risks affecting the trusts to ensure coordinated and comprehensive oversight of cross-cutting themes; and
- Work collaboratively with system partners to improve the quality and safety of clinical services, care experience and reduce health inequalities across BNSSG.

4. Membership

4.1. Members of the Committee shall be appointed by the Board and shall comprise:

- At least t~~T~~wo Non-Executive Directors from each Board, one of whom shall be appointed as the Committee ~~Co-~~Chair.
- ~~At least two Executive Directors from each Board~~
- The Group Chief Medical and Innovation Officer.

- The Group Chief Nursing and Improvement Officer.
- The Hospital Managing Director of North Bristol NHS Trust.
- The Hospital Managing Director of University Hospitals Bristol and Weston NHS Foundation Trust.

Other Group Executive Directors may attend meetings of the Committee on an ad hoc basis~~.~~

4.2. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

5. Quorum and Attendees

5.1. The quorum necessary for the transaction of business shall be;

- At least two ~~one~~ Non-Executive Director~~s~~
- At least two Executive Directors.

5.2 The Committee may invite non-members to attend all or part of its meetings as it considers necessary and appropriate, at the discretion of the Chair.

5.3 Regular attendees of the Committee may include:

- The Trust Medical Director from each of UHBW and NBT.
- The Trust Director of Nursing from each of UHBW and NBT.
- The Trust Chief Operating Officer from each of UHBW and NBT.
- The Trust Director of Quality Governance from each of UHBW and NBT.

6. Frequency

6.1. The Committee shall meet a minimum of 6 times per annum.

6.2. Additional meetings may be called at the request of the Chair.

7. Authority

7.1. The Committee is authorised:

- to investigate any activity within its terms of reference,
- to seek any information required from any employee of the Trusts in order to perform its duties, and to direct all employees to cooperate with any requests made by the Committee,
- to obtain, at the Trust's expense, outside legal or other professional advice on any matter within its terms of reference~~, and~~
- to call any employee to be questioned at a meeting of the Committee as and when required, and
- to secure the attendance of people from outside either NBT or UHBW ~~rs~~ with relevant experience and expertise if it considers this necessary.

8. Meeting administration

8.1. The Trust Secretariat shall act as the secretary of the Committee.

8.2. Papers will be circulated in accordance with the Trusts' Standing Orders and minutes will be circulated to all members.

9. Reporting

9.1. An upward ~~exception~~ report will be provided to the Boards via the Committee Chair – highlighting business transacted and making any recommendations as deemed appropriate within the remit of the Committee.

9.2. The Committee will conduct an annual review of its effectiveness.

Version 1.~~0~~1

Date Approved: ~~08/04/2025~~

Date of Next Review Date: ~~08/04/2026~~

	Finance & Estates Committee	Audit Committee	Digital Committee	People Committee	Quality & Outcomes Committee	Remuneration Committee	NBT Charity Committee
NEDS	• Martin Sykes (C) • Roy Shubhabrata • Sarah Purdy	• Richard Gaunt (C) • Martin Sykes • Linda Kennedy	• Roy Shubhabrata (C) • Richard Gaunt • Shawn Smith • Sue Balcombe	• Linda Kennedy (C) • Marc Griffiths • Martin Sykes • Shawn Smith (non-voting)	• Sarah Purdy (C) • Marc Griffiths • Sue Balcombe • Shawn Smith	Ingrid Barker (C) All other NEDs	Richard Gaunt (C) Sarah Purdy
Executive Directors	• Group Chief Finance & Estates Officer • Hospital Managing Director (UHBW) • Hospital Managing Director (NBT) • Group Chief People and Culture Officer	• Group Chief Finance & Estates Officer	• Group Chief Digital Information Officer • Group Chief Finance & Estates Officer • Group Chief Medical & Innovation Officer • Group Formation Officer	• Group Chief Nurse and Improvement Officer • Group Chief Digital Information Officer • Group Formation Officer • Group Chief People and Culture Officer • Group Chief Medical & Innovation Officer	• Hospital Managing Director (UHBW) • Hospital Managing Director (NBT) • Group Chief Medical & Innovation Officer • Group Chief Nurse and Improvement Officer	N/A	

NB: Organ Donation Committee (UHBW) chaired by Marc Griffiths

NB: Organ Donation Committee (NBT) chaired by Sarah Purdy