Trust Board Meeting in Public
Thursday 24 November 2022
10.00-14.00
Virtual/ L&R Room 4 & 5
A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcome and Apologies for Absence: *John Iredale, Non-Executive Director* *Ike Anya, Non-Executive Director* *Steve Curry, Chief Operating Officer*	Information	Chair	Verbal	10.00
2.	Declarations of Interest	Information	Chair	Enc.	-
STANDING ITEMS					
3.	Minutes from the previous meeting	Approval	Chair	Enc.	-
4.	Action Chart from Previous Meeting	Approval	Trust Secretary	Enc.	-
5.	Matters Arising from Previous Meeting	Discussion	All	Verbal	-
6.	Chair's Briefing	Information	Chair	Verbal	10.05
7.	Chief Executive's Briefing	Discussion	Chief Executive	Enc.	10.10
KEY DISCUSSION ITEMS					
8.	Patient Story	Discussion	Chief Nursing Officer	Enc.	10.20
PEOPLE					
9.	Guardian of Safe Junior Doctor working hours	Discussion	Chief Medical Officer	Enc.	10.50
10.	Bi-Annual Freedom to Speak-Up report	Discussion	Director of Corporate Governance	Enc.	11.05
QUALITY					
11.	Quality Committee Upward Report	Information	NED Chair	Enc.	11:25
BREAK (10 minutes)					**11.35**
12.	East Kent Maternity Report	Information	Chief Nursing Officer	Enc.	11.45
FINANCE, IM&T & PERFORMANCE					
13.	Integrated Performance Report	Discussion	Chief Operating Officer	Enc.	12.00
14.	Finance & Performance Committee Upward Report 14.1. Finance Report - Month 7	Discussion	NED Chair Chief Finance Officer	Enc.	12.35
15.	Elective Recovery Self-Certification	Information	Chief Operating Officer	Enc.	12.50
LUNCH (35 minutes)					**12.55-13.30**

GOVERNANCE & ASSURANCE					
16.	Audit Committee Upward Report 16.1. Revised Standing Orders & Standing Financial Instructions (SFIs) 16.2. Board Assurance Framework 16.3. Revised Terms of Reference	Approval	NED Chair	Enc.	13.30
17.	Acute Provider Collaboration Board Upward Report	Approval	Trust Chair	Verbal	13.45
CLOSING BUSINESS					
18.	Any Other Business	Information	Chair	Verbal	13.55
19.	Date of Next Meeting: *Thursday 26 January 2023*				
END					

TRUST BOARD DECLARATIONS OF INTEREST

Name	Role	Interest Declared
Ms Michele Romaine	Chair	• Nothing to declare.
Mr Kelvin Blake	Non-Executive Director	• Non-Executive Director of BRISDOC who provide GP services to North Bristol NHS Trust. • Trustee, Second Step. Provide mental health services for the Bristol North Somerset and South Gloucestershire area. • Trustee, West of England Centre for Integrated Living. Provide a range of services to disabled people living in the Bristol, North Somerset and South Gloucestershire area. • Director, Bristol Chamber of Commerce and Initiative. • Member of the Labour Party.
Professor John Iredale	Non-Executive Director	• Professor of Medical Science, University of Bristol. • Interim Executive Chair of Medical Research Council. • Trustee of British Heart Foundation • Chair of the governing board, CRUK Beatson Institute. • Board member of The Francis Crick Institute
Mr Tim Gregory	Non-Executive Director	• Employed by Cornwall Council as Service Director – Regulatory Services.
Mr Richard Gaunt	Non-Executive Director	• Non-Executive/Governor of City of Bristol College. • Non-Executive Director of Alliance Homes, social housing and domiciliary care provider
Ms Kelly Macfarlane	Non-Executive Director	• Sister is Centre Leader of Genesiscare Bristol – Private Oncology. • Sister works for Pioneer Medical Group, Bristol. • Managing Director, HWM Limited, a Halma Company.

Name	Role	Interest Declared
Professor Sarah Purdy	Non-Executive Director	• Pro Vice-Chancellor and Professor of Primary Care, University of Bristol • Shareholder (more than 25% but less than 50%) Talking Health Limited • Fellow of the Royal College of Physicians • Fellow of the Royal College of General Practitioners • Fellow of the Royal College of Physicians Edinburgh • Member of the British Medical Association • National Institute for Health Research Health and Social Care Delivery Research Funding Panel Member – will cease 31.05.22 • Vice-Chair, Board of Trustees, Venturers Trust, Bristol • Member, Board of Trustees, Bristol Student Union Indirect Interests (ie through association of another individual eg close family member or relative) via Graham Rich who is: - Chair, Armada Topco Limited - Director, Helios Ltd - Director, Talking Health Ltd - Chair, EHC Holdings Topco Limited
Ms Sandra Harding	Associate Non-Executive Director	• Founder, HCPG Ltd • Board Trustee, POhWER • Vice Chair of Governors, Marksbury Primary School • Councillor, Marksbury Parish Council • Member of the Chartered Society of Physiotherapy • Member of the Professional Development Committee of the Chartered Society of Physiotherapy • Registered with the Health and Care Professions Council

Name	Role	Interest Declared
Dr Ike Anya	Associate Non-Executive Director	• Locum Consultant in Public Health Medicine: NHS Lothian, Berkshire East and Berkshire West Directorates of Public Health and Public Health of Scotland. • Member of the British Medical Association • Fellow of the Faculty of Public Health • Honorary Senior Teaching Fellow, University of Bristol • Teach sessions on ethics and global health, London School of Hygiene and Tropical Medicine • Honorary Lecturer, Imperial College
Ms Maria Kane	Chief Executive	• Advisory Group Member of CHKS, a provider of healthcare intelligence and quality improvement services (remuneration donated to charity) • Visiting Professor to the University of the West of England (unremunerated)
Mr Steve Curry	Chief Operating Officer	• Nothing to declare.
Mr Tim Whittlestone	Medical Director	• Director of Bristol Urology Associates Ltd. • Undertakes occasional private practice (Urology Specialty) at company office. This is undertaken outside of NBT contracted hours. • Chair of the Wales and West Acute Transport for Children Service (WATCh). • Wife is an employee of the Trust.
Mr Glyn Howells	Chief Financial Officer	• Governor and Vice Chair of Newbury College (voluntary). • £25 voucher received as a thank you gift for speaking at a Royal College of Surgeons/Society of British Neurosurgeons Leadership Development Course on 18 November 2021. Donated to Southmead Hospital Charity.

Name	Role	Interest Declared
Professor Steve Hams	Chief Nursing Officer	• Visiting Professor, University of Worcester • Director, Curhams Limited (dormant company) • Strategic Advisor, Liaison Group Limited • Independent Chair of Trustees, Infection Prevention Society • Strategic Advisory Board Member, Shiny Mind (Mental Health)
Mr Neil Darvill	Director of Information Management and Technology (non-voting position)	• Wife works as a senior manager for Avon and Wiltshire Partnership Mental Health Trust. • Stepbrother is an employee of the Trust, working in the Cancer Services Team.
Ms Jacqui Marshall	Director of People and Transformation (non-voting position)	• Nothing to declare.

NHS North Bristol NHS Trust

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DRAFT Minutes of the Public Trust Board Meeting held virtually and in Learning & Research Building room 4 on Thursday 29 September 2022 at 10.00am

Present:

Michele Romaine	Trust Chair	**Maria Kane**	Chief Executive Officer
Tim Gregory	Non-Executive Director	**Glyn Howells**	Chief Finance Officer
Sarah Purdy	Non-Executive Director	**Tim Whittlestone**	Chief Medical Officer
Richard Gaunt	Non-Executive Director	**Jacqui Marshall**	Chief People Officer
John Iredale	Associate Non-Executive Director	**Steven Hams**	Chief Nursing Officer
Sandra Harding	Associate Non-Executive Director	**Steve Curry**	Chief Operating Officer
		Neil Darvill	Chief Digital Information Officer

In Attendance:

Xavier Bell	Director of Corporate Governance & Trust Secretary	**Richard Thomas**	Director of Communication s
Kate Debley	Deputy Trust Secretary (*Minutes)*	**Gifty Markey**	Patient Experience Lead (*present for minute item TB/22/09/07*)

Presenters:

Rhona Galt	Associate Director of Culture, Leadership & Development (*present for minute item TB/22/09/08*)	**Megan Murphy**	Sustainable Development Manager (*present for minute item TB/22/09/10*)
Sam Willitts	ICS Head of Sustainability (*present for minute item 22/09/10*)		

Observers: For the first time since the start of the Covid-19 pandemic, observers were invited to attend the public session. No observers attended, but a recording of the meeting was published on the Trust's website.

TB/22/09/01 Welcome and Apologies for Absence **Action**

Michele Romaine, Trust Chair, welcomed everyone to NBT's Trust Board meeting in public, for which a recording would also be made available on the Trust's website.

Apologies were noted from Kelvin Blake, Non-Executive Director, and Kelly Macfarlane, Non-Executive Director.

TB/22/09/02 Declarations of Interest

No Declarations of Interests were noted relating to the agenda, nor were any updates required to the Trust Board register of interests as currently published on the NBT website and annexed to the Board papers.

TB/22/09/03 Minutes of the previous Public Trust Board Meeting

RESOLVED that the minutes of the Public Meeting held on 28 July 2022 were approved as a true and correct record.

TB/22/09/04 Action Log and Matters Arising from the Previous Meeting

Xavier Bell, Director of Corporate Governance, presented the Action Log and noted that there were no actions due for completion.

RESOLVED that the Action Log was noted and no matters arising were raised.

TB/22/09/05 Chair's Business

The Trust Chair provided an update as follows:

- Since the last meeting she had visited Weston General Hospital and seen further examples of the IT difficulties that Trust staff face when they are based in buildings that belong to other organisations. The Chair had heard that in Urology particularly there is often a need for NBT staff to access patient records on UHBW's systems and this is not straightforward. The Chair further noted she had been impressed by the Renal unit at Weston, and had spoken to a number of patients who were very appreciative that the service had continued throughout the Covid pandemic.

- The Trust Chair advised that she had visited ward 26A Cardiology the previous day. As part of this visit she had attended the Board Round and made a note of the patients who were due to be discharged that day as well as what was still required to achieve this. When she had then returned to the ward at 2pm she had been pleased to see that good progress had been made. The Chair noted a further insight from her visit that there appear to be delays to discharge for some patients which are dependent on the position at UHBW. For example, a patient may be waiting for a Multi-Disciplinary Team (MDT) review at UHBW, but if the MDT is only held once a fortnight then the patient will need to remain at NBT until there is an outcome from the MDT. The Chair further noted that this had reinforced to her the importance of developing a clinical strategy within the Acute Provider Collaborative.

- The Trust Chair and Maria Kane, Chief Executive, had launched the Trust's Black History Month programme of events the previous day. The Chair noted whilst there are a number of activities going on this month, it is equally important to ensure that consideration of these issues continues throughout the year.

TB/22/09/06 Chief Executive's Briefing

Maria Kane, Chief Executive, presented the Chief Executive's Briefing. In addition to the content of the written report, the following was noted:

- The Trust continues to be on target for 104 week waits, which are currently at zero. The trajectory for 78 week waits indicates that this should reach zero by March 2023. Maria emphasised the importance of sustaining this performance alongside reducing ambulance handover delays.
- There has been another spike in Covid cases and there are currently 82 cases in the hospital, with three in ICU.
- Maria confirmed that following the death of HM Queen Elizabeth II, the Trust followed all national protocols and observed the bank holiday for the state funeral.
- There are still some teething issues with the Electronic Patient Record (EPR) system, but these are being worked through with the system providers and the hope is they should all be resolved within the next three weeks or so.

- The Covid and flu staff vaccination programme is running well in the Brunel Building atrium, with just over 2000 people having been vaccinated so far.

RESOLVED that the Chief Executive's briefing was noted.

TB/22/09/07 Staff and Patient Story: Barry's Story

Gifty Markey, Head of Patient Experience, joined the meeting.

Tim Whittlestone, Chief Medical Officer, introduced Barry's Story and noted that one of the reasons that the story was being brought to the Board is that, whilst it was positive from the patient's perspective, it still provides some learning for the Trust.

The Trust Board then watched a video recording of Barry talking about his experience of surgery to remove skin cancer on his face. The Board heard that whilst the surgery was more complex than had originally been anticipated, a senior consultant was brought in at short notice and there was a positive outcome and good patient experience.

Steve Hams, Chief Nursing Officer, noted that stories such as Barry's help highlight the fact that when pathways involve a number of different organisations and specialties there is increasing complexity, and the number of people who are involved with these patients can be significant. Steve further noted the importance of considering how best to engage with these patients to help them better understand the complexity of their pathways.

The Trust Chair noted that Barry would have been seen in Outpatients initially, and wondered to what degree an assessment had been carried out in relation to how complex the surgery was likely to be. The Chair asked what might have happened if a senior consultant had been unable to attend the surgery at such short notice and suggested that the need for their attendance could have been identified pre-operatively.

Sarah Purdy, Non-Executive Director, suggested that it would be helpful for the Board if the Patient Experience Team were to also engage with partners across the system in producing patient stories for complex cases that have involved a number of different organisations and specialties.

In relation to the Top Themes and Top 10 Words set out in the accompanying presentation, Maria Kane, Chief Executive, asked how programmes of work will be developed so that the same set of negatives are not seen in a year's time. Gifty Markey advised that Patient Experience Leads are working with Divisional Teams to review the qualitative data. Steve Hams added that the free text comments in Friends & Family Test responses also provide good insight, but noted that the Trust needs to get better at using this information. Steve advised that consideration of qualitative patient experience data would form part of the next phase of the Patient Experience Improvement Programme.

Tim Gregory, Non-Executive Director, asked how the insight from patient experience is fed back to clinical teams and in particular when a multi-disciplinary team is involved. Tim Whittlestone advised that currently patient experience feedback mainly tends to be passed on to clinical teams when concerns are raised. Tim noted that whist fortunately most cases go well, the Trust still needs to learn from these. The Trust Chair noted that even in celebrating stories which are generally very positive, there is nearly always something that can be learned for the Trust.

Gifty Markey left the meeting.

TB/22/09/08 WRES/WDES Submission and Action Plan

Rhona Galt, Associate Director of Culture, Learning & Development, joined the meeting.

Jacqui Marshall, Chief People Officer, introduced the Annual Equality, Diversity & Inclusion Update on Workforce Race Equality Standard (WRES), Race Disparity and Model Employer and Workforce Disability Equality Standard (WDES). Jacqui noted that the data was drawn from a number of sources including the staff survey, ESR, and recruitment database, and that the data makes up the Trust's annual submission to NHS England.

Rhona Galt provided a summary of the WRES and WDES data and noted that the umbrella description Black, Asian & Minority Ethnic (B.A.ME) was that used by NHS England for the submission. Rhona advised that whilst a small amount of progress had been made, there was there was no significant change to the data compared to the previous year. Just under 20% of the Trust's workforce are from a B.A.ME background, with no one from a B.A.ME background in the senior workforce. Rhona further advised that 2.44% of Trust staff self-identify as having a disability, which is an increase from the previous year's rate of 1.79%; however, 23% of staff have not identified themselves at all and their disability status is unknown.

During the ensuing discussion the following key points were noted:

- Tim Gregory, Non-Executive Director, asked about the experiences of international colleagues and Jacqui Marshall advised that the Trust provides a considerable amount of pastoral care with accommodation being provided for the first three months whilst they get settled into their roles and the wider community. Jacqui noted that the Trust has a good reputation among international staff and that retention rates are good. Jacqui further noted that there is an ambitious international workforce, particularly in nursing, and development roles are being identified in order to provide opportunities for progression beyond bands 6 and 7.

- Sarah Purdy, Non-Executive Director, asked how well understood the experience of colleagues who fall under the B.A.ME umbrella term is, particularly given that individuals will come from many different backgrounds and that the profiles of different sections of the workforce are likely to be very different. Rhona acknowledged that it has been a learning curve for the Trust's B.A.ME Staff Network that members have very different experiences depending on their role in the Trust.

- The Trust Chair noted that not seeing diversity in senior staff is concerning and that it is important for the Trust to take positive action. The Chair further noted that it is important to have clear targets and be accountable to staff, and that in some circumstances expecting a specific level of

qualification for certain roles can be discriminatory due to varying levels of access to opportunity.

- John Iredale, Non-Executive Director, noted that in many other sectors the umbrella term B.A.ME is not used and instead there is more granularity in the analysis of individual ethnic groups. John noted his agreement with the Trust Chair that there should be clear targets, as in his view it is important that this data should be presented with both a benchmark and target. Jacqui Marshall advised that the Trust is bound by the NHS England reporting structure but that the data that sits beneath the umbrella of B.A.ME is key.

- John Iredale noted his view that the data in relation to the percentage of staff who have self-identified as having a disability looked unrealistic given that it is believed 20% of the general population identify as having a disability. Jacqui agreed that there is some concern that staff may not be declaring disabilities, and in particular invisible disabilities.

- Maria Kane, Chief Executive, noted the importance of ensuring that race and disability equality issues from a patient perspective are also being considered as part of the work on the Trust's Clinical Strategy.

- Steve Hams, Chief Nursing Officer, noted that there has been found to be differences in the way in which individuals from different cultures consider potentially opportunities; and that for some cultures it is more usual to wait to be offered opportunities rather than proactively seeking them. Steve noted the importance of understanding different cultures and therefore how to get the best out of people, as well as ensuring that there are a sufficient number of opportunities at more senior levels in the organisation.

- Tim Gregory asked how the Trust is promoting itself within different communities and Jacqui advised that a great deal of outreach work is being undertaken with system colleagues and the local authorities. There is also a programme targeting schools within the five areas that have the highest levels of social deprivation in order to speak to students about trainee and apprenticeship opportunities and the potential career pathways that lead from these.

- Maria Kane asked whether the Trust was being ambitious enough about its priorities, noting that in her view more targets were needed over the next 12 months. It was therefore agreed further consideration would be given to the priorities and that progress against key performance indicators would be brought back to the Board in March 2023.

RESOLVED that the Annual Equality, Diversity & Inclusion on Workforce Race Equality Standard, Race Disparity and Model Employer and Workforce Disability Equality Standard be noted and that:

- **Further consideration to be given to the Trust's priorities and progress against key performance indicators to be brought back to the Board in March 2023.** **JM**

TB/22/09/09 Integrated Performance Report

Steve Curry, Chief Operating Officer, presented the Integrated Performance Report and the Trust Board discussed the four key domains of Responsiveness, Safety and Effectiveness, Patient Experience and Well Led.

Responsiveness

- Tim Gregory, Non-Executive Director, noted that Finance & Performance Committee had discussed ambulance handovers and trolley waits at its most recent meeting. The Committee had noted that as these metrics improve there are likely to be increased numbers of diverts to the Trust so pressure within the hospital may not be alleviated. Steve Curry noted that the report reflects a good period which had primarily been driven by good decisions, but that this has also come at some cost in relation to distributed risk. Steve further noted that there are also now increased numbers of patients testing positive for Covid and that this has an impact on flow within the hospital even if the majority of cases are incidental. Steve advised that requests for mutual aid from colleagues within the system have started to increase and that further engagement may be needed with provider partners to share the work the Trust is doing and make it clear that whilst there may be an apparent reduced risk at the 'front door' there is still considerable risk carried across the hospital. Steve further advised that a balance needs to be struck in relation to how much mutual aid can be provided, particularly as high numbers of patients with No Criteria to Reside is still a significant issue.

- Richard Gaunt, Non-Executive Director, noted that the number of patients with No Criteria to Reside appears to be increasing. Steve Curry advised that this continues to be a significant issue for the Trust, but provided reassurance that work is ongoing with system partners to try and improve this.

- Sarah Purdy, Non-Executive Director, asked about stroke trajectories noting that a number of these are currently RAG rated Red in the report. Steve Curry advised that this has been a focus of discussion at recent Divisional Performance Reviews, but further noted that in relation to Thrombolysed <1 hour, there are very low numbers involved so even just one patient breaching can skew the rating. Steve noted that a challenge in this area is that there are high numbers of presentations that mimic the symptoms of Stroke, however it is also important to ensure that all genuine Strokes are treated as soon as possible as the positive impact of doing this within one hour is significant.

Safety and Effectiveness

- Steve Hams, Chief Nursing Officer, noted that in relation to the Perinatal Quality Surveillance Monitoring Tool data, rates of PROMPT and Fetal Wellbeing and Surveillance training have now been restored to a more acceptable level.

- Steve Hams noted that there has been an increase in falls resulting in moderate harm and there is some evidence that there may be an increased risk of falling as a result of there being fewer Healthcare Assistants to physically assist patients. Steve confirmed that this data will continue to be observed closely.

- Tim Whittlestone, Chief Medical Officer, noted that C.Difficile cases have now fallen just below the national trajectory and that the focus will now be on maintaining this and continuing the improvement strategy and educational workstream.

- In relation to rates of Venous Thromboembolism (VTE) Risk Assessment completion, Tim Whittlestone noted that there are currently some issues in relation to reporting this data via the Careflow system and that whilst a fix is being developed he has asked for the results of regular manual spot check audits across each Division to be provided to him. The Trust Chair noted that it was important that this data collection issue is resolved as soon as possible, and preferably before the Trust Board is due to review the next Integrated Performance Report. It was confirmed that if there are any clinicians failing to comply with the use of the new Electronic Patient Record system then this will be addressed by Tim Whittlestone as Chief Medical Officer.

Patient Experience

- Steve Hams, Chief Nursing Officer, noted that there has been a rise in formal complaints received in August and that analysis is being undertaken to determine why this might be. In relation to the responsiveness rate to complaints, Steve advised that this is being addressed through monthly Divisional Performance Reviews and that he is committed to developing a plan to address performance in this area over the next few months.

Well Led

- Tim Gregory, Non-Executive Director, noted that the Trust is currently highly dependent on agency staff and asked whether there is sufficient availability going into winter. Jacqui Marshall, Chief People Officer, advised that whilst there are Trust level, system and national targets to reduce agency spend, availability of agency staff is a critical issue. Jacqui further advised that an Associate Director of Nursing Workforce Recovery would be starting in post the following week who will be looking at reconfiguring agency spend.

- The Trust Chair noted that levels of appraisal completion in the Trust were only at just over 50% and Jacqui advised that this is a known and planned deviation due to the introduction of the Electronic Patient Record and the amount of mandated training that staff have had to complete Jacqui further advised that it had been agreed exceptionally for this year that each area has its own plan for appraisal completion.

RESOLVED that the Trust Board:

- **Noted the Integrated Performance Report for September 2022 (August 22 data).**
- **Approved the Provider Licence Compliance Statements.**

TB/22/09/10 **NBT Green Plan 2021/22 Review & Routemap to Net Zero Carbon by 2030**

Megan Murphy, Interim Sustainable Development Manager, and Sam Willitts, ICS Head of Sustainability, joined the meeting and presented the Routemap to Net Zero Carbon by 2030 and the NBT Green Plan 2021/22 Review.

Routemap to Net Zero Carbon by 2030

In relation to the identified key barrier to supply chain decarbonisation, John Iredale, Non-Executive Director, asked how it would be possible for the Trust to influence the wider NHS supply chain. Glyn Howells, Chief Finance Officer, advised that this will be through ensuring that the Trust's spend is directed at responsible suppliers, with decisions around spending being based not just on price but also on sustainability impacts. Sam Willitts noted that there is an opportunity for the wider public sector to work together to make clear that there are expectations for suppliers to meet the Net Zero by 2030 commitment.

Neil Darvill, Chief Digital Information Officer, asked whether there was any tracking of carbon footprint in relation to technology investment. Neil noted that since the Covid pandemic the Trust now uses twice the number of devices and that there may be some value in tracking this separately as usage is only likely to increase in future. Megan Murphy advised that procurement element of the Trust's greenhouse gas footprint is currently based on spend but that it is important that capability is developed so that the footprint of different items can also be tracked.

Tim Gregory, Non-Executive Director, asked about the investment position on this work, and the balance that will need to be struck between provision of care and the aim to meet Net Zero targets. Glyn Howells advised that the aim is to integrate consideration of carbon into the business case process and noted that investing in carbon reduction will save the Trust money in the longer term.

NBT Green Plan 21/22 Review

The Trust Chair asked about the position in relation to alignment with UHBW on this work. Megan Murphy advised that a governance structure is currently being mapped with the aim of moving into a joint working structure with UHBW, particularly as there is different specialist expertise in each of the two Trusts. Glyn Howells further advised that NBT is ahead on this work, so the Associate Director of Strategic Estate Development and Sustainable Health has overall responsibility within the Integrated Care System and will have a joint team reporting to her.

In relation to the two acute provider Trusts, the Trust Chair asked if there was any mechanism for ensuring that new ways of working are adopted at both Trusts when these have been proven at one of the Trusts. Simon Willitts advised that decisions remain with individual Trusts, but that learning is shared. The Trust Chair noted that the Acute Provider Collaborative Board may be an appropriate forum for a shared view to be taken on this work. Maria Kane, Chief Executive, agreed with this and noted that she was keen to ensure that work is not duplicated or double counted between the two Trusts. Maria further noted that the Acute Provider Collaborative shared corporate services ethos may be the best place to embed this programme.

RESOLVED that the NBT Green Plan 2021/22 Progress Review and Routemap to Net Zero Carbon by 2030 be noted.

TB/22/09/11 Finance & Performance Committee Upward Report

Tim Gregory, Non-Executive Director and Committee Chair, presented the Finance & Performance Committee Upward Report.

Tim noted that the Committee had expressed some frustration over the provision of IT access at certain sites used by NBT staff but managed by other organisations. Tim further noted that the Committee's view was that it is incumbent on the Trust to ensure that this is raised and considered at a system level. It was therefore agreed that the Trust Chair would pick up this issue with the system's digital lead, as well as the ICS Chair. Maria Kane, Chief Executive, noted her view that confirmation of a single digital strategy for the ICS would be the most effective enabler to improve the Trust's service offering and the Trust Chair confirmed that a single digital strategy is now on the Acute Provider Collaborative Board work plan. **MR**

Glyn Howells, Chief Finance Officer, then presented the Finance Report for August 2022.

Concern was noted in relation to the Trust's ability to deliver the CIP plans for next year and Glyn advised that plans would be brought to Trust Board for review as they evolve and in order to provide reassurance. Glyn further noted his view that there may be up to 5% waste in the organisation that can be identified and eradicated.

Richard Gaunt, Non-Executive Director, noted his view that transformation rather than CIP is required in order to reduce costs and that this is a wider system and national issue. Steve Curry, Chief Operating Officer, noted that the forecast out-turn position is made up of a number of elements including some operational spend and some accounting treatment and that these will all need to come together to achieve a balanced position. Steve further noted that transformation will be the key to achieving this, with a key part of the Patient First agenda being to see a balanced position recurring within four years. This balance will need to include not only increasing CIP, but also developing services for a progressive approach.

The Trust Chair asked whether language and expectation around CIP should be changed so that the amount divisions are expected to deliver is smaller and more likely to be within their gift. Some of the more significant expectations could then be moved into transformation programmes. Steve Curry noted his view that a matrix approach will be required and that for divisions to deliver they will need to be enabled to spend but also made accountable for savings.

Maria Kane, Chief Executive, noted that there are number of people within divisional and corporate senior management teams who have not previously been

responsible for CIP delivery at this level and that it needs to be clear to them that they are stewards of public finance and that there is an imperative to seek improvements and productivity gains wherever possible. Maria further noted that in addition to transformation at scale there are also some patient improvement and quality gains that can be made at 'ground level' that can feed into the CIP programme.

RESOLVED that the Finance & Performance Committee Upward Report be noted.

TB/22/09/12 Quality Committee Upward Report

Sarah Purdy, Non-Executive Director and Committee Chair, presented the Quality Committee Upward Report.

Sarah noted that the Committee had welcomed the update that four inpatient wards had been the first to achieve accreditation under the NBT Quality Accreditation Programme.

In relation to the Annual Safeguarding Report, Sarah noted an amendment to the Upward Report that the Committee had been assured rather than reassured that training levels had been discussed in detail at the September Safeguarding Committee.

RESOLVED that the Quality Committee Upward Report be noted.

TB/22/09/13 FPPR Update Report

Xavier Bell, Director of Corporate Governance, presented a Fit and Proper Persons Update and the contents were noted.

RESOLVED that the Fit and Proper Persons Update be noted.

TB/22/09/14 Any Other Business

No items of other business were noted.

TB/22/09/15 Questions from the public

No questions from the public were received.

TB/22/09/16 Date of Next Meeting

The next Board meeting in public was scheduled to take place on Thursday 24 November 2022, 10.00 a.m. Trust Board papers will be published on the website and interested members of the public are invited to submit questions in line with the Trust's normal processes.

The meeting concluded at 13:00

Trust Board - Public ACTION LOG

Meeting Date	Agenda Item	Minute Ref	Action No.	Agreed Action	Owner	Deadline for completion of action	Item for Future Board Meeting?	Status/ RAG	Info/ Update	Date action was closed/ updated
27/1/22	Annual Emergency, Preparedness, Resilience & Response (EPRR)	TB/22/01/08	65	Board to be informed once NBT is fully compliant against the NHS Core Standards for Annual Emergency, Preparedness, Resilience & Response (EPRR)	Steve Curry, Chief Operating Officer	Oct-22	Yes	Open	March update: Steve Curry noted that process were being put in place to achieve 100% compliancy and assurance would be given following a further assessment in October 2022.	31/03/2022
29/9/22	WRES/WDES Submission and Action Plan	TB/22/09/08	75	Further consideration to be given to the Trust's priorities and progress against key performance indicators to be brought back to the Board in March 2023.	Jacqui Marshall, Chief People Officer	Mar-23	Yes	Closed	Added to the workplan for March 2023	18/11/2022
29/9/22	Finance & Performance Committee Upward Report	TB/22/09/11	76	The Trust Chair to discuss the provision of IT access with the system's digital lead, as well as the ICS	Michele Romaine, Trust Chair	Dec-23	No	Open		

North Bristol NHS Trust

Report To:	Trust Board Meeting (Public)		
Date of Meeting:	24 November 2022		
Report Title:	Chief Executive's Briefing		
Report Author & Job Title	Suzanne Priest, Executive Co-ordinator		
Executive/Non-executive Sponsor (presenting)	Maria Kane, Chief Executive		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to: • Receive and note the content of the briefing.		
Report History:	The Chief Executive's briefing is a standing agenda item on all Board agendas.		
Next Steps:	Next steps in relation to any of the issues highlighted in the Report are shown in the body of the report.		

7

Executive Summary	
The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments.	
Board Assurance Framework/Trust Risk Register Links	Does not link to any specific risk.
Financial implications	None identified.
Equality, Diversity, and Inclusion Assessment (EIA)	N/A
Appendices:	N/A

NHS North Bristol NHS Trust

1. Purpose

The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments over the past month.

2. Background

The Trust Board receives a report from the Chief Executive to each meeting which details important changes or issues within the organisation and the external environment.

3. Performance

New front door measures have been stepped up to aid the offloading of ambulances. The South West region has been highlighted as the most pressurised at the front door and has the highest bed occupancy rates in the country.

RTT recovery work continues with all of the required 104 week waits cleared. The number of 78 week waits is decreasing with the anticipated trajectory meeting the required target by 31 March 2023.

Cancer position has significantly improved.

4. Notification of Industrial Action

The Royal College of Nursing has notified Trusts of the results of the ballot which was held with its members. The threshold for strike action was reached at NBT. There are negotiations continuing at a national level to agree derogations. Further ballot results from Unison, GMB and Unite are expected by the end of November.

Work is ongoing throughout the region, our system and within the organisation to help to mitigate the impact of these strikes on our patients.

5. Ministerial visit

Minister for Health and Social Care, Helen Whately visited the Trust last week, and after a whistlestop tour of ED, our frailty and complex care facilities, and a discussion with the Hospital at Home team, the Minister led a system wide roundtable discussion. Attendees included executives from the ICB, Directors of Adult Social Care from our three local Councils, Sirona and Brunel Care. Colleagues from DHSC also accompanied the MP on her visit.

6. Perinatal Culture and Leadership Development Programme

Following a regional nomination process, our Maternity and Neonatal leadership team have been selected to participate in the first wave of the Perinatal Culture and Leadership Development programme. The aim is to support the teams to create a positive culture of openness, safety and continuous improvement. This first wave is due

to commence this month and will take around six months to complete. It is anticipated that all maternity and neonatal teams will have been enrolled by March 2024.

7. Visit with the New Vice Chancellor at University of Bristol

I met with the new University of Bristol Vice Chancellor, Professor Evelyn Welch, to extend a welcome to her in her new role. Professor Welch was joined by Professor Jane Norman, Dean of Health Sciences on her visit to Southmead. University of Bristol remains one of our closest research and training partners and we had a valuable opportunity to discuss our shared priorities.

8. Visit by Dr Sean O'Kelly – CQC Chief Inspector of Hospitals

I welcomed Dr Sean O'Kelly and Cath Campbell, Regional Director from the CQC. They had asked to visit and to see our UEC pathway and discuss contextual issues as we head into Winter.

9. Visit from Julie Sharma, Interim Chief Executive of Sirona Care and Health

Julie Sharma, CEO from Sirona Care and Health came for a visit earlier this month to discuss delayed discharges, out of hospital services and workforce challenges.

10. Engagement & Service Visits

I am continuing to spend time with as many services and teams across the hospital as I can, and I continue to meet with regularly with Clinical Consultant colleagues. This enables me to gain a better understanding of the challenges and opportunities faced in different specialties and practices across the Trust.

In November I visited the following areas:

- Women and Children's Services
- Estates
- Improvement Team
- Apprenticeship Team

This month I have seen consultant colleagues from Orthopaedics, Psychiatry, Clinical Psychology, Intensive Care, Spinal and Dermatology.

11. Summary and Recommendations

The Trust Board is asked to note the content of this report and discuss as required.

NHS North Bristol NHS Trust

Mental Health Patient Experience

NBTCARES

Why This Story?

- Our Trust values reflect our commitment to ensure all patients including mental health patients experience the best possible care.
- We are committed to the parity of esteem agenda and value mental health as much as physical health.
- We are committed to close the inequality gap between physical and mental health.
- We are committed in reducing the stigma that can be associated with mental health.
- Following the pandemic, mental health services have seen an exponential increase in demand from both children and adults.

Ciaran's experience

- Ciaran is a 26 year old young man who has experienced poor mental health for the last 10 years and reached out to Southmead Hospital for the first time in February 2022.
- Ciaran felt well supported by the Mental Health Liaison Team (MHLT) within our Emergency Department, particularly in comparison to other options he had explored.

https://youtu.be/c8Ss1h5naNo

What does Ciaran's experience tell us?

- Nationally and locally evidence shows that over 50% of peoples experience of first time contact with mental health services is within an emergency department or medical unit.
- It is important to demonstrate and validate the individual for whatever presentation has brought them to a point of crisis. A bad experience in this critical time can have significant detrimental impact to the individual further along in their patient journey.
- New evidence also shows that positive engagement in initial meeting and follow ups translates into patients remaining in therapy and active engagement with services.
- Ciaran's story shows the power of listening and validating patient concerns and importantly listening to what the patients needs, in this case onward referral.
- It Identifies learning for us to set realistic expectations, and our need to proactively engage partner organisations to gain the information on changing waiting times.
- It demonstrates to us that mental health is our business within an acute healthcare environment and with system engagement we can ensure a positive outcome for those in our care.

The MHLT

The mental health liaison team within NBT comprises of two services;

1. **The emergency zone -** encompassing the emergency department, and the acute medical unit. - This part of the team operates from 07:30hrs -22:00hrs 7 days per week/ 365 days a year. In the Winter the team will be increasing it's hours again to midnight. The emergency zone team also operates the PAC clinic for planned outpatient appointments to reduce overnight waits within the emergency department.
2. **The inpatient service -** This operates Mon-Fri on a 9-5 basis and covers all wards and divisions with exception of outpatients. The ambition is to make this part of the service a 7 day service.

Overall the team receives approximately 3,000 referrals a year but has seen an increase, specifically in the complexity of referrals. The Mental Health Act assessments within NBT alone have increased by 40%.

MHLT Approach

- The Team has a safe space to assess and signpost patients when they attend the Emergency Department.
- The Team has a referral process depending on risks and patients needs.
- The Team use a standardised risk assessment whilst in the Emergency Department.
- The Team have an opportunity to refer to other services with Avon and Wiltshire Mental Health Partnership NHS Trust.
- Able to see patients on site to support them urgently which helps in emergency situations.
- The video below explains how the team works.

https://www.youtube.com/watch?v=uXkbQ2Qvx10

Current Service Development

The NBT MHLT has;

- PLAN accreditation and re-accreditation - first accredited in 2018.
- Been **Southwest winners and finalists in the parliamentary awards** for last two consecutive years both in mental health and emergency medicine categories.
- Developed the Planned Assessment Clinic (PAC) as alternative face to face appointment and assessment service that reduces time spent within ED. Data shows a 53% reduction in time spent within the ED for EDOU patients and a 38% reduction in patients within ED excluding EDOU.
- To date 100% satisfaction and other positive qualitative comments from those that have used the service.
- Extended operational hours in last winter period. Review of extended hours showed 45.8% reduction in overnight stays for the purpose of mental health assessment.
- Continue request for Core 24 service within the emergency department.
- Currently completing a mental health strategy to be included in trust strategy.

North Bristol NHS Trust

Report To:	Public Trust Board Meeting		
Date of Meeting:	24 November 2022 (Report covering 01/07/22 – 31/10/22)		
Report Title:	Guardian for Safe Working (Junior Doctors)		
Report Author & Job Title	Dr Lucy Kirkham, Trust Guardian for Safe Junior Doctor Working		
Executive/Non-executive Sponsor	Direct to Trust Board		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
	X	X	X
Recommendation:	Trust Board are asked to: • read and note this report from the Guardian of Safe Working • note ongoing Junior Doctor Contract changes. • consider the appointment of PA to previously held CF posts • to look competitively at other providers of exception reporting software when the current contract expires • approve the New SOP for issuing a GOSW fine		
Report History:	This paper sets outs the background and context around the introduction of the Guardian of Safer Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust. It shows: • Exception Report data • Locum data • Guardian's actions • Gaps on rotas and plans to fill		
Next Steps:	• Promote and support exception reporting system to consultants and trainees • Continue to look at creative workforce and IT solutions to minimise gaps		

Executive Summary

The New Junior Doctors' Contract was introduced with effect from October 2016, subject to a phased implementation between October 2016 and August 2017. In 2019 there was a further contract refresh agreed covering April 2019 - March 2023.

Junior Doctor Contract Refresh - 2019

The BMA's Junior Doctors Committee endorsed an offer negotiated with NHS Employers which would see changes being made to, and additional investment in, the 2016 Junior Doctors contract alongside a multi-year pay deal. Changes included:

- Leave for life changing events – employers must allow leave for life changing events (it is for the doctor to decide what is a deemed life a changing event)
- Breaks for nights shifts – a nights shift of 12 hours or more will require a 3rd 30 minute break.
- Facilities – where a non-resident on-call rota requires the trainee to be on site within a specified time or where the department specify the distance from the Trust when NROC then the department will meet the cost of overnight accommodation.

- Facilities – where a trainee has worked a night and is too tired to drive home the Trust must provide rest facilities (which we do anyway) or the department must meet the cost of travel home and reasonable expenses on the return to work.
- Exception reporting – extension of what can be exception reported i.e., missed supervisor meetings or no time provided for coming audits / e-portfolio.

August 2021: BMA statement on the TCS (2016 Terms and conditions of service for NHS doctors and dentists in training in England) and junior doctor rostering during the response to the COVID-19 pandemic

https://www.bma.org.uk/news-and-opinion/statement-on-junior-doctor-rostering-and-workforce-management-during-the-covid-19-pandemic

The NBT Trust Guardian for Safe Junior Doctor Working will:

1. Interact with the Trust Board in a structured report covering rota gaps, gap management, locum usage exception reporting and the Postgraduate Doctors Forum (PDF)
2. Ensure Exception Reporting by junior doctors for breaches of contract are acted upon. These comprise exceptions for:
   - Safety reasons
   - Excess hours – Leading to TOIL (the preference) or Payment where TOIL is not possible
   - Excess hours leading to work pattern reviews
   - Missed education sessions
3. Set up and attend a PDF – these forums harness the junior doctor's ideas and energy on better ways of working as well as offering a channel to discuss contract, education and rota issues. The DME, HR and exec attendance is desirable.
4. The Guardian may levy a fine if a breach of the following occurs:
   - The 48-hour average weekly working limit
   - Contractual limit on maximum of 72 hours worked within any consecutive 7-day period
   - Minimum 11-hour rest has been reduced to less than 8 hours
   - Where meal breaks are missed on more than 25 per cent of occasions over a 4-week period.
   - The minimum 8 hours total rest per 24-hour non-resident on-call (NROC) shift
   - The minimum NROC overnight continuous rest of five hours between 22:00 & 07:00
   - The maximum 13-hour shift length
   - The minimum 11 hours rest between resident shifts

Penalties will be levied against the department where the doctor works; the fine will be set at four times the basic or enhanced rate of pay applicable at the time of the breach. The doctor will receive 1.5 times the applicable locum rate, and the JDF will retain the remainder of the penalty amount.

Risks	• eRostering to alert contract breaches and enable leave booking for trainees. • Exception's alert ISCs
Financial Implications	Financial implications are set out in the report
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices	Appendix 1: GOSW fines SOP Appendix 2: Medical Workforce SOP on rota and rostering Appendix 2.1: Flow charts on rotation milestones

North Bristol NHS Trust

HIGH LEVEL DATA – ROTA GAPS, GAP MANAGMENT, LOCUM USAGE, EXCEPTION REPORTING & PDF

Total number of Doctors in Training (DiT) and Clinical Fellows (CF)

Division	WTE
Anaesthesia, Surgery, Critical & Renal Division	224.4
Core Clinical Services Division	48.6
Medicine Division	174.7
Neurosciences & Musculoskeletal Division	114.5
Women and Children's Division	40.3
Ring Fenced Funding - GP/Psychiatry Foundation	21.0
HR Division – Post graduate	11.4
Grand Total	**634.9**

NBT rota designs have continued to meet the 2016 junior doctor contract requirements

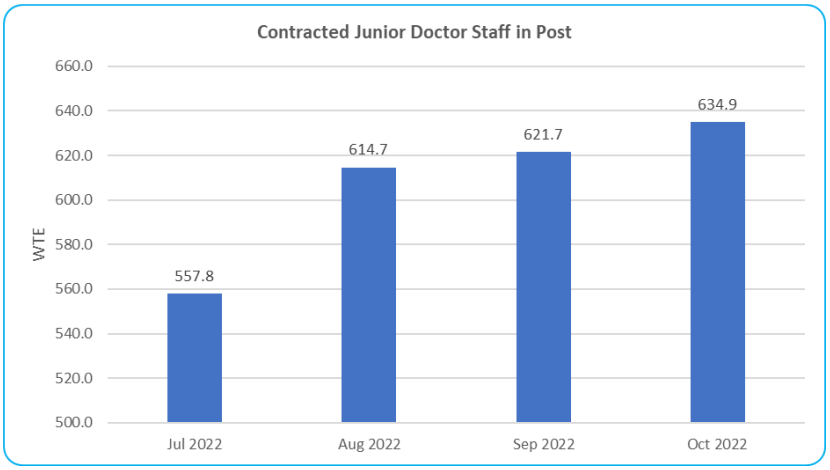
1. ROTA GAPS

1.1. All gaps are detrimental to patient care and Postgraduate Doctor training

1.2. Gaps can be caused by short a long-term sickness.

1.3. Recorded sickness absence in the last 4 months for PGDs was 1.2% as opposed to 1.9% between March and June

1.4. The bar chart shows an overall increase of 77.4 WTE in junior doctor staffing between July and Oct. 11.4 of these WTEs is from the creation of new posts in establishment (5 of which are in Histo/cell pathology). The remainder are from the filling of gaps.



1.5. The table below show the specialties that had negative net movement of >1WTE (for ST1/CT1/IMT1 and above)

Division	Cost Centre	Jul 2022	Oct 2022	Variance
	General Surgery Med Staff	26.8	25.2	-1.6
Anaesthesia, Surgery, Critical & Renal Division Total		**26.8**	**25.2**	**-1.6**
	Gastro Specialty	8.0	6.0	-2.0
	Haematology Specialty	3.6	2.6	-1.0
	Respiratory Specialty	19.5	17.7	-1.8
Medicine Division Total		**31.1**	**26.3**	**-4.8**
	Neurodegenerative Disease Budget	1.5	0.5	-1.0
	Neurosurgery Med Staff	20.0	18.0	-2.0
Neurosciences & Musculoskeletal Division Total		**21.5**	**18.5**	**-3.0**
	Sm Obs/Gynae Medical	28.3	25.6	-2.7
Women and Children's Total		**28.3**	**25.6**	**-2.7**

2. GAP MANAGEMENT

2.1. CF Adverts:

- Recruitment into CF gaps is continuous and ongoing

2.2. Medical Support Workers:

- 29 Doctors from Myanmar started at NBT Nov 2021
  - 23 now have GMC registration – 6 of which are working at NBT as CFs – 2 in medicine, 2 in urology and 2 in general surgery.
  - 7 are not in GMC registered roles – 2 of these are working or soon to start at NBT as healthcare support workers while they work towards PLAB2 and getting GMC registration; the others have dependent visas and are at various stages towards getting GMC registration.
- The second cohort of 30 MSWs from Myanmar started July 2022:
  - Contract is until March 2023. Although we're hopeful NHSE&I might consider extending their contracts, as they did for the first cohort last year, we don't expect to hear about this until a few weeks before their contract ends.
  - With the financial constraints ahead, contract extensions are far from guaranteed.
  - 1 MSW has moved into a CF post elsewhere and a further 10 have passed PLAB2 or membership exams enabling them to get GMC registration.
- Invaluable clinical teaching fellow for the MSWs now appointed with funding from Southmead charity

2.3. Optimising NBT locum reach

- Postgrad Doctors Forum suggestion of using 'Locums Nest' app
- A successful pilot has been run at NBT in the emergency specialties resulting in 30+ new locums signing up to work shifts at NBT
- The next phase of the pilot is to expand into Anaesthetics, and Medicine entirely.
- Great Western went live with Locums Nest on Monday 14th November and have signed a Memorandum of Understanding (MOU) with NBT to allow for staff sharing without laborious on-boarding processes
- Signing a MOU is planned for with Royal United Hospital Bath and Gloucester Royal Hospital
- UHBW are looking at collaborating
- As a result of Locums Nest app, we have **56 locum applications** from doctors who currently work at the planned MOU sites.

2.4. **Potential to decrease dependence on CFs by converting some CF posts into Physicians Associate posts**

- **Unlikely that PA's will gain prescribing and radiology requesting until >2023 as date pushed back by GMC thus limiting their usefulness**
- OMB report written by Sue Nutland and the PA lead (Dr Phil Braude) ready for discussion. This outlines the role of PAs, benefits to the organisation, and business case model to convert existing clinical fellow posts. Therefore, the case is based upon staffing skill mix rather than additional investment.
- Not taking this report to OMB now, as there needs to be a wider piece of work on alternative roles, and this will now fall under the new Associate Director for Resourcing and Workforce Planning

2.5. Medical Workforce Resilience project

- This project is within the Division of Medicine. It takes a root and branch approach looking at the roles and tasks completed by the MDT within the emergency department. The aim is to ensure optimal staffing for the delivery of high-quality patient care.

3. LOCUM USAGE - BANK AND AGENCY

3.1. BY DIVISION: Biggest user of Bank – Medicine

Locum Bookings (Bank) by Department	Requested Shif	Requested H	Filled Hours	Estimated Cost
ASCR Division	632.00	6221.70	5508.75	£329,421.25
Clinical Governance Division	9.00	52.00	52.00	£2,860.00
Core Clinical	28.00	342.50	342.50	£24,767.50
Finance Division	1.00	8.00	8.00	£337.50
HR Division	19.00	114.26	114.26	£4,846.70
Medicine Division	1506.00	13518.44	11027.44	£592,945.60
Neuro & MSK Division	549.00	5411.91	4762.91	£248,958.45
W&C Division	104.00	1065.75	1039.25	£73,528.75
Winter Pressures	771.00	6214.50	5129.00	£231,538.25
Grand Total	**3619.00**	**32949.06**	**27984.11**	**£1,509,204.00**

Locum Bookings (Agency) by Department	Requested Shift	Agency Filled Sl	Requested H	Agency Filled H	Estimated Cost
Neuro & MSK Division	64	64	612.67	612.67	£39,820.60
Grand Total	**64**	**64**	**612.67**	**612.67**	**£39,820.60**

3.2. BY GRADE: Commonest grade is F2/ST1-2

Locum Bookings (Bank) by Grade	Requested Shif	Requested H	Filled Hours	Estimated Cost
Locum F1	45	402.5	215	£9,932.50
Locum F2	2580	22835.55	18896.55	£907,045.00
Locum ST3+	989	9670.51	8832.06	£590,239.00
Locum Spec Doc	4	36	36	£1,770.00
GPVTS1	1	4.5	4.5	£217.50
Grand Total	**3619**	**32949.06**	**27984.11**	**£1,509,204.00**

Locum Bookings (Agency) by Grade	Requested Shift	Agency Filled Sl	Requested H	Agency Filled H	Estimated Cost
Locum F2/ST1-2 Core	47	47	470.67	470.67	£28,728.10
Locum ST3+	17	17	142	142	£11,092.50
Grand Total	**64**	**64**	**612.67**	**612.67**	**£39,820.60**

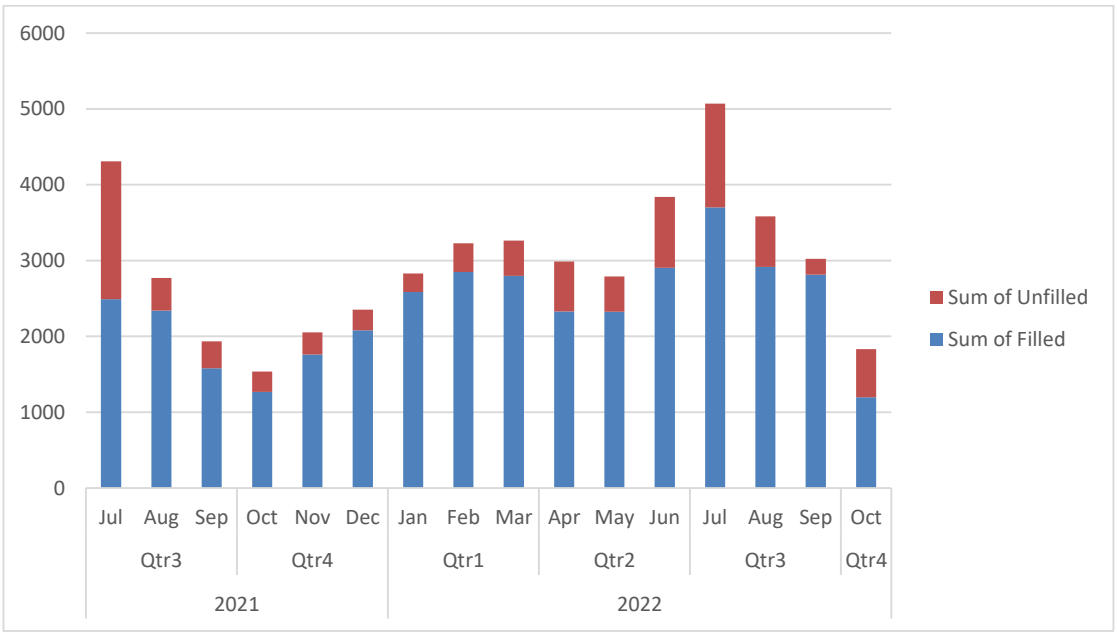
3.3. BY REQUEST REASON: Commonest reasons are additional capacity and then vacancy

Locum Bookings (Bank) by Request Reason	Requested Shif	Requested H	Filled Hours	Estimated Cost
Additional Capacity	1907	17630.11	15192.16	£829,403.80
Annual Leave	26	172.92	160.42	£8,653.90
Bank Only Paid Study Day	13	89.76	89.76	£3,744.20
Bereavement Leave	2	25	12.5	£645.00
Covid 19	34	342.25	220.75	£12,493.75
Emergency Domestic Carer Leave	1	4	4	£240.00
Increased Dependency/High Acuity	1	4	4	£300.00
Sickness	238	2174.56	1952.56	£121,970.70
Study Leave	13	98.5	85.5	£3,930.00
Vacancy	1344	12064.21	10030.71	£512,896.40
Waiting List Initiative	10	86	86	£6,450.00
Supernumerary	5	32.5	32.5	£1,560.00
Parental Leave	8	88	72	£4,327.50
Covid Recharge	1	9.75	9.75	£438.75
Enhanced Care	1	7.5	7.5	£462.50
Allocate on Arrival	15	120	24	£1,687.50
Grand Total	**3619**	**32949.06**	**27984.11**	**£1,509,204.00**

Locum Bookings (Agency) by Request Reason	Requested Shift	Agency Filled Sl	Requested H	Agency Filled H	Estimated Cost
Additional Capacity	59	59	567.67	567.67	£36,208.10
Vacancy	5	5	45	45	£3,612.50
Grand Total	**64**	**64**	**612.67**	**612.67**	**£39,820.60**

3.4. **Current locum requests in Medicine Division**

- Medicine Division needs to cover most absences with a locum due to shift work and ward care thus accounting for their large Bank usage.
- This bar chart shows the **total hours requested by Medicine Division split into filled and unfilled**.
- Medicine Division are requesting more hours than the same time last year.
- It will be interesting to see if the unfilled hours decrease as NBT moves the whole of Medicine on to Locums Nest as a means of more effectively accessing a wider locum pool.



4. EXCEPTION REPORTS

Exception Reports (ER) over past 4 months		Number flagged as immediate safety concern (ISC)
Number relating to hours of working	259	3
Number relating to pattern of work	6	2
Number relating to educational opportunities	9	
Number relating to service support available to the doctor	11	9
TOTAL NUMBER OF EXCEPTION REPORTS	**285**	**14**

109 reports in previous 4-month period

4.1. There has been a sustained perception by the PDF that there is under reporting via the exception reporting system of the true extra hours worked by the PGDs

4.2. Increased reporting is not necessarily a bad thing as it reveals problem areas and recognises extra work with TOIL or payment

4.3. The increased reporting in Aug is entirely related to T&O – 49 reports (usually has 1-2 a month). This related to a change in the August specialty induction and encouragement by the F2 prog lead to exception report. The exception reports were a valuable tool to engage with the T&O leads to swiftly address the issue. The T&O PGDs were satisfied with the improvement and exception reporting has fallen again.

4.4. Increased reporting in Sept and Oct is largely within Medicine.

	EXCEPTIONS BY YEAR	
	2021	2022
JAN	37	29
FEB	33	28
MAR	16	27
APRIL	52	31
MAY	46	28
JUNE	61	24
JULY	51	44
AUG	27	89
SEPT	44	79
OCT	47	74
NOV	29	
DEC	21	

4.5. **BREAKDOWN OF REPORTS**

4.5.1. IMMEDIATE SAFETY CONCERNS – 14

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ISC	Grade	Rota	Issues & actions
9	7 x F2 2 x CT1	Resp Medicine	Below minimum staffing on 27b – should be 2 SHOs – 18 patients ➔ Escalated to Resp and Divisional leads. Meeting held btwn Divisional and Resp leads. I met PGDs and meeting planned 17/11 with PGDs, Resp leads and myself. All in agreement consultants available and supportive. No safety concerns re patient escalation. Concern over less time with patients, jobs incomplete, discharges delayed no locum yet found
1	ST 3+	Gen Med	No cover for night shift. Evening Reg stayed until 02.00 and Consultant stayed until 04.30. ➔ Acute sickness. Fully supportive senior team. No repetition
2	F1	Gen surgery	Asked to hold vascular bleep in addition to gen surg take bleep.
1	F1	Gastroenterology	Acute sickness, No middle grade. F1 did not call for consultant for support despite being available. ➔ F1 discussed with supervisor and encouraged to call consultant.
1	F1	Vascular surgery	An acutely unwell at the end of the shift. Junior shoes to manage with guidance from Med Reg. rather than hand over. Well managed. Debriefed with supervisor.

4.5.2. EDUCATIONAL EXCEPTION REPORTS -

Number of exceptions	Rota	Issues
3	T&O F2	Missed F2 teaching due to ward commitments
4	Gen Med F2	Missed F2 teaching due to ward commitments
2	Gen Med F1	Missed F1 teaching due to ward commitments

***All F1/2 mandatory teaching is available as a video recording and is sent out to doctors unable to attend**

4.5.3. 'HOURS' EXCEPTION REPORTS BY SPECIALTY -

SPECIALTY	TOTAL Reports
General Medicine (includes acute medicine)	**90**
T&O	**56**
Geriatric medicine	**26**
Gastroenterology	**20**
Respiratory Medicine	**16**
Neurosurgery	**11**
Neurology	**9**
Vascular surgery	**7**
Urology	**6**
Infectious diseases	**6**
Nephrology	**6**
General Surgery	**5**
Anaesthetics	**1**
TOTAL	**259**

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5. POSTGRADUATE DOCTOR FORUM – Held in person and via Teams in July 2022 and Sept 2022

5.1. Improved engagement asked for by Trust Board:

- Guest speakers trialled – No noticeable increase in PDF uptake as a result
  - 1st speaker – Expedition Medicine – July PDF
  - 2nd speaker - Library
- Refreshed posters in Mess
- Offer of £5 Vu voucher for all PDF attendees
- Banner added to intranet and dates on LINK calendar
- Re-recorded GOSW videos for Induction and Educational Supervisors
- Continue to recruit new Reps via posters and monthly email – currently 23 reps across specialties

5.2. Ideas generated in PDF – app for locum contacts, Lanyard to indicate at end of shift to encourage timely departure

6. Other issues arising:

6.1. **Rotas sent out late – It is a contractual requirement that doctors receive their individualised rotas 6 weeks before commencing duties**

- Rotas were sent out late for August on-boarding and were reported on in the last Board report
- Xmas rotas in some specialties have again been late to be issued and have caused some distress to the PGDs
- An apology has been issued to all PGDs for this contractual breach

- I have consulted the BMA and other GOSW; no fines are issuable, and no compensation can be offered unless a PGD can demonstrate loss arising from the lack of rota
- Medical Workforce in response to this breach have devised a comprehensive and practical SOP which details a timeline for communicating, escalating, and issuing rotas for NBT
- **The SOP 'rota and rostering' has been discussed at the Medical Professional's Group and will be shared with the PGDs and the PDF on 22/11/22 – attached along with flowchart for rota issuing.**
- Some further work needs to be undertaken by Medicine Division to ensure oversite of all rota writers and that they have the admin support they need

6.2. **Need to set up a mechanism to administer fines**

- The previous GOSW did not administer any fines over the 5 years in post using instead the 'threat' of a fine to engage teams with improvements
- During the last 4 months there have been several finable incidences but with no mechanism in place fining was not a realistic option:
    - 8 exceptions in Aug/Sept in T&O where the PGD stayed late following a 13hr shift
        - The PGDs were not asked by a senior to stay late
        - Measures were put in place in T&O to prevent this happening again without the need to fine
    - 1 exception in COTE where an F1 agreed to swap a shift and worked 8 days in a row exceeding the maximum 72 hrs in 168 allowed for in the contract
        - Messaging sent out again to all PGDs and COTE that these swaps are not to be made as any clinical error made when working during a contractually breaching shift will be indefensible
- **GOSW fines SOP attached for approval by Trust Board**

6.3. **Allocate not very user friendly/does not 'encourage' exception reporting**

- Consideration when Allocate contract expires (14 months) of moving to competitor DRS because:
    - DRS developing an App - trainees can complete exception at home rather than staying even later
    - Allows trainees to notify one other trainee when they exception report (an 'I am Spartacus' idea to show others it is ok to exception report)
    - Interacts with roster to add on any TOIL to the trainee's rota if agreed
    - Shows trainee what they are paid if payment is agreed
    - Calculates fines
    - Greater end user refinement in defining exception types
    - Shows location

7. Networking

7.1. The Guardian is in contact by WhatsApp and Zoom with national and regional groups
7.2. NHS-Employers remote meetings to network with them and other Guardians
7.3. Webinar BMA GOSW conference

8. **LNC**

8.1. Guardian and junior BMA rep attends meetings or sends reports to each meeting. Increases awareness of current issues and interfaces with BMA.

9. SUMMARY

9.1. **NBT is compliant with:**

- BMA contract rules regarding rota construction
- Electronic reporting system in place (eAllocate)
- Postgraduate Doctor Forum – meetings being held as required by New Contract

- Exception Reporting Policy
- LNC involvement
- All national requirements as listed by NHS Employers

9.2. **Concerns:**

- Late sharing of individualised rotas with postgrad doctors after the 6-week deadline in several specialties
- Unfilled gaps in rotas remain a concern.
- Is Allocate the best system for encouraging exception reporting?
- Need to set up a system for issuing a fine when appropriate

9.3. **Recommendations**

The Trust Board is asked to:

- read and note this report from the Guardian of Safe Working
- note ongoing Junior Doctor Contract changes.
- consider the appointment of PA to previously held CF posts
- to look competitively at other providers of exception reporting software when the current contract expires
- approve the New SOP for issuing a GOSW fine

Dr Lucy Kirkham, Trust Guardian for Safe Junior Doctor Working

North Bristol NHS Trust

Guardian of Safe Working (GOSW) Fines
Division: *Trust-Wide*

Specific staff groups to whom this policy directly applies	Likely frequency of use	Other staff who may need to be familiar with policy
All Divisions	Infrequent	

Main Author(s):	Dr Lucy Kirkham - GOSW
Consultation:	Medical Workforce
Date of Approval:	Approval requested from Trust Board Nov 2022
Next Review Due:	Nov 2025
Version:	1.0

1. Purpose	**This Standard Operating Procedure (SOP) aims to enable the Guardian of Safe Working Hours to issue fines in incidences of breach of contract as outlined by NHS Employers and the BMA according to the 2018 Junior Doctor contract refresh.**
2. Key Messages	**This SOP sets out:** **A. Finable situations for breach of the 2018 Junior Doctors contract refresh** **B. How much the fines are** **C. Who will administer the fines** **D. Who will pay the fines** **E. Where the monies are held** **F. Disbursement of fines**
3. Who should read this	**DODs, Divisional Leads, Specialty Leads**
4. Roles responsible for carrying out this procedure	**GOSW to identify any situation that warrants a fine** **GOSW to determine if a fine should be issued** **GOSW to administer fine according to the below guidance** **DOD/specialty manager to transfer fine money to GOSW account** **Monies to be held in an GOSW account held within Medical Workforce budget** **Monies to be distributed by PDF in collaboration with the GOSW**

A. Fines can be issued by the GOSW in the following situations as outlined by NHS Employers:

Rule	Notes
Max 48 hour average working week	A guardian of safe working hours fine will apply if this rule is breached
Max 72 hours work in any consecutive period of 168 hours	A guardian of safe working hours fine will apply if this rule is breached
Max 13 hour shift length	On-call periods can be up to 24 hours
46-hours of rest required after any number of rostered night shifts	
Max 4 consecutive long shifts*, at least 48 hours rest following the fourth shift	Long shift (a shift rostered to last longer than 10 hours)
Max 4 consecutive long daytime/evening shifts, at least 48 hours rest following the fourth shift	Long evening shift: a long shift starting before 16.00 rostered to finish after 23.00 (a long shift starting after 16.00 will fall in to the definition of a night shift)
Max 4 consecutive night shifts. At least 46 hours rest following the third or fourth such shift	Night shift: at least 3 hours of work in the period 23.00 to 06.00. Rest must be given at the conclusion of the final shift, which could be the third or fourth
Max 7 consecutive shifts* (except on low intensity on-call rotas), at least 48 hours rest following the final shift	Low intensity on-call: duty on a Saturday and Sunday where 3 hours, or less, work takes place on each day, and no more than 3 episodes of work each day. Up to 12 consecutive shifts can be worked in this scenario provided that no other rule is breached
Max frequency of 1 in 3 weekends can be worked	Weekend work (any shifts/on-call duty periods where any work falls between 00.01 Saturday and 23.59 Sunday) Authorisation for a rota using a pattern greater than 1 in 3 should require a clearly identified clinical reason agreed by the clinical director and be deemed appropriate by the guardian of safe working.
Normally at least 11 hours continuous rest between rostered shifts (separate on-call provisions below).	Breaches of rest subject to time off in lieu (TOIL) which must be given within 24 hours. In exceptional circumstances where rest is reduced to fewer than 8 hours, time will be paid at a penalty rate and the doctor is not expected to work more than 5 hours the following day. A guardian of safe working hours fine will apply in this circumstance

30 minute break for 5 hours work, a second 30 minute break for more than 9 hours A third 30-minute paid break for a night shift rostered to last 12 hours or more	A guardian of safe working hours fine will apply if breaks are missed on at least 25 per cent of occasions across a 4 week reference period. Breaks should be taken separately but if combined must be taken as near as possible to the middle of the shift
Specific to on-call working patterns	
No consecutive on-call periods apart from Saturday & Sunday. No more than 3 on-call periods in 7 consecutive days	A maximum of 7 consecutive on-call periods can be agreed locally where safe to do so and no other safety rules would be breached; likely to be low intensity rotas only
Day after an on-call period must not be rostered to exceed 10 hours	Where more than 1 on-call period is rostered consecutively (e.g. Saturday/Sunday), this rule applies to the day after the last on-call period
Expected rest while on-call is 8 hours per 24 hour period, of which at least 5 hours should be continuous between 22.00 and 07.00	If it is expected this will not be met, the day after must not exceed 5 hours. Doctor must inform employer where rest requirements are not met, TOIL must be taken within 24 hours or the time will be paid. A guardian of safe working hours fine will apply in this circumstance.
No doctor should be rostered on-call to cover the same shift as a doctor on the same rota is covering by working a shift	Unless there is a clearly defined clinical reason agreed by the clinical director and the working pattern is agreed by both the guardian and the director of medical education

B. How much are the fines?

- The GOSW will determine if the additional hours that breached the TCS limits occurred at normal time or time plus 37% for 'night' (21.00 - 07.00) hours
- **The fine will be set at four times the basic or enhanced rate of pay applicable at the time of the breach as per guidance from NHS Employers**
- **The doctor will receive 1.5 times the applicable locum rate, and the GOSW will retain the remainder of the penalty amount for disbursement by the Postgraduate Doctors Forum in collaboration with the GOSW**
- Where the 48-hour limit is breached the hours that cause the breach will be the final hours worked in the cycle that take the average hours over 48. The same logic applies to where the maximum 72-hour limit in any consecutive 168-hour period is breached
- In order to assess if a fine for missed breaks needs to be levied, all of the exception reports confirming a break has been missed would need to be looked at over a 4-week period. The doctor would need to have missed at least 25% of breaks for the guardian to levy a fine for each missed break.
- If a fine is issued for missing breaks the doctor receives no additional payment, as they are already paid for breaks
- The fine for missing breaks should be twice the relevant hourly rate for the time in which the break was not taken

C. Who will administer the fine?

The guardian of safe working hours will levy a fine on the department employing the doctor for those additional hours worked

D. Who will pay the fine?
The DOD of the division and specialty manager will make payment into the GOSW account held within Medical Workforce's budget

E. Where will the monies be held?
The monies will be held in an account set up in the GOSW name within Medical Workforce's budget. The Head of Medical Workforce will have oversight of the account.

F. Disbursement of fines:

- The money raised through fines must be used to benefit the education, training and working environment of trainees.
- The guardian of safe working hours should devise the allocation of funds in collaboration with the Postgraduate Doctors' Forum.
- These funds must not be used to supplement the facilities, study leave, IT provision and other resources that are defined by HEE as fundamental requirements for doctors in training and which should be provided by the employer/host organisation as standard.

North Bristol NHS Trust

Postgraduate Doctors eRostering

Division: *Trust-Wide*

Specific staff groups to whom this policy directly applies	Likely frequency of use	Other staff who may need to be familiar with policy

Main Author(s):	Stephanie Beere, Medical HR Manager Sue Nutland, Associate Director of Medical Workforce Katherine Bryce, eRostering Manager
Consultation:	Guardian of Safe Working Medical Professionals Group
Date of Approval:	[State the date the document was approved by lead clinician/ committee in full e.g. 31 October 2015]
Next Review Due:	[State the latest review date which should by default, be 3 years from the approval date. The date should be stated in full]
Version:	1.0

1. Purpose	**This Standard Operating Procedure (SOP) aims to support the management of new & existing medical staff accessing work schedules & individual rosters within the allotted T&Cs time frame.**
2. Key Messages	**This SOP sets out North Bristol NHS Trust's approach to the management of information about existing & new medical staff coming into the organisation who are required to be rostered and/or added to the system for absence management purposes to meet national contract terms and conditions and provides instruction on the steps that should be adhered to in order to ensure a smooth transition into the Trust. This SOP also sets out how to support changes to a doctors' rostering requirements in line with rotation of doctors within the organisation as part of their training posts.** **The current Junior Doctor contract 2016 requires all doctors to be provided with a schedule of their working arrangements including pay information within 8 weeks of starting the Trust (and/or details of working schedule if**

	doctor is rotating to a new department within the organisation) and a working roster of their shifts within 6 weeks of starting in the Trust and/or rotating within the organisation. Failure to comply with this contract requirement could result in breaches of their contract and financial penalties to the Trust. **This SOP will outline escalation processes for all parties to ensure the deadlines are met.**
3. Who should read this	**Medical HR, eRostering, Rota Coordinators**
4. Roles responsible for carrying out this procedure	**Medical HR, eRostering, Rota Coordinators**

5. Procedure:

Key Objectives

- Adopt a robust process for managing information about new medical staff starting/leaving within the organisation involving multiple departments working together.
- To detail which area is responsible for specific parts of rota development and publication within the timeframes set in this SOP.
- To provide a robust process that fully informs the eRostering system to allow both national and internal terms and conditions relating to rota provision for medical staff to be fully realised.
- To ensure that where rostering is not in place via Healthroster, being fully utilised or for any reason not available that paper based rosters are issued by departments within the national Code of Practice regulations.
- Ensure that any changes that have a potential effect on other services are communicated to those services in a timely manner.
- Ensure all medical staff (all grades) are added to the system for rostering and absence management purposes.
- Ensure rota patterns held within the E-Rostering system are correct and up to date
- To assurance to the Divisions/rota coordinators that correct medical staff are available on the system to be allocated/rostered shifts.,
- Escalation processes in place should medical staff be missing from the system; patterns are incorrect or not rostered or are on target to receive their rosters against the national deadline.

Junior Doctor terms and conditions of Service – 2016 (2018 refresh)

Terms and conditions for junior doctors in training makes provision for the agreed Code of Practice in relation to issuing of Work Schedules and individual rotas withing a set timeframe. Failure to meet these deadlines will result in the Trust being in breach of it contract with the doctors concerned. These are:

12 Weeks Before Rotation	HEE to provide the Medical Workforce team with names joining Trust Specialties will issue Medical Workforce with the generic rota. Any changes to generic roster communicated to E-roster by Medical Workforce
8 Weeks before rotation	**Work schedules must be issued by Medical Workforce Team** Medical Workforce to send appropriate work schedule Advisors/Coordinators to contact rota coordinators / departments Specialties will confirm to Medical Workforce and eRostering that they have all the information needed to allow them to develop individual rotas
6 Weeks before rotation	**Rotas must be sent to new starters by Specialty Rota Co-ordinators** Rota Coordinators / Department release individual rosters to doctors

Medical Workforce Responsibilities

- It is Medical Workforce responsibility to provide departments with the names, grades, and contact details of all junior doctors joining the Trust at least 8 weeks prior to their commencement date. There will be occasions where Medical Workforce will not have this information available due to late notifications from HEE or late internal recruitment. In these cases departments will be kept fully updated from Medical Workforce on a weekly basis.
- Medical Workforce will also add all incoming staff to the roster system to enable rosters to be built and issued in the appropriate timelines. This will be completed at least 8 weeks before rosters are due to be published. Quality assurance checks must take place to ensure this information is correct.

Timeline

- 16 weeks prior to rotation, Medical Workforce will engage with departments to ensure the generic rota pattern is correct, truly reflective of numbers, shift types and times.
- Any changes to the generic rota pattern should be communicated to E-Rostering via the Service Desk (https://servicedesk.nbt.nhs.uk/app/hrsupport/HomePage.do) by the 12 week deadline to ensure the correct rota pattern is built within the eRostering system.
- It is Medical Workforce responsibility to ensure that doctors details are available on eRoster before the 8 week deadline.

- Medical Workforce will provide contact email addresses for incoming doctors to Specialty Ro-Coordinators and eRostering team via the helpdesk (https://servicedesk.nbt.nhs.uk/app/hrsupport/HomePage.do) at 12 weeks prior to rotation.
- Medical Workforce Team will contact rota coordinators at 8 weeks to ensure on track to meet 6 week deadline. The team will make contact each week till 6 week deadline, will escalate as per below if unable to get sufficient confirmation of meeting roster deadline.

Further escalation based on Division below:

Advisor / Co-ordinator	Division	Email – phone number
Trudy Jouxson – Advisor Melanie Evans – Co-ordinator	ASCR	Trudy.jouxson@nbt.nhs.uk Tel: 01174145984 Melanie.evans@nbt.nhs.uk Tel: 01174145982
Trudy Jouxson – Advisor Siretta Francis – Co-ordinator	Medicine	Trudy.jouxson@nbt.nhs.uk Tel: 01174145984 Siretta.francis@nbt.nhs.uk Tel: 01174145988
Joe Marriott – Advisor Siretta Francis – Co-ordinator	NMSK	Joseph.marriott@nbt.nhs.uk Tel: 01174145991 Siretta.francis@nbt.nhs.uk Tel: 01174145988
Joe Marriott – Advisor Melanie Evans – Co-ordinator	Core Clinical	Joseph.marriott@nbt.nhs.uk Tel: 01174145991 Melanie.evans@nbt.nhs.uk Tel: 01174145982
Joe Marriott – Advisor Melanie Evans – Co-ordinator	W&C	Joseph.marriott@nbt.nhs.uk Tel: 01174145991 Melanie.evans@nbt.nhs.uk Tel: 01174145982

eRostering Responsibilities

- It is the eRostering teams' responsibility to ensure that any changes to the generic rota pattern is updated and built into the eRoster system.
- They will also ensure that all junior doctors are sent their log in details to the eRostering system to enable them to view their shifts, and that annual leave and study leave entitlements are uploaded to individual accounts.
- eRostering will assist and support rota coordinators / departments with any issues queries around the rostering system and the issuing of the rosters to the individual doctors. Requests for support can be raised via the service desk https://servicedesk.nbt.nhs.uk/app/hrsupport/HomePage.do
- If urgent support is required, or issues need to be escalated contact the eRostering & eJob planning manager.

Timeline

- eRostering will make any necessary changes to rostering patterns/ shift types etc on receipt of e-rota work schedule provided by Medical Workforce. This will be completed 10 weeks prior to rotation.
- eRostering will upload all annual leave and study leave to the doctors eRoster account 8 weeks prior to rotation, on receipt of the information from the department.
- eRostering will also ensure that all doctors are sent their eRoster log in details at least 6 weeks prior to rotation to enable them to view their shifts once published.

Further escalation for assistance with the system below:

Katherine Bryce – eRostering Manager	Katherine.Bryce@nbt.nhs.uk	0117 4148752
Claire Davies – eRostering facilitator	Claire.Davies@nbt.nhs.uk	0117 4148759
Nicholas Standen - eRostering facilitator	Nicholas.Standen@nbt.nhs.uk	0117 4148697
Nuno Cruz - eRostering facilitator	Nuno.Cruz@nbt.nhs.uk	0117 4148754

Samantha Howard - eRostering facilitator	Samantha.Howard@nbt.nhs.uk	0117 4148759

Please note – There will be departments who do not use Healthroster or any rostering system. All the timeline principles apply to all rota distribution regardless of the format in which rotas are provided.

Department Responsibilities

- It is the Specialties (Clinical Leads and Rota Co-ordinators) responsibility to ensure that they provide Medical Workforce with the correct rota prior to the issuing of Work Schedules and that individual rotas are sent to junior doctors by the contractual deadline of 6 weeks. In the event of these deadlines being unachievable the department will escalate issues through the routes and timelines outlined below.

Timeline

- Will issue Medical Staffing with the generic rota at least 12 weeks before rotation
- Contact all new doctors to give them department info and advise on deadline for submitting leave dates at 12 weeks before rotation
- Provide eRostering with annual and study leave allowances via the Service Desk at least 8 weeks before rotation (https://servicedesk.nbt.nhs.uk/app/hrsupport/HomePage.do).
- Will confirm to Medical Workforce and eRostering that they have all the information needed to allow them to publish rotas at least 8 weeks before rotation.
- Rotas are published or sent manually to junior doctors before the 6 week deadline.

Escalation points for Specialty Rota Co-ordinators if issues are not being resolved are:

- Medical HR Manager
- General Manager
- People Partner
    - These individuals must be contacted in the event not having the required information to enable them to meet the above deadlines at a minimum of 2 weeks before said deadline.

At least one week before each deadline the information is still not available issues must be escalated to the Clinical Director, Guardian of Safe Working and Associate Director of Medical Workforce.

Late appointments or rotational doctor names from HEE

- There will be occasions where local appointments are made after the 8 and 6 week deadline for issuing work schedules and rotas. In these cases the generic workforce for that rota will have already been created and can therefore be supplied to the appointed doctor on issuing of their offer letter.
- Rota slots will also have been allocated by the 6 week deadline and when appointments are post 6 weeks the rota slot will be left empty. This must not prevent the issuing of rotas of all those doctors already appointed. The newly appointed doctor will be allocated a vacant slot by Specialties and this will be issued by the department when appointment is confirmed.
- The above will apply to late notification of rational appointments from HEE.

Failure to meet these contractual deadlines

- The Guardian of Safe working can levy fines against departments who persistently fail to meet the contractual provisions outlined in the “Code of Practice”. In addition this can also be applied if there is proven detriment to the junior doctor contractually i.e. missed significant event leave, and childcare issues.
- Persistent failure to meet these deadlines will be reported through the Guardian of Safe Working Trust Board report.

NHS North Bristol NHS Trust

MEDICAL ROTATION MILESTONE DATES

NBTCARES

DEPARTMENT DEADLINES

12 WEEKS

Issue Medical staffing with new generic rota.

Write to all DiT to give deadline for leave applications

8 WEEKS

Issue eRostering with annual / study leave entitlement

7 weeks

Confirm to Medical staffing they have all required information to issue rota

+ 6 weeks

Publish rota's on eRoster or send paper rota.

DEADLINE MUST NOT BE MISSED UNDER ANY CIRCUMSTANCES –

FAILURE TO MEET DEADLINE COULD RESULT IN DEPARTMENT FINES WHERE DETRIMENT IS PROVEN TO THE TRANEE

MEDICAL STAFFING DEADLINES

NHS North Bristol NHS Trust

16 WEEKS

Engage with depts to identify any changes in rota patterns

8 WEEKS

Work schedule issued

DEADLINE MUST NOT BE MISSED UNDER ANY CIRCUMSTANCES

8 weeks

Final deadline for all doctors names and grade is entered onto eRoster

7 weeks

Medical staffing will contact a Depts to ensure they have all the info needed to publish rotas

NBTCARES

EROSTERING DEADLINES

NHS North Bristol NHS Trust

10 WEEKS

Make necessary changes to rota patterns

8 WEEKS

Will upload annual leave and study leave entitlements

+ 6 weeks

Ensure that log in details are communicated to all new starters

NBTCARES

NHS North Bristol NHS Trust

Report To:	Trust Board		
Date of Meeting:	24 Nov 2022		
Report Title:	Freedom to Speak Up Bi-Annual Report November 2022		
Report Author & Job Title	Hilary Sawyer, Lead Freedom to Speak Up Guardian		
Executive/Non-executive Sponsor	Xavier Bell, Director of Corporate Governance & Trust Secretary		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose	**Approval**	**Discussion**	**To Receive for Information**
		x	

Recommendation:

Board is:

Asked to:
Review and discuss the updated FTSU data, trends and themes

Asked to note:

- Improvement in awareness and understanding of FTSU including through Speak Up Month and launch of the FTSU e-learning modules as mandatory in October
- The need for clear follow-up response and actions by managers and leaders to issues raised
- Expansion of the FTSU Champion network and Speak Up Month activity (Appendix 1)
- Publication of updated NHSE FTSU guidance, policy and FTSU reflection and planning tool to help deliver the NHS People Promise that every voice counts.
- NBT's FTSU policy has been re-drafted consistent with the new NHSE policy, which focuses on the importance of inclusive and consistent speaking up arrangements driving learning through listening. We are aiming for this to be active by the end of 2022.

Reminded to:

- Complete the HEE/NGO FTSU e-learning modules including the 'Follow-up' module for leaders, as committed to in May 2022
- Role-model and regularly communicate the value to NBT of workers speaking up, consistent with NBT's refreshed Values and Behaviours Framework, encouraging workers to feel empowered and safe to do so.

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	Asked to: • Support inclusion and consultation with the FTSU Guardian in training for management and leadership development plans on speaking up, listening up and follow up learning culture • Ensure adequate resourcing of the FTSU Lead Guardian role in terms of hours, and other support (including communications)
Report History:	This is a bi-annual report to Trust Board. The last report was in May 2022.
Next Steps:	• See body of report

Executive Summary

Effective speaking up arrangements help protect and improve patient safety and support and improve the experience of NHS workers through empowered, respected, and valued worker voice. Freedom to Speak Up Guardians proactively promote a 'business as usual' speaking up culture for continuous learning through listening, active response and positive cultural change.

Summary position on 2022/2023 data

The data show a drop in the number of concerns in Q1 2022/23, followed by increase in Q2 and subsequently into October 2022 (possibly reflecting increased awareness and Communications in Speak Up Month, and increasing pressures within the workforce).

This report:

- Outlines the most recent information around concerns being raised
- Highlights progress, planned next steps, and suggested actions for NBT Leadership

Key themes from the last six months:

- Patient flow and safety risks in AMU, wards and escalation areas
- Bullying/harassment from colleagues
- Timeliness/effectiveness/responsiveness of management communication
- Inappropriate attitudes/behaviours from colleagues or manager
- Staffing levels and patient safety
- Turnover/retention, staff morale and wellbeing
- Recruitment process consistency, fairness, transparency
- Opportunities for progression and retention
- Management processes/response/fairness having impact on staff
- Parking arrangement clarification

Risks	Freedom to Speak Up is an important mitigation for the Recruitment and Retention risk recorded on the Board Assurance Framework The Care Quality Commission (CQC) assesses a Trust's speaking up culture under the Well-Led domain of its inspections
Financial implications	The FTSU role is currently funded at 0.6 WTE. This needs to be reviewed for 2023 in light of the increasing workload and benchmarked against other NHS organisations and regulatory expectations.

Equality, Diversity and Inclusion Assessment (EIA)	Freedom to speak up relies upon a fair, inclusive and open culture that supports all staff, including those with protected characteristics, to speak up and bring diversity of voice and experience. Demographic/equalities data of staff speaking up is challenging to collect robustly; this is being reviewed with the aim to improve and provide more detail in future. The Trust is working to gradually improve the diversity and representation of all staff groups within the FTSU network.
Appendices:	Appendix 1: Summary of Speak Up Month 2022 activity

1. Purpose

1.1 The purpose of this report is to update the Board on Freedom to Speak Up (FTSU) activity at North Bristol NHS Trust (NBT) over the past 6 months: including 1) the number and types of concerns raised trends, themes and learning; comparing this activity to the national picture and relevant internal data; 2) update on actions taken to further improve Speaking Up culture, 3) to provide assurance and make recommendations to the Board and NBT Leadership.

2. Background

2.1 Freedom to Speak Up Guardians were introduced to NBT from November 2017. The number of volunteer Guardians has varied and is now four, with an increasing network of FTSU Champions being recruited to increase visibility, awareness, reach and diversity, and to support engagement and accessibility of FTSU. A (0.6WTE) substantive Lead Guardian role was introduced in mid-January 2021.

2.2 The Lead Guardian role brings ring-fenced time to support:

- NBT workers to be able to speak up (including awareness and response)
- a positive speaking up culture of continuous learning through listening and response
- the organisation in becoming a more open and transparent place to work, where staff speaking up is highly valued, influencing the organisation's improvement
- training for managers and leaders in 'listening up' and 'following up'
- identification and actions addressing any barriers to speaking up
- assessment of trends and responses to issues being raised

and hold the Board to account for taking appropriate action to create a positive speaking up culture across NBT.

2.3 This FTSU network of Guardians and Champions meets quarterly to discuss data, themes, actions and support needed, with the Senior Lead for FTSU and the NED for FTSU, and representation from Staff Side.

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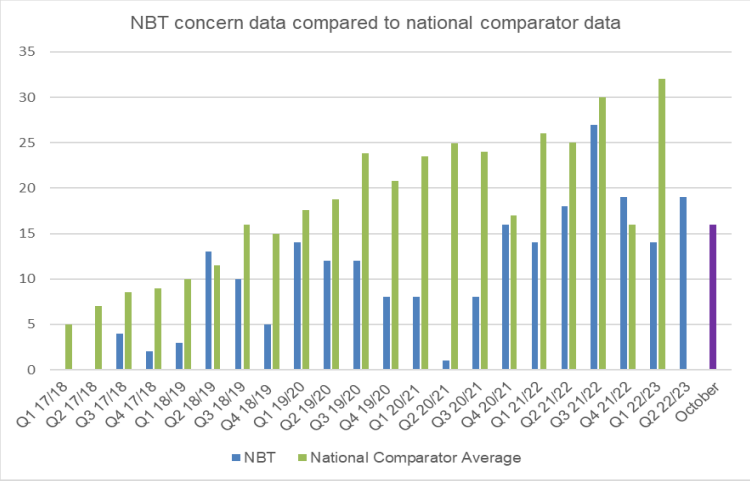
3 How NBT Compares to the National Picture; An update of NBT FTSU data and themes vs. national benchmarking:

3.1 Chart 1 shows the comparison with the national average for Medium Acute Trusts. National data is only available currently to Q1 2022/23. The data show that the number of concerns raised at NBT remains at a higher level since introduction of the Lead Guardian role, with a drop in concerns compared to the estimated national average in Q1 2022/23. There was an increase in concerns in Q2 and subsequently into October 2022 (possibly reflecting increased awareness and Communications in Speak Up Month).

3.2 The national data shows a large range in number of concerns raised in comparator organisations with various factors influencing this, including whether an anonymous concerns-raising App is in use.

Chart 1: Number of concerns per quarter NBT v Mid-Acute National Average since Q2 17/18



3.3 The number of cases is only one measure; cases can be complex and involve several colleagues and multiple interactions over an extended period before a robust outcome is achieved.

3.4 Appropriate to the issues raised and the support that the individual wants, support may be listening and advice, support for the individual to action/challenge themselves, or escalation for action and response.

3.5 The majority of concern cases have been dealt with by the Lead Guardian.

3.6 In addition to the above, FTSU Champions have been approached for advice, support and signposting.

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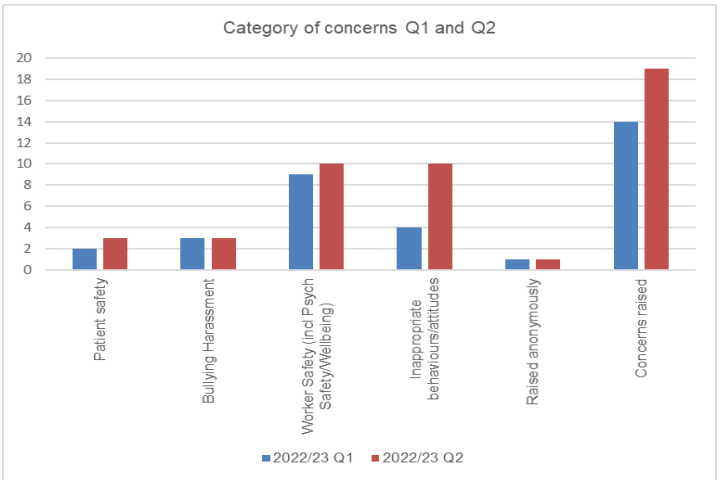
4 A closer look at NBT's data:

Chart 2: 2022/23 Q1 and Q2 data by type of concern:



4.1 From April 2022 the NGO guidance included a category for "Inappropriate attitudes and behaviours", in addition to Patient safety/quality, Bullying and harassment, and Worker safety/wellbeing categories.

4.2 As has been shown nationally, since Q1 more concerns have since been categorised in this newest category and/or worker wellbeing, rather than as bullying or harassment (Source: NGO communication bulletin to FTSU Guardians).

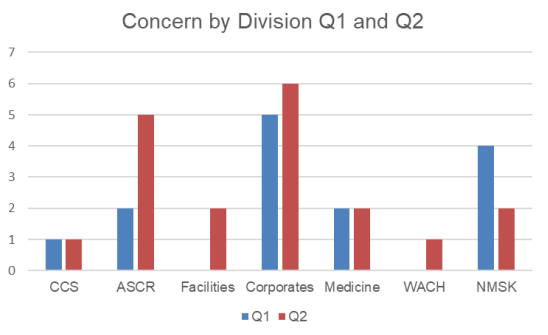
4.3 A case may include elements of patient safety/quality, bullying or harassment, and/or worker safety, as well as other matters. All categories that apply for each case must be recorded.

4.4 Taken together the vast number of concerns relate to behaviours and relationships. Some concerns have recorded the knock-on effect to patient safety of these issues. The themes of concerns are discussed further below.

4.5 **Chart 3: 2022/23 Q1 and Q2 data by worker group raising concerns**
Chart 4: 2022/23 NBT Concerns raised by Division/Directorate

Chart 3:

Chart 4:



4.6 Concerns have been raised across all Divisions although in varying numbers. In Q1 unusually there were no concerns raised with a Guardian; the volunteer Guardian based in Facilities was on leave and contacts were made to FTSU Champions for support.

4.7 Themes of FTSU Concerns in the last six months (and from anecdotal conversations):

- Patient flow and safety risks in AMU, wards and escalation areas
- Bullying/harassment from colleagues
- Timeliness/effectiveness/responsiveness of management communication
- Inappropriate attitudes/behaviours from colleagues or manager
- Staffing levels and patient safety
- Turnover/retention, staff morale and wellbeing
- Recruitment process consistency, fairness, transparency
- Opportunities for progression and retention
- Management processes/response/fairness having impact on staff
- Parking arrangement clarification

This appears to correlate with themes of issues raised with our Trade Union colleagues.

4.8 **Leadership/management behaviours/responsiveness appears to be a major overarching theme**. This is not to say this is deliberate non-compassionate action/response but likely a reflection of pressures and demands but suggests a need to be able to invest some time and energy into supporting staff.

4.9 **Anecdotally raised themes** (issues and topics raised informally during team/ward visits and engagement events):

- Staffing level concerns across professions/staff groups and across sites
- Staff feeling at risk of blame if not skilled for other wards moved to or unwelcomed on other wards
- Other staff groups concerned for nursing and support worker colleagues on the wards
- Flow aspects with bed occupancy, discharge capacity, SDEC, AMU corridor and patient dignity
- Turnover, morale and opportunity elsewhere
- Flexible working need
- Civility between colleagues and in connection with patients/families
- Frustration in career progression
- Presence and attitude of managers
- Space and time for peer reflective practice and wellbeing support
- Need for better dissemination of information to staff
- Cost of living pressures
- Support for international nursing and medical staff (training, career and wellbeing)
- Times for accessing wellbeing offers, training and CPD opportunities

Further feedback is also being collated coming through a Speak Up Month exercise (see appendix 1)

Staff have expressed on walkarounds that they are more aware of FTSU/speaking up; some have suggested that they feel their line (middle) managers do their best to respond to concerns raised directly with managers locally, but that they feel the thematic response needs to come from higher management layers. There is still a commonly expressed view of 'what is the point in saying anything, nothing will change'.

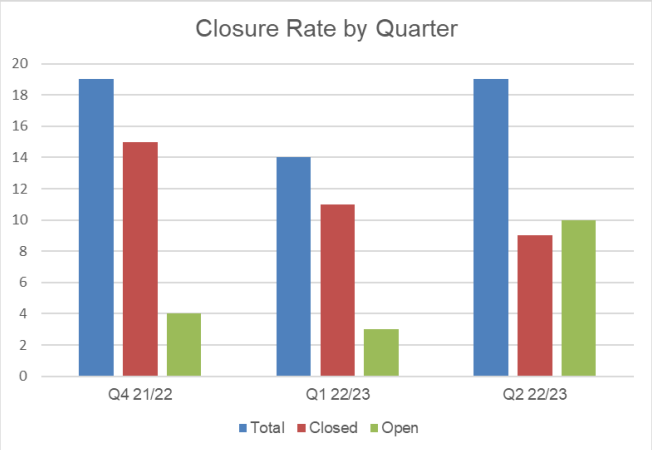
4.10 **Anonymous cases:** two cases have been raised anonymously to a Guardian during 2022/23 to date.

4.11 **A majority of concerns were raised confidentially;** only seven concerns were dealt with openly during this period. Concern resolution is more effective and efficient when issues can be dealt with openly. It is recommended that this should be an area of organisational focus within NBT to ensure staff feel able to raise matters openly with no fear of any disadvantageous treatment. This should be strongly role modelled by NBT's leadership as an expectation of all managers.

4.12 **Case closure:** An action from the 2022 Internal Audit was to include monitoring of response times and concerns closure rates from Q4 onwards in the report to Board. The

majority of cases from Q4 2021/22 and Q1 2022/23 have been closed; those remaining open involve more complex issues. Average time to closure of concerns raised from Q4 2021/2022 to Q2 2022/23 was 52 working days.

4.13 **Chart 5: FTSU Closure Rate Q4 2021/22 onwards:**



4.14 **Satisfaction levels with the FTSU Service 2022/23:** it has not been possible to obtain a response for all concerns, however of those that responded to the question: 'Given your experience, would you speak up again?' all responses were 'Yes'

Recent feedback:

- The FTSU service was brilliant and I would definitely use the service again if needed.
- I'm extremely grateful for the Guardian's help and support.
- I was treated with respect and reassured that this was confidential.
- I was given space to consider what I wanted to do without pressure.
- Thank you to the Guardian for supporting a way forward.
- I was extremely grateful for help, advice and support on this matter and can only thank you.
- Thank you for taking time to listen and help centre my thoughts and decide next steps.
- It was really helpful to be listened to, helping me process my feelings and order my thoughts about appropriate action, or otherwise.
- The Guardian's time, effort, care and support has been really appreciated.
- Thank you for your understanding and care about culture at NBT around staff welfare and your help in how to deal with things.
- I would use the FTSU process again and have encouraged others to use it since.
- I was grateful to have someone to speak through my issue with and happy that the best person to speak to was found.

4.15 **Disadvantageous treatment (detriment):**
To date there have been no incidences of disadvantageous treatment reported for concerns raised to date in 2022/23.

4.16 **FTSU Reflection on Opportunity:**

Behind the above data and each concern is a staff experience story, each of which is a learning opportunity for NBT.

We are all under sustained pressures to deliver services that put the patient first, as well as supporting each other to thrive together.

Our Restorative Just Culture and FTSU aligned Vision is that 'NBT is a safe and fair place where everyone's voice is encouraged, valued and listened to, helping us to continually learn and improve'. The NHS People Promise is that 'we each have a voice that counts'. If we can work together with compassion and without defensiveness, it will feel safer for matters to be dealt with openly without fear.

The reports of failings in recent investigations such as the Kirkup report on East Kent maternity and neonatal services and the Ockenden review serve as reminders of the vital importance of staff feeling able to speak up, active listening, and effective response.

It is suggested that NBT ensures investment in time for joined up, reflective training, supporting the skills and responsive approaches for managers and leaders to understand and feel this value.

4.17 **Key FTSU Q1 and 2 Actions:**

- **Expansion of the FTSU Champion network -** a further 11 voluntary FTSU Champions have been appointed and trained in October/November.
- **Increased awareness through walkarounds, drop-in events** including wellbeing events in WACH and Cossham, and student training
- **FTSU refreshed policy drafted**
- **Speak Up Month activity (Appendix 1) including mandatory FTSU e-learning launch** appears to have been successful in continuing to raise awareness and understanding; Communications apprentice project support for this period was invaluable
  - **Mandatory FTSU e-learning launch:** There have been 876 completions of FTSU e-learning modules, including 821 completions of the speak-up core module, 44 Listen up module completions (for managers), and 11 of the Follow up module for senior leaders

4.18 **Key focus and next steps advised for the organisation:**

- Clear communication by timely feedback response and actions to staff speaking up, including for system/national challenges, no matter the route of speaking up (whether locally, to organisational themes from employee feedback or through FTSU) to build confidence so that workers continue to believe that NBT values worker voice for safety, wellbeing and improvement
- Clear messaging from leadership that there will be zero tolerance of disadvantageous treatment of anyone speaking up
- Corporate and clinical education teams to proactively work with the Lead Guardian to embed blended FTSU training for workers (including internationally educated nurses and medical workers), managers and leaders (and further communication of the Listen Up and Follow-up e-learning modules)

- Leadership to complete the three e-learning modules; current completion rates are low
- Ensure adequate resourcing of ring-fenced time for the Lead FTSU Guardian through consideration of additional hours and possible additional ring-fenced hours for another Guardian for:
    - Time to respond to an increased number of concerns well
    - Time and space to hold the clear big picture vision of a healthy speaking up learning culture while responding to and managing the concerns, relational working at all levels and supporting culture development including breaking down barriers
    - Robust and timely ability to action and follow up through managers and leaders across the organisation (including emerging themes and risks) and subsequently with the person speaking up
    - Resourcing of time and resources for proactive culture work around FTSU
    - Ensure FTSU Guardian wellbeing and support including ability to stay energised
- Consider how stakeholders in employee voice/engagement/cultural improvement development across the Trust engage best as a working alliance together for thematic organisational learning e.g., Civility work, promoting positive and inclusive behaviours

5. Recommendations

The Trust Board is asked to:

- Consider action Trust leadership can take to communicate clear response and actions to key themes of concerns and issues raised, and hence the value of worker voice and speaking up in influencing the organisation
- Complete the FTSU e-learning modules including the 'Follow-Up' module
- Role-model and regularly communicate the value to NBT, of workers speaking up, consistent with NBT's refreshed Values and Behaviours Framework
- Support assurance of the importance of inclusion and consultation with the FTSU Guardian in training for management and leadership development plans
- Ensure adequate resourcing of the FTSU Lead Guardian role in terms of hours, wellbeing and communications support (hours and printing etc)
- Contribute to the FTSU reflection and planning tool including via a survey ahead of a Board development seminar in May 2023

Appendix 1: Summary of Speak Up Month 2022 activity

The NGO's overall theme this year was **"Freedom to Speak Up for Everyone"** with each week having a specific focus:

- **Week 1: Speak Up for Safety**
- **Week 2: Speak Up for Civility**
- **Week 3: Speak Up for Inclusion**
- **Week 4: FTSU for Everyone**
- 

Speak Up Month 2022 activities at NBT included opportunities to:

- **Learn more about what speaking up is about and mandatory launch** (including video by Steve Hams and Jacqui Marshall) of the Freedom to Speak Up (FTSU) e-learning modules; Speak Up, Listen Up, Follow Up
- **Engage with the lead FTSU Guardian, Guardian and Champion network members through walkabouts and drop-ins**, to learn more, reflect current issues and how workers feel the speaking up and listening up environment is here at NBT
- **Continuing to gradually evolve our FTSU Champion network** to provide representative and accessible points of contact to support workers speaking up
- **Raised awareness through various communications** on LINK What's New page, operational bulletin, Maria's midweek message, Staff Facebook group, Twitter including information about what Guardians and Champions do (and the differences)
- Further developed related content on the FTSU LINK pages

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Drop-in sessions included:

- Joint drop-in information stalls outside Vu with People teams in #SpeakUpforCivility week and resources on LINK
- In #SpeakUpforInclusion week supported BAME network leads drop-in clinic on Monday evening and provided a staff networks engagement drop-in space
- #FTSU for everyone week included information provision for agency workers and a sessions for the patient and carer partnership group

Walkarounds included visits to:
Wards including Elgar, WACH, Discharge and CSM teams, Switchboard, Ambleside, Pathology, Kendon House teams, Facilities, L&R, Cossham teams

- Support from Maria Kane, Steve Curry, Steve Hams, Xavier Bell.
- Shadowed a visit to Retained Estates portering by Glyn

Medicine ward 'Listening Tree' exercise:

Following a Nursing and Midwifery Staffing Summit in mid-September, a follow-on appreciative exercise has been conducted on Medicine wards in October Speak Up month by encouraging staff voice contributing positive improvement ideas. These ideas will be collated with the aim of a 'You spoke up, we listened, we followed up and responded' approach. This can potentially be extended to other Divisions.

National Guardian Office (NGO) podcasts during October Speak Up Month:

- NGO #SpeakUpforSafety podcast with Dr Henrietta Hughes, Patient Safety Commissioner
- NGO #Speak Up for Civility podcast with Chris Turner (from Civility Saves Lives)
- NGO #SpeakUpforInclusion podcast with Lord Victor Adebowale, Chair of NHS Confederation
- NGO #FTSUforEveryone podcast with Danny Mortimer, CEO of NHS Employers and Deputy CEO of NHS confederation

National Guardian's article: We all have a duty to speak up for safety, civility and inclusion | HSJ Partners | Health Service Journal

Report To:	Trust Board - Public		
Date of Meeting:	24 November 2022		
Report Title:	Quality Committee Upward Report		
Report Author & Job Title	Aimee Jordan, Senior Corporate Governance Officer & Policy Manager		
Executive/Non-executive Sponsor (presenting)	Sarah Purdy, Non-Executive Director and Chair of QC		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
	X		
Recommendation:	The Trust Board should receive the report for assurance and note the activities Quality Committee has undertaken on behalf of the Board.		
Report History:	The report is a standing item to the Trust Board following each Committee meeting.		
Next Steps:	The next report will be received at Trust Board in January 2022.		

Executive Summary	
The report provides a summary of the assurances received and items discussed and debated at the Quality Committee (QC) meeting held on 16 November 2022.	
Risks	Link to BAF risks: Patient Flow and Ambulance Handovers Long Waits for Treatment Covid-19 Pandemic / Infectious Diseases
Financial implications	No financial implications identified in the report.
Does this paper require an EIA?	No as this is not a strategy or policy or change proposal
Appendices:	N/A

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1. Purpose

1.1 To provide a highlight of the key assurances received, items discussed, and items for the attention of Trust Board from the Quality Committee (QC) meeting held on 16 November 2022.

2. Background

2.1 The QC is a sub-committee of the Trust Board. It meets monthly with alternating deep-dive meetings and reports to the Board after each meeting. It was established to provide assurance to the Trust Board on the effective management of quality governance and risk management.

3. Meeting on 16 November 2022

3.1 Matters Arising

The Committee received a verbal update from the Chief Nursing Officer on the Kirkrup Report and noted that a report would be brought back to the Board focusing on the lessons learned.

The Committee also discussed the status of the Trust's blood stock levels and noted that the amber alert that was triggered by the NHS Blood and Transplant service has been stood down and there were no further actions for provider organisations.

3.2 Organ & Transplant Annual Report

The Committee received this annual report covering NBT's organ donation activities for 2021/22 and it was confirmed that NBT performed in line with national best practice guidance.

The Committee supported the intention to use the dormant charity funding (£7000) for the promotion of organ donation amongst the general public, particularly with regard to sensitive and appropriate promotion around donation by children and young people.

The Committee recognised the importance of organ donation and the quality impact on patients.

3.3 Infection Prevention & Control (IPC) Annual Report Including C.Difficile update

The Committee received the Infection Prevention & Control Annual Report which summarised the work undertaken at the Trust during the period 1 April 2021 to 31 March 2022.

The Committee received assurance that the Trust maintains a 'zero tolerance' of Healthcare Acquired Infection (HCAI), and that post-infection reviews are undertaken and Trust-wide learning occurs where cases are reported.

The Committee also received a presentation on C. Difficile infection rates that highlighted the actions taken to successfully decrease C. Difficile infections.

The Committee thanked the team for their ongoing work and acknowledged the successes, particularly recognising the success of the decreased C. Difficile infection rates.

3.4 Tissue Viability Annual Report

The Committee received the annual report which summarised the work undertaken at the Trust to manage pressure injuries during 2021-2022.

The Committee welcomed the report, which provided a great deal of assurance and showed a significant reduction in pressure injuries despite not achieving a reduction in the agreed Key Performance Indicators (KPI) level.

The Committee acknowledged the successes of the team and thanked them for their ongoing work.

3.5 Regulation 28 Response

The Committee received an update on the Regulation 28 Response that was raised by the Coroner as a result of the Patient Safety Investigation, noting concerns about the quality of the investigation and the learning opportunities. It was recognised that the investigation did not fully explore the risk assessment process the ward team followed.

The Committee received assurance regarding the standard and quality of patient safety investigations at the Trust and noted the recent positive internal audit into PSIRF that receive a 'significant assurance with minor improvements required' finding.

The Committee agreed that the current governance model for patient safety investigations would be reviewed to look at opportunities for improvement.

The Committee requested that a focused review of the falls risk assessment and intervention be brought to a future committee for further discussion and assurance.

3.6 CQC Assurance

The Committee received an update which covered:

- A brief update on the Trust's ongoing engagement with CQC inspectors, which continued to be helpful and constructive.
- An update on the feedback following the CQC Monitoring Visit to the Urgent and Emergency Care
- The publication of the 2022 CQC State of Health Care and Adult Social Care Report.

Discussion focused on the “moral injury” element of the UEC report and the importance of understanding the impact of the current issues on staff wellbeing and following up on the issues with increased transparency.

3.7 Paterson Inquiry – final report

The Committee received the final report on the Patterson Inquiry and discussed the measures implemented such as the changes to the consent policy, changes to the appraisal process and the establishment of the Medical Staff Decision-Making Group to share learnings and review potential or actual concerns with practice & safety to practice implications with UHBW, Spire and Nuffield hospitals.

The Committee received assurance that each recommendation from the independent Paterson Inquiry report has been addressed and long-term measures have been implemented including the Consent and Shared Decision-Making programme.

3.8 Risk Report – Quality and relevant BAF Risks

The Committee reviewed the Trust Level Risks (TLRs), including patient safety and patient experience risks and the Board Assurance Framework (BAF) risks across its areas of responsibility.

The Committee discussed the highest-scoring patient safety risks and were reassured that the workplan would be reviewed to ensure that the agenda reflected the risks on the risk register.

The Committee recognised that the BAF risk relating to respiratory illness and Covid-19 remained under review and noted the potential for it to increase as a result of the winter period.

3.9 Clinical Policies Update Progress Report

The Committee received an update on the progress of the clinical policies and received assurance that positive progress has been made to reduce the backlog of policies past review date.

3.10 **Other items:**

The Committee also received the following items for information:

- The Committee receive updates on the Trust’s Never Events.
- Sub-committee upward reports:
    - Drugs & Therapeutics HLR's
    - Patient Safety & Clinical Risk Committee
    - Clinical Effectiveness & Audit Committee
- Quality Committee forward work-plan 2022/23

4. Identification of new risk & items for escalation

No specific new risks identified.

5. Recommendations

The Trust Board should receive the report for assurance and note the activities Quality Committee has undertaken on behalf of the Board.

NHS North Bristol NHS Trust

Report To:	Trust Board - Public		
Date of Meeting:	24th November 2022		
Report Title:	Reading the signals Maternity and neonatal services in East Kent – the Report of the Independent Investigation.		
Report Author & Job Title	Fiona Scriven, Quality Lead for Women's, and Children's Lauren Oakes, Programme Manager Jessica Pepler, Continuous Improvement and Learning Lead		
Executive/Non-executive Sponsor (presenting)	Prof. Steven Hams, Chief Nursing Officer		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	Trust Board is asked to: • Note the findings and recommendations of the Kirkup Report. • Note the actions required in response to the recommendations. • Consider the organisational approach to reputation management. • Consider if the Board has sufficient representation of maternity care. • Receive a thematic analysis of the Ockenden and Kirkup Reports at the January 2023 meeting.		
Report History:	The Kirkup report was published on 19th October 2022. This paper provides a summary of the report and any immediate actions required of the organisations.		
Next Steps:	The Women's and Children's Division are undertaking a detailed gap analysis of the Kirkup report, this will be presented to the Quality Committee. The Board will receive a thematic analysis of the Ockenden and Kirkup reports, which will offer the opportunity for the Board to consider its assurance mechanisms and insight into our maternity services.		

Executive Summary

North Bristol NHS Trust

"Reading the signals: Maternity and neonatal services in East Kent - the Report of the Independent Investigation" (known as the Kirkup Report) was published on 19th October 2022. It involved the detailed review of 202 cases, of which 48% could have had a different outcome if it was not for failures in:

- Teamworking
- Professionalism
- Compassion
- Listening
- The Trust's response to safety incidents, including learning following safety incidents and the Trust Board's response

Four key areas for action were identified focussing on monitoring performance, standards of clinical behaviour (including professionalism), teamworking, and organisational behaviour (including response to safety incidents).

The report made five recommendations, only one of which (the second part of Recommendation 4) is aimed at trusts: "Trusts be required to review their approach to reputation management and to ensuring there is the proper representation of maternity care on their boards."

The two immediate actions for consideration are:

- The organisational approach to reputation management.
- Consideration if the Board has sufficient representation of maternity care

Risks	Nil
Financial implications	Nil
Does the paper require an Equality, Diversity, and Inclusion Assessment (EIA)?	Not required
Appendices:	The report can be accessed here

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1. Purpose

1.1 This paper summarises the report into the maternity and neonatal services in East Kent (known as the Kirkup Report, after Dr Bill Kirkup who led the review).

1.2 This paper details the findings (referred to as Key Action Areas), recommendations and NBT's actions, where applicable.

2. Introduction to the Kirkup Report

2.1 The report was published on 19th October 2022. Its full title is "Reading the signals: Maternity and neonatal services in East Kent - the Report of the Independent Investigation".

2.2 The report reviewed 202 cases and concluded that the outcome could have been different for 48% of these cases if care had been given to nationally recognised standards. It specified failures in the following areas:

- Teamworking
- Professionalism
- Compassion
- Listening
- The Trust's response to safety incidents, including learning following safety incidents and the Trust Board's response

2.3 The report criticised the Trust for treating each case as "just another one-off" and states that "they ignored the warning signs and strenuously challenged repeated attempts to point out problems".

2.4 Similarly, the report recognises that this is the latest in several "major service failures" including at Shrewsbury and Telford and those assumed failures which have triggered the upcoming report about Nottingham's services. As a result, the report has identified four key areas for action with a total of five recommendations that aim to address "very difficult and uncomfortable issues" that Dr Kirkup considers will lead to repeated failures if unresolved.

3. Key Action Area 1: Monitoring safe performance - finding signals among noise

3.1. The review found that maternity services collect a large amount of data, but that the significance of a majority of this is "dubious". It also expressed concern that some measures "conceal" the meaning of the data due to their presentation in larger unrelated groups, for example, the significance of the number of safety incidents could be concealed within the reporting of perinatal mortality. This can lead to false reassurance of performance.

3.2. The review also identified difficulties in reporting this data in a meaningful way, as a comparison between units can lead to "rankings" which do not specify if units are outliers (positive or negative) due to practice or due to chance.

3.3. The review concludes that effective monitoring of outcomes has huge benefits for clinicians, leads, managers, Boards, and regulators, by enabling conversations about safety performance informed by relevant data. The review suggests that measures used in the future are required to be readily available (and ideally already routinely collected), meaningful and risk-adjustable.

3.4. The review acknowledges that identification of valid measures is difficult due to the (mostly) physiological nature of pregnancy and childbirth, and the fact that poor outcomes are less common

4. Key Action Area 2: Standards of clinical behaviour - technical care is not enough

4.1. The review describes how caring for patients is a technical skill that requires competence but that it also requires kindness and compassion. Unfortunately, the review heard many "graphic accounts" from families and staff that described care well below expected and required standards. It also recommends that it is not assumed that such failures are isolated to the Trust.

4.2. The review specifies a lack of compassion both between staff members (also described as "unprofessional conduct") which impacts on safe and effective working, and a lack of compassion and kindness when caring for women and their families. This was described both during care where a failure to listen meant vital information was ignored impacting on patient safety, but also in the aftermath of safety incidents which prolonged the harm to families.

4.3. The review also describes how role-modelling impacts on good clinical behaviour, as more junior staff were exposed to senior colleagues' behaviours creating a "negative cycle of declining standards". This then led to the "normalisation" of these behaviours which resulted in acceptance and embedding of them as "the way we do things here [East Kent]".

4.4. The review acknowledges that compassion should be the heart of all clinical care, but these poor behaviours displayed are difficult to correct, especially when displayed by a minority of consultants who use their status as a "shield" when challenged. The review recommends that "reasonable and proportionate" sanctions be required in order to address poor behaviours before they are embedded and deter "defiant reactions to challenge".

4.5. The review notes that role-modelling, exposure, and observation are far more effective than classroom teaching. It is particularly important that staff are taught about compassionate care and professional behaviours early in their training and careers, and that this is then further embedded in all continuous professional development opportunities.

4.6. The review described a need to change the perception of some staff about those in clinical leadership roles. These roles are "integral to the effective and safe functioning of services" requiring the appropriate skills and time to be undertaken effectively. This is not always understood or accepted by clinicians.

5. Key Action Area 3: Flawed teamworking - pulling in different directions

5.1. The review emphasises that clinical care is incredibly reliant on effective teamworking between different groups of professionals, especially in perinatal care, and it recognises that “flawed teamworking” has been a significant finding in almost every failed maternity service.

5.2. The review found dysfunctional teamworking within and across professional groups, including between midwifery and obstetric staff, and between obstetric and neonatal staff. It describes “many examples” that resulted in conflict, prevention of information sharing, vulnerable staff, complacency and a lack of accountability. The review criticised that the lack of teamworking between areas and professional groups resulted in a blame culture following safety incidents, often aimed at the most junior midwife or doctor involved.

5.3. The review acknowledged that the divergence between professional groups is particularly striking in maternity care, resulting from a “struggle for ‘ownership’ of maternity care” as opposed to working towards a common goal. The review emphasised that this is often reflected in the language used when discussing birth which can expose women to risk to both their physical and mental health.

5.4. The review commented that the effects of this were particularly noted amongst the obstetric trainees who felt pressurised, unsupported, and obliged to carry out tasks before achieving competence. This resulted in (and was compounded by) recruitment difficulties and the overuse of locum doctors. The review also raised concerns about the assessment and competency of locum doctors, and the current patterns of working and training for junior doctors considering the fragmentation of their work and the lack of support they currently receive.

5.5. The review comments that a common goal and shared understanding would improve teamworking within maternity and neonatal care. It suggests that this would be aided by national guidance giving the same objectives for both midwifery and obstetric staff.

5.6. The review confirms that multidisciplinary training is key so that it reflects daily working with other disciplines, but that this should include opportunities to increase the understanding of others’ roles and responsibilities and the contributions that they make.

6. Key Action Area 4: Organisational behaviour - looking good while doing badly

6.1. The review comments that reputational management is often the “default response” of many organisations scrutinised by the public, such as in the NHS. However, it is explicit in stating that this can contribute to organisational failure if it leads to “denial, deflection, concealment and aggressive response to challenge”, preventing learning and improvement. This can manifest as manipulation or misrepresentation of information, for example, to avoid inquests and scrutiny.

6.2. The review noted that NHS England are limited in what actions they can take when there are “difficulties” with clinical services. One of their only options is to replace chief executives and chairs in the hope that the incomers will be able to solve issues that others could not (described in the report as reminiscent of the “heroic leadership” model”).

However, the review commented that this often results in two consequences: halting progress towards recovery due to new ideas and new ways of working and incentivising a lack of transparency. The review recommends that NHS England review their actions, including providing support for trusts in difficulties and incentivising organisations asking for help, discouraging concealment of problems, and treating their identification as a "sign of readiness to learn".

6.3. The review states that "the need for openness, honesty, disclosure and learning must outweigh any perceived benefit of denial, deflection and concealment" and proposes legislation to oblige public bodies to be honest and open in all their interactions with families and official bodies.

7. Recommendations from the Kirkup Report

7.1. As a result of the above findings, five recommendations have been made. They are detailed below with comment of actions for NBT where applicable.

7.2. Recommendation 1

- The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.
    - This recommendation does not require action from NBT at this time, although we will welcome future recommendations of which measures to report and monitor to enable identification of areas for improvement.

7.3. Recommendation 2:

- Those responsible for undergraduate, postgraduate, and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning
- Relevant bodies, including Royal Colleges, professional regulators, and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance
    - The first point of this recommendation includes reference to "those responsible for continuing clinical education" which includes the Practice Development team responsible for maternity-specific training. The Training Needs Analysis is currently under review, compassionate care is included throughout the training programme.
    - The second point of this recommendation does not require action from NBT at this time, but we await this report and will respond to any findings and recommendations within it.

7.4. Recommendation 3:

- Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be

improved, with reference to establishing common purpose, objectives, and training from the outset.

- Relevant bodies, including Royal Colleges, professional regulators, and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance
    - The first point of this recommendation does not require action from NBT at this time, but we await this report and will respond to any findings and recommendations within it. However, we are making strides towards our maternity and neonatal services presenting as a single perinatal team, starting with the trial of Perinatal Quality Governance meetings instead of separate specialty governance meetings
    - The second point of this recommendation does not require action from NBT at this time, but we await this report and will respond to any findings and recommendations within it.

7.5. Recommendation 4:

- The Government reconsider bringing forward a bill placing a duty on public health bodies not to deny, deflect and conceal information from families and other bodies.
- Trusts be required to review their approach to reputation management and to ensure there is proper representation of maternity care on their boards.
- NHS England reconsider its approach to poorly performing trusts, with reference to leadership.
    - The first and third points of this recommendation do not require action from NBT currently, but we welcome the results of any actions at a national level.
    - The second point of this recommendation requires action from NBT.
        - NBT Maternity Services is aware that the number of reports into maternity services at present, of which the Kirkup Report is just one, has resulted in national and local media attention and public awareness and interest. The Divisional Management Team will continue to work with the NBT communications team and the Maternity Voices Partnership to develop appropriate messaging to share with women and their families, to reassure them of current NBT Maternity Services and of the learning being done.
        - The Local Maternity and Neonatal System (LMNS) has identified an underdeveloped approach to 'maternity voices' and is seeking to expedite plans to ensure women and their families across Bristol, North Somerset, and South Gloucestershire (BNSSG)are actively listened to and involved.
        - NBT Maternity Services has both Executive and Non-Executive Board Level Maternity Safety Champions, as per national recommendations. We have strong links with our Safety Champions and undertaking both meetings and walkarounds on alternate months to ensure that Maternity and Neonatal Services are represented adequately and accurately at Board meetings.
        - The Trust will need to review the approach to reputation management and consider robust representation of maternity services on the Board.

7.6. Recommendation 5:

- The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.
- This recommendation is aimed specifically at East Kent Hospitals University NHS Foundation Trust, so no action is required, but NBT Maternity Services acknowledges that it is still important that the findings and recommendations are accepted, and learning is completed from this report regardless of the Trust specified.

8. Related Activity Ongoing and Planned within NBT

8.1. In addition to the responses to the recommendations detailed in Section 7, the Key Action Areas described in Sections 3-6 have been scrutinised for learning points that are pertinent to NBT Maternity and Neonatal Services.

8.2. There are clear links between the findings regarding teamworking and ongoing work and training within the division relating to the “Civility Saves Lives” campaign.

8.3. There are planned projects within the maternity service relating to informed consent and supported decision making which will relate to the theme of ensuring women and families are listened to by clinicians.

8.4. The Royal College of Midwives has recently launched the “Rebirth Project” which reflects the findings in the report relating to language around pregnancy and birth. NBT Maternity Services will incorporate these findings into its service and training programme.

9. Summary and Recommendations

9.1. Board is asked to:

- Note the findings and recommendations of the Kirkup Report.
- Note the actions required in response to the recommendations.
- Consider the organisational approach to reputation management.
- Consider if the Board has sufficient representation of maternity care.
- Receive a thematic analysis of the Ockenden and Kirkup Reports at the January 2023 meeting.

Report To:	Trust Board		
Date of Meeting:	24 November 2022		
Report Title:	Integrated Performance Report		
Report Author & Job Title	Lisa Whitlow, Associate Director of Performance		
Does the paper contain	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	N/A	N/A	N/A
Executive/Non-executive Sponsor (presenting)	Executive Team		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to note the contents of the Integrated Performance Report.		
Report History:	The report is a standing item to the Trust Board Meeting.		
Next Steps:	This report is received at the Joint Consultancy and Negotiation Committee, Operational Management Board, Trust Management Team meeting, shared with Commissioners and the Quality section will be shared with the Quality and Risk Management Committee.		

Executive Summary	
Details of the Trust's performance against the domains of Urgent Care, Elective Care and Diagnostics, Cancer Wait Time Standards, Quality, Workforce and Finance are provided on in the Integrated Performance Report.	
Risks	The report links to the BAF risks relating to internal flow, staff retention, staff engagement, productivity, and clinical complexity.
Financial implications	Whilst there is a section referring to the Trust's financial position, there are no financial implications within this paper.
Does this require an Equality, Diversity and Inclusion Assessment?	Not applicable.
Appendices:	Appendix 1: IPR

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North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

November 2022 (presenting October 2022 data)

Contents

NHS North Bristol NHS Trust

North Bristol Trust Integrated Performance Report

NHS North Bristol NHS Trust

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Trend	Benchmarking (in arrears except A&E & Cancer as per reporting month)	
																			Peer Performance	Rank
Responsive	A&E 4 Hour - Type 1 Performance	R	95.00%	60.00%	60.82%	60.18%	61.80%	60.78%	51.53%	52.74%	55.54%	64.14%	59.32%	50.99%	60.83%	56.43%	57.47%		48.00%	2/10
	A&E 12 Hour Trolley Breaches	R	0	-	29	59	20	295	367	449	360	176	297	304	57	261	482		4-1384	5/10
	Ambulance Handover < 15 mins (%)		65.00%	-	36.19%	24.32%	20.33%	22.25%	28.72%	31.90%	28.93%	30.54%	29.50%	26.70%	25.68%	27.12%	24.42%			
	Ambulance Handover < 30 mins (%)	R	95.00%	-	56.62%	53.71%	50.34%	47.71%	48.49%	51.53%	53.02%	61.09%	55.43%	54.11%	61.52%	58.63%	48.54%			
	Ambulance Handover > 60 mins		0	-	621	664	645	827	684	681	538	430	527	486	364	439	710			
	Average No. patients not meeting Criteria to Reside			-	241	250	248	295	304	302	301	317	280	349	395	368	381			
	Bed Occupancy Rate			99.42%	97.26%	97.12%	96.92%	98.16%	97.51%	97.43%	96.94%	98.15%	98.32%	97.98%	97.86%	98.63%	98.57%			
	Diagnostic 6 Week Wait Performance		1.00%	31.87%	41.80%	40.32%	44.30%	45.45%	40.00%	40.25%	43.61%	40.13%	41.00%	42.75%	48.09%	48.27%	39.36%		35.57%	8/10
	Diagnostic 26+ Week Breaches		0	986	1286	1264	1341	1617	1767	2160	2498	2690	2761	2753	2842	3044	2755			
	RTT Incomplete 18 Week Performance		92.00%	-	70.37%	69.68%	66.67%	65.61%	65.17%	64.71%	64.23%	65.62%	64.80%	65.78%	65.82%	66.30%	66.31%		56.22%	2/10
	RTT 52+ Week Breaches	R	0	2559	2068	2128	2182	2284	2296	2242	2454	2424	2675	2914	3131	3087	3062		11-11795	3/10
	RTT 78+ Week Breaches	R		74	577	497	469	501	511	458	491	473	443	439	441	394	375		0-1667	4/10
	RTT 104+ Week Breaches	R		62	93	138	158	184	177	96	71	48	34	32	33	30	27		0-301	7/10
	Total Waiting List	R		39389	37268	37297	37264	37210	38498	39101	39819	40634	42326	46900	48766	49025	48871			
	Cancer 2 Week Wait	R	93.00%	47.03%	42.70%	53.75%	58.38%	41.42%	66.47%	69.78%	57.66%	46.16%	39.21%	40.99%	40.18%	35.85%	-		59.07%	9/10
	Cancer 31 Day First Treatment		96.00%	91.86%	88.51%	86.94%	79.59%	79.18%	89.91%	80.99%	81.82%	83.77%	85.53%	91.20%	87.36%	87.76%	-		92.54%	9/10
	Cancer 62 Day Standard	R	85.00%	70.34%	57.34%	74.07%	67.52%	56.88%	51.17%	58.66%	56.48%	50.15%	48.40%	45.10%	55.59%	58.90%	-		59.26%	6/10
	Cancer 28 Day Faster Diagnosis	R	75.00%	66.19%	59.95%	66.29%	57.52%	47.10%	72.01%	72.93%	66.82%	72.83%	70.87%	58.29%	48.83%	35.18%	-		59.78%	10/10
	Cancer PTL >62 Days		242	345	501	663	899	781	528	472	641	689	555	667	858	529	328			
	Cancer PTL >104 Days		0	50	158	108	140	197	135	167	133	161	134	172	147	123	63			
	Urgent operations cancelled ≥2 times		0	-	-	2	2	2	0	0	0	1	1	1	1	2	-			

RAG ratings are against Current Month Trajectory. For metrics with no trajectory, RAG rating is according to comparison with previous month, except for Urgent Operations Cancelled ≥ 2 times which is RAG rated against National Standard.

Performance Scorecard

NHS North Bristol NHS Trust

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Trend
Quality Patient Safety & Effectiveness	5 minute apgar 7 rate at term			0.90%	1.26%	0.22%	1.15%	0.73%	0.00%	1.02%	1.08%	0.26%	1.25%	0.49%	0.44%	0.93%	1.26%	
	Caesarean Section Rate			28.00%	37.35%	39.23%	40.60%	39.15%	38.14%	42.08%	43.36%	42.82%	46.53%	45.12%	45.01%	42.86%	43.45%	
	Still Birth rate			0.40%	0.39%	0.21%	0.21%	0.22%	0.00%	0.23%	0.24%	0.24%	0.00%	0.22%	0.00%	0.42%	0.19%	
	Induction of Labour Rate			32.10%	29.05%	34.12%	35.21%	33.56%	38.39%	39.72%	34.09%	35.41%	39.35%	35.15%	31.57%	33.33%	28.97%	
	PPH 1500 ml rate			8.60%	3.94%	3.59%	3.02%	2.01%	2.44%	1.42%	2.26%	2.39%	4.86%	4.08%	2.65%	4.11%	3.77%	
	Never Event Occurrence by month		0	0	0	0	1	0	0	0	1	1	0	0	0	0	0	
	Commissioned Patient Safety Incident Investigations				2	1	1	5	1	3	4	3	1	1	1	-	-	
	Healthcare Safety Investigation Branch Investigations				1	-	-	1	-	1	1	-	1	1	1	-	-	
	Total Incidents				984	997	1011	1329	1170	1311	1210	1129	1188	1337	1265	1110	1233	
	Total Incidents (Rate per 1000 Bed Days)				33	35	35	46	44	44	42	37	41	46	40	36	39	
	WHO checklist completion			95.00%	99.36%	99.84%	99.87%	99.76%	99.61%	98.73%	99.31%	98.85%	98.19%	98.39%	98.08%	97.58%	97.42%	
	VTE Risk Assessment completion	R		95.00%	94.53%	93.84%	94.55%	93.80%	93.99%	92.63%	93.42%	93.38%	93.59%	90.32%	89.81%	88.69%	-	
	Pressure Injuries Grade 2				19	12	16	16	19	18	19	19	14	25	16	17	14	
	Pressure Injuries Grade 3			0	0	0	0	0	0	0	0	1	1	0	0	0	2	
	Pressure Injuries Grade 4			0	0	0	1	0	1	0	0	0	0	0	0	0	0	
	PI per 1,000 bed days				0.51	0.32	0.35	0.41	0.75	0.61	0.63	0.50	0.31	0.86	0.48	0.43	0.41	
	Falls per 1,000 bed days				6.29	6.32	7.10	8.43	7.57	6.22	6.96	5.63	5.91	6.90	7.20	7.25	6.35	
	#NoF - Fragile Hip Best Practice Pass Rate				35.71%	100.00%	61.90%	64.29%	54.17%	64.58%	40.00%	42.25%	46.30%	24.24%	42.55%	18.97%	-	
	Admitted to Orthopaedic Ward within 4 Hours				28.57%	40.00%	23.81%	21.43%	20.83%	14.58%	71.11%	19.72%	22.22%	9.09%	19.57%	5.17%	-	
	Medically Fit to Have Surgery within 36 Hours				36.36%	100.00%	80.95%	69.05%	62.50%	66.67%	48.89%	45.07%	48.15%	27.27%	52.17%	22.41%	-	
	Assessed by Orthogeriatrician within 72 Hours				77.78%	100.00%	90.48%	73.81%	66.67%	89.58%	91.11%	74.65%	87.04%	75.76%	89.13%	50.00%	-	
	Stroke - Patients Admitted				90	85	73	103	67	78	92	105	40	85	68	72	43	
	Stroke - 90% Stay on Stroke Ward			90.00%	78.13%	68.06%	75.00%	67.47%	72.73%	65.08%	77.14%	48.72%	59.26%	65.45%	84.62%	68.75%	-	
	Stroke - Thrombolysed <1 Hour			60.00%	27.27%	66.67%	100.00%	84.62%	60.00%	44.44%	100.00%	60.00%	100.00%	55.56%	70.00%	64.29%	-	
	Stroke - Directly Admitted to Stroke Unit <4 Hours			60.00%	40.58%	45.95%	30.16%	40.22%	32.73%	32.81%	23.08%	35.71%	50.00%	39.29%	70.00%	46.88%	-	
	Stroke - Seen by Stroke Consultant within 14 Hours			90.00%	97.18%	84.21%	80.88%	81.44%	75.41%	91.30%	84.21%	90.91%	96.43%	96.55%	93.18%	91.67%	-	
	MRSA	R	0	0	0	0	0	0	0	4	0	1	1	-	0	0	0	
	E. Coli	R		4	8	3	2	6	1	5	5	1	4	3	3	2	2	
	C. Difficile	R		5	4	1	6	6	1	6	7	4	5	3	3	4	1	
	MSSA			2	1	0	5	3	2	2	1	2	2	0	1	8	3	
Quality Caring & Experience	Friends & Family - Births - Proportion Very Good/Good				98.53%	91.53%	93.75%	93.85%	94.37%	94.81%	97.50%	91.14%	88.41%	-	88.57%	83.33%	92.98%	
	Friends & Family - IP - Proportion Very Good/Good				92.25%	92.52%	91.50%	93.28%	93.51%	91.18%	90.39%	92.72%	90.96%	90.79%	91.04%	91.52%	91.40%	
	Friends & Family - OP - Proportion Very Good/Good				94.80%	94.21%	95.26%	94.37%	94.11%	94.82%	94.32%	93.83%	93.90%	-	-	92.76%	94.07%	
	Friends & Family - ED - Proportion Very Good/Good				73.94%	74.24%	80.64%	80.10%	70.24%	63.70%	68.93%	77.44%	70.80%	-	75.12%	72.19%	70.56%	
	PALS - Count of concerns				93	86	100	102	111	150	0	129	116	168	154	151	142	
	Complaints - % Overall Response Compliance			90.00%	69.12%	72.13%	69.09%	69.23%	80.85%	78.33%	78.57%	78.69%	73.47%	78.18%	76.27%	76.92%	75.76%	
	Complaints - Overdue				6	11	4	5	10	10	0	4	5	6	1	3	7	
	Complaints - Written complaints				44	52	58	56	43	43	0	48	53	46	62	64	77	
Well Led	Agency Expenditure ('000s)				1576	1350	1314	1363	1147	1581	1838	1846	1205	2111	1726	1292	2616	
	Month End Vacancy Factor				6.87%	6.44%	7.71%	7.26%	7.41%	7.27%	6.64%	7.51%	8.07%	8.66%	8.57%	8.65%	8.69%	
	Turnover (Rolling 12 Months)	R		16.98%	15.21%	15.27%	15.50%	15.89%	16.51%	17.16%	16.71%	17.28%	17.41%	17.57%	17.04%	17.22%	17.17%	
	Sickness Absence (Rolling 12 month -In arrears)	R		4.83%	4.56%	4.58%	4.64%	4.71%	4.81%	5.02%	5.17%	5.13%	5.22%	5.44%	5.48%	5.42%	5.49%	
	Trust Mandatory Training Compliance				82.12%	81.97%	82.13%	82.23%	82.27%	81.67%	82.38%	83.89%	84.98%	82.80%	83.56%	84.40%	83.49%	

RAG ratings are against Current Month Trajectory. For metrics with no trajectory, RAG rating is according to comparison with previous month, except for Urgent Operations Cancelled ≥ 2 times which is RAG rated against National Standard.

Executive Summary | November 2022

NHS North Bristol NHS Trust

Urgent Care
UEC pressures continued to increase in October, with The Trust recording a significant increase in ambulance handover delays and 12-Hour trolley breaches. Despite this, four-hour performance improved slightly on the previous month, reporting at 57.47% in October, and ranking second out of ten reporting AMTC peer providers. Four-hour performance and ambulance handover times continue to be impacted by high bed occupancy driven mainly by the high volume of patients with No Criteria to Reside. The Trust is working as part of the Acute Provider Collaborative to develop a joint view of the NC2R issue. Key drivers include increased volume of bed days for patients no longer meeting the Criteria to Reside awaiting discharge on D2A pathways. Trust-wide internal actions are focused on improving the timeliness of discharge, maximising SDEC pathways and best practice models for ward and board rounds to improve flow through the Hospital. The Trust is working closely with system partners to influence and support schemes which will reduce NC2R patient numbers including D2A.

Elective Care and Diagnostics
The Trust has been successful in continuing to maintain clearance of zero capacity breaches for patients waiting >104-weeks for treatment. The Trust continues to treat patients based on their clinical priority, followed by length of wait. Diagnostic performance improved significantly in October at 39.36% (6803 breaches); this improvement was largely due to backlog reduction. It was not possible to report data for four of the nationally reportable modalities due to the transition to a new EPR system. The Trust is working towards achieving year-end NHS improvement targets across all modalities. The in-year improvement target for diagnostics is that no more than 25% of patients will wait greater than 6-weeks for their procedure and no patient will wait greater than 26-weeks. The Trust is sourcing additional internal and external capacity for several test types to support recovery of diagnostic waiting times; it is anticipated that the improvement seen in diagnostics performance will continue and will be followed by a similar improvement trend for 26-week performance in the coming weeks.

Cancer Wait Time Standards
There has been a period of sustained week-on-week improvement in PTL reduction since September and the Trust continues to deploy actions with the aim of de-escalating from its current Tier 1 status. There were a number of movements in the September position for Cancer with the number of patients breaching 62-Day Performance at 58.90% compared to 55.59% in August. 31-Day First Treatment standard was stable on the previous month at 87.76% in September. TWW and 28-Day Faster Diagnosis Standard deteriorated in September, reporting at 35.85% and 35.18% respectively. Instances of clinical harm remain low month-on-month and the Trust has had no reports of harm in 12-months as a result of delays over 104-Days. The Trust is working closely with regional and national colleagues with a “deep-dive” visit carried out on the 31/10/22 – 01/11/22. The formal report is pending, however immediate feedback is in keeping with our own local assessment and recovery plans. South West region have now made a recommendation to remove NBT from Tier 1 and Tier 2 status; we are awaiting national outcome of the recommendation.

Quality
Within Maternity, staffing pressures continue to be challenging although the pipeline of new starters is improving and staffing vacancies are on a decreasing trajectory into next year. Learning themes have been identified from staff and service user feedback, and improvement work is ongoing to address these with input from other areas of the Trust and external stakeholders (e.g. Maternity Voices Partnership). There were no MRSA cases reported in October and NBT remains below trajectory for C. Difficile cases. The reporting of and response to harm from pressure injuries and falls continues to reflect a positive safety culture within a challenged operational environment. A positive and sustained reduction in medication incidents has been seen. NBT remains nationally in the lowest quartile for SHMI indicating a lower mortality rate than most other Trusts. The rate of VTE Risk Assessments performed on admission has fallen further below the national target of 95% compliance. Leadership responsibilities have been determined medically and within Pharmacy for the improvement work and a number of specific steps agreed as outlined in this report. This has direct oversight from the CMO as a priority area.

Workforce
NBT’s Rolling 12-month staff turnover decreased from 17.22% in September to 17.17% in October. Trust vacancy factor increased from 8.66% in September to 8.69% in October with current vacancies at 774.03 wte. Rolling 12-month sickness absence increased from 5.42% in September to 5.49% in October with ongoing hot spots in additional clinical services and estates and ancillary staff. Temporary staffing demand increased by 1.88% (23.52wte) from September to October, however, as bank use increased (3.49%, 23.76wte), unfilled shifts increased by only 0.29% (1.14wte).

Finance
The financial plan for 2022/23 at Month 7 (October) was a deficit of £5.8m. The Trust has delivered a £11.1m deficit, which is £5.3m worse than plan. This is predominately driven by the non-delivery of savings in the first seven months of the year and high levels of premium pay spend, including on agency and incentives, partially offset by slippage on service developments and investments. In month, the Trust has recognised £0.7m of ESRF funding in addition to that assumed in the plan. Whilst the Trust has not reached the required activity levels to receive this, there has been a national approach of no clawback from commissioners in Months 1 to 7 for non-delivery. In BNSSG this has been recognised in provider positions in month. The Trust completed a detailed forecast in September. At month 7 the Trust has seen a £0.5m deterioration against the expected in month position. The Month 7 CIP position shows £3.4m schemes fully completed, with a further £3.4m schemes on tracker and £1.6m in pipeline. There is an £8.8m shortfall between the 2022/23 target of £15.6m and the schemes on the tracker. If pipeline schemes are included this is a £7.2m shortfall. Given the position at Month 7, the risks and mitigations impacting on the delivery for the required year end break even position have been reviewed. Cash at 31 October amounts to £99.4m, an in-month increase of £10.1m which is linked with receipt of pay award funding and reduction in payables. Total capital spend year to date was £14.1m compared to a plan of £12.1m.

Responsiveness

Board Sponsor: Chief Operating Officer
Steve Curry

Responsiveness - Indicative Overview

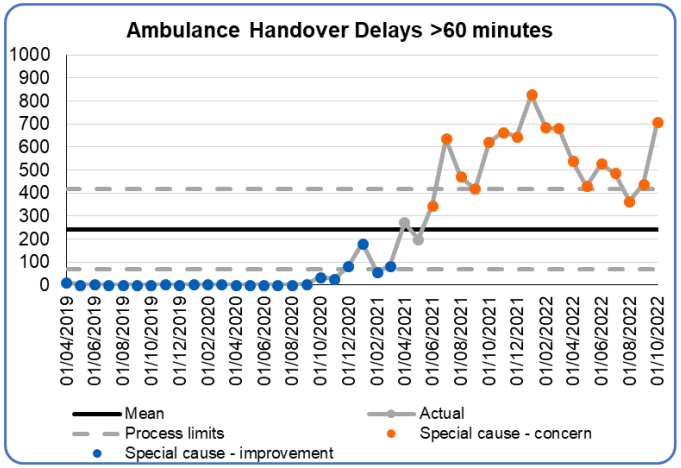
NHS North Bristol NHS Trust

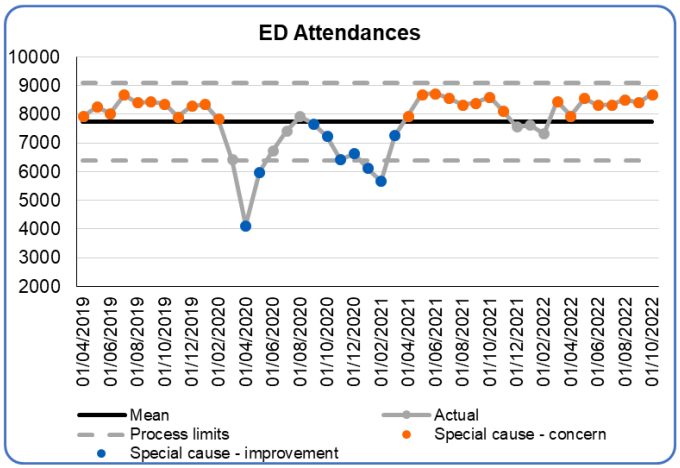
Delivery Theme	Delivery Indicator	Key Improvement /Delivery Action
Urgent & Emergency Care	Pre-Emptive Transfers	Green to Amber – out of hospital flow compromising full functionality
	Level 6 Brunel Plan	Green to Amber – first 12 beds due on 11/01/2023
	D2A	Reporting delays in delivery – NC2R levels remain high
RTT	104 week wait	On track
	78 week wait	On track
Diagnostics	25% 6-week target	As per previous reports diagnostic plan now showing improvement trend
	Zero 26-week waits	Plan in place – six-week position showing improvement, lag to 26-week position
Cancer PTL	>62-day PTL volume	Amber to Green - target delivered – embedding actions underway to sustain
	>62-day PTL %	Amber to Green - reduced from c.35% to c.7% – embedding actions underway to sustain

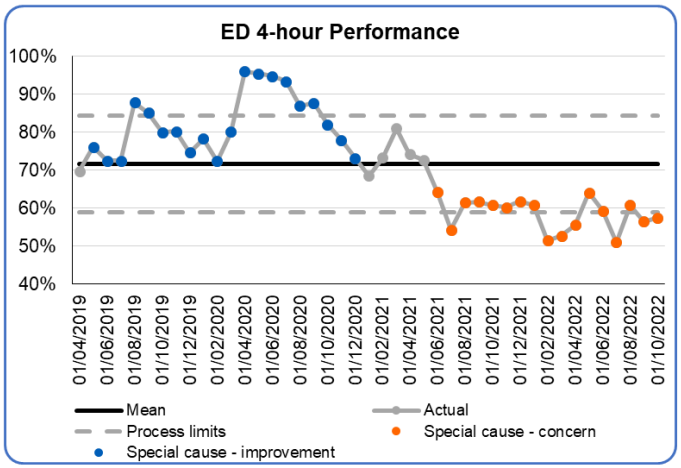
Rating reflects the reported period against in-year plan

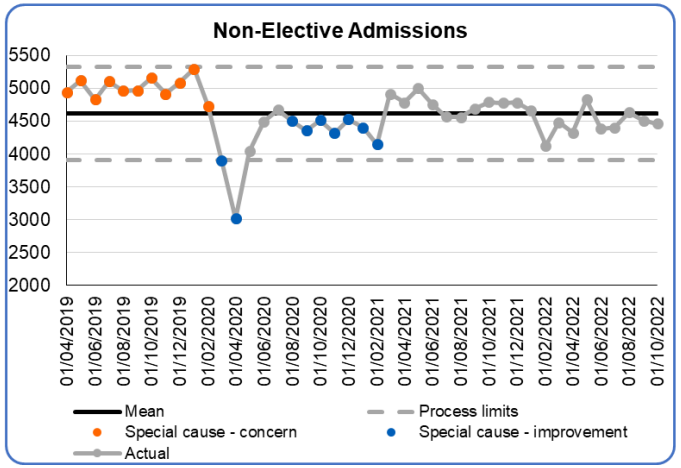
Urgent and Emergency Care

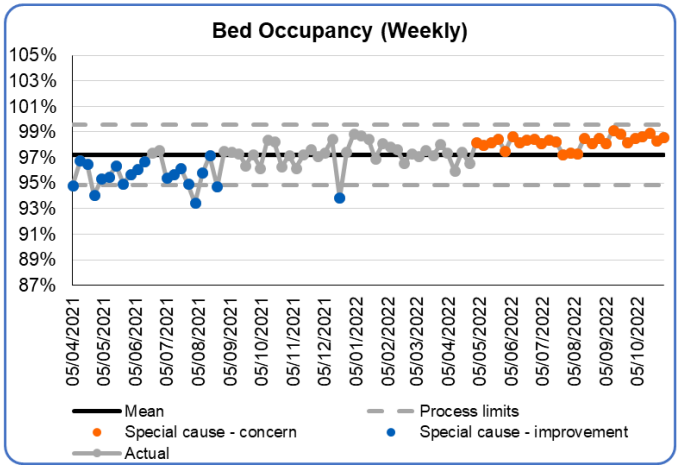
NHS North Bristol NHS Trust

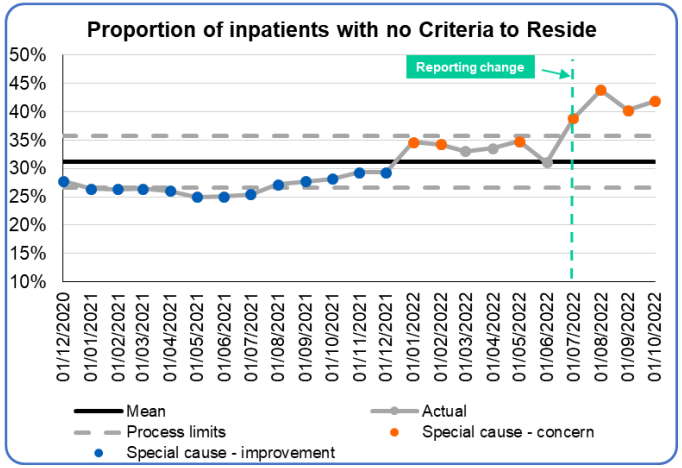












The increase in proportion of inpatients with no Criteria to Reside has resulted from the EPR change which provides improved data capture for these patients.

Urgent and Emergency Care

NHS North Bristol NHS Trust

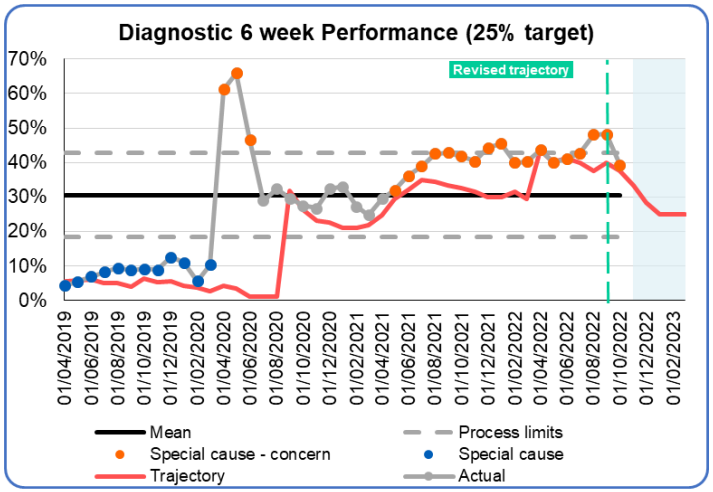
What are the main risks impacting performance?

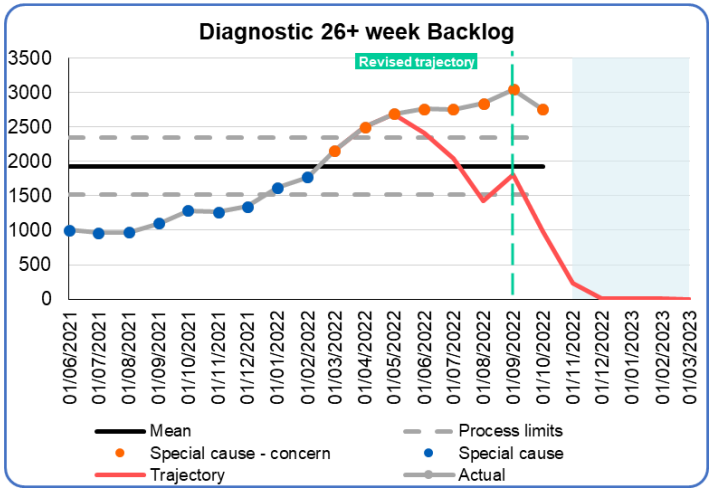
- Prolonged ambulance handover waits - driven by high bed occupancy.
- Patients with No Criteria to Reside have risen to as high as 44% of the hospital's bed capacity – a further deterioration.
- Lack of community capacity and/or pathway delays fail to support bed occupancy requirements.
- The continued pressure of unfilled nursing shifts to safely manage escalation capacity in times of high bed demand.
- There was a 3.96% increase in ED attendances in October (8696) compared to the same month in 2019/20 (8365).

What actions are being taken to improve?

- Ambulance handovers – the Trust continues to implement the pre-emptive ED transfer process. However, rises in No Criteria to Reside patients means that its impact is adversely mitigated at times. Use of double occupancy and boarding on wards, emphasis on early discharge of P0 patients all enacted on all Trust wards.
- The Trust is working closely with system partners to influence and support contingencies for the delayed impact of D2A, these include provision of a care hotel, development of virtual wards and further spot purchasing P3 capacity.
- Continued introduction of the UEC plan for NBT, this includes key changes such as implementing a revised SDEC service, mapping patient flow processes to identify opportunities for improvement and implementing good practice ward level patient review and discharge processes (including actions recommended from the ECIST review).
- Contingency planning for winter bed capacity underway – sixth floor plan implementation has commenced.
- The tactical bed deployment approach, shared through the winter planning update to Trust Board, has been enacted. The aim is to reduce the bed capacity footprint going into winter, to allow it to be deployed at the appropriate time.

Diagnostic Wait Times





What are the main risks impacting performance?

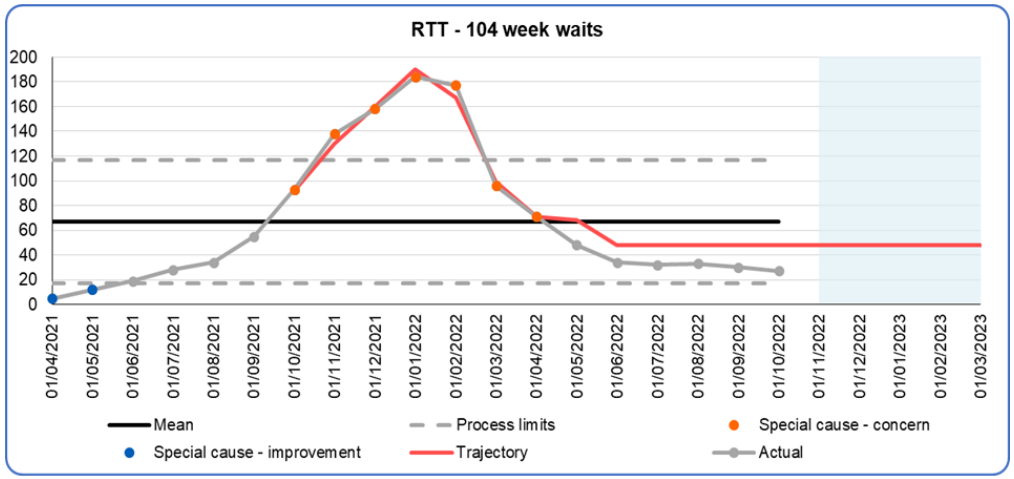
- Imaging equipment downtime.
- Staff absence.
- Reliance on independent sector.
- A series of 'deep dive' approaches to delivering in-year diagnostic commitments (25% waiting no longer than 6-weeks and zero 26ww breaches) has concluded that there are three rate limiting constraints which will need to be addressed to achieve compliance: recruitment to the additional radiology activity, increasing Endoscopy activity; and securing additional Echocardiology capacity. Mitigations have been developed and are positively impacting the overall position from October as anticipated.
- The Trust remains committed to achieving the national requirements in-year, within the context of these risks.

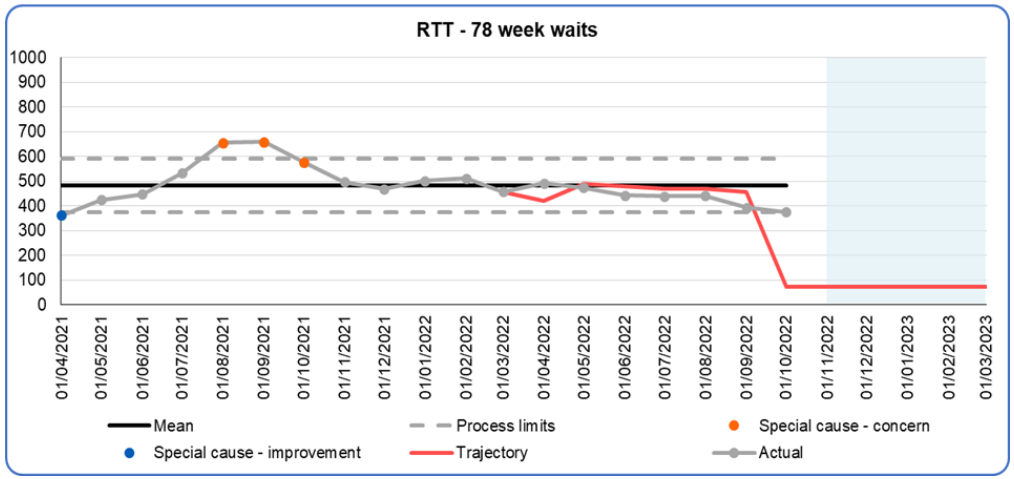
What actions are being taken to improve?

- Endoscopy – Utilising capacity from a range of insourcing and outsourcing providers, transfers to the IS, WLIs and employment of a Locum. Work is ongoing across the system to produce a shared PTL and to provide mutual aid to equalise wait times across organisations.
- Non-Obstetric Ultrasound – The Trust continues to utilise capacity from Medicare Sonographers. In addition, substantive staff are delivering WLIs and outsourcing continues to PPG.
- New appointment times introduced increasing future capacity in CT & MRI. Weston CT capacity ongoing as well as MRI & CT at Nuffield.
- Echocardiography – Ongoing use of Xyla insourcing and agency capacity, and use of IMC agency commenced in September. In October, the IMC agency activity was over double of that delivered the previous month, and a similar level of activity is planned for November.
- Proactive workforce development and planning continuing to yield some positive results.
- WLIs are helping to mitigate impact of staffing shortfalls during the week.

Please note due to configuration issues following implementation of the Trust's new EPR, four test types have been omitted since July-22.

Referral to Treatment (RTT)





What are the main risks impacting performance?

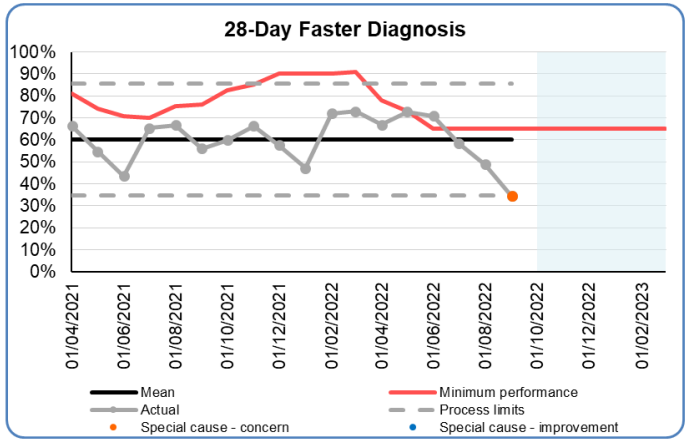
- Significant challenges to performance due to operating theatre staff absences (including COVID-19) and intense bed pressures including the rise in COVID-19 positive Inpatients.
- Impact of UEC activity on elective care.
- Any potential surge in COVID-19 related admissions.
- Any potential impact of nursing industrial action.

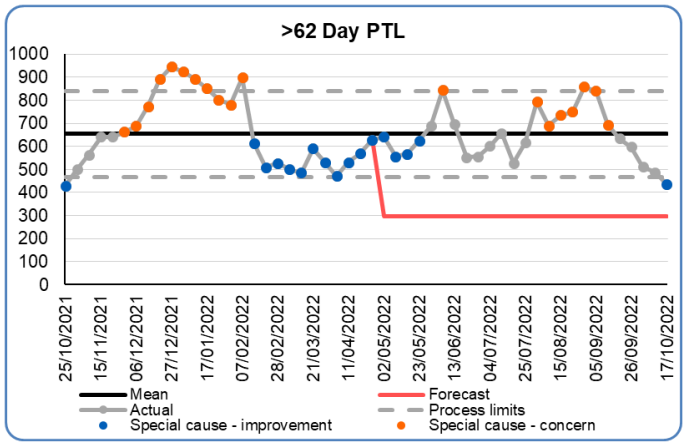
What actions are being taken to improve?

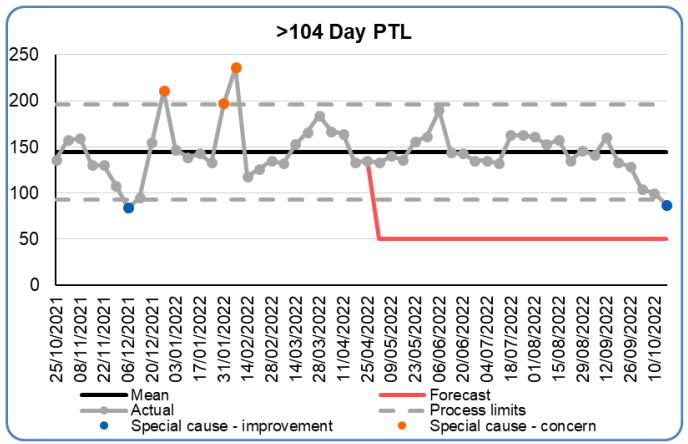
- Continued achievement of zero capacity related 104ww position.
- Extensive planning by the Elective Recovery team has resulted in a revised 78ww capacity breach projection for NBT. As a result, the Trust has committed to a zero 78ww breach position at year-end for capacity related breaches.
- There is some risk within the revised offer including an assumption that the second Green ward will function continuously over winter, that the Brunel Building sixth floor UEC capacity plan will be delivered and that any potential COVID-19 impact can be mitigated in terms of bed capacity and staffing losses.
- Options for Independent Sector (IS) transfer are limited to patients meeting IS treatment criteria. The Trust has transferred all suitable patients into available capacity across local IS Providers.
- The Trust is actively engaged with the Getting It Right First Time (GIRFT) programme of work and working with specialists in theatre utilisation improvements to ensure use of available capacity is maximised.

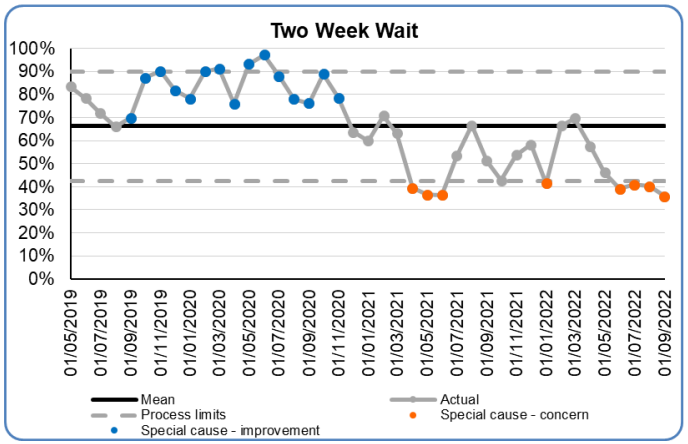
Cancer Performance

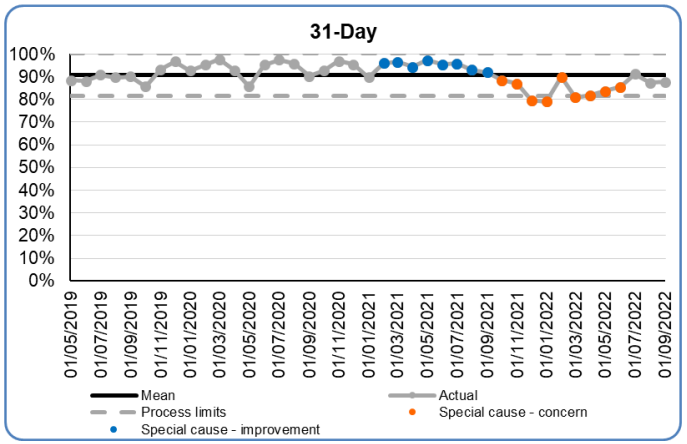
NHS North Bristol NHS Trust

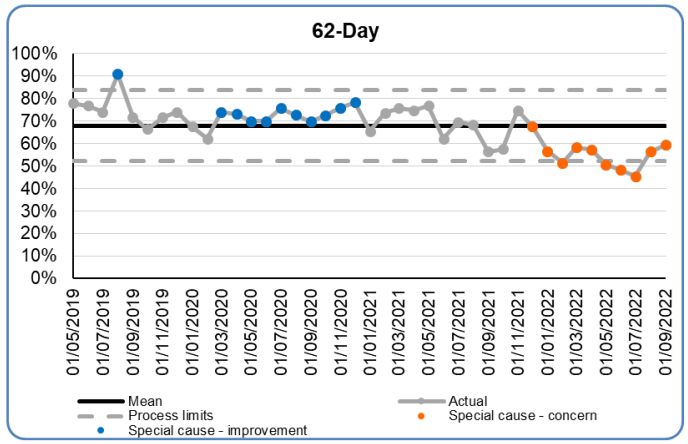












Cancer Performance

NHS North Bristol NHS Trust

What are the main risks impacting performance?

- Retention in the Cancer Services Team.
- Increased referrals.
- Reliance on non-core capacity.
- Skills shortages.
- Q2 CQUIN Delivery.

What has improved?

- Previously described bridging plans for the Cancer Services Team have been enacted and longer-term recruitment plans are in place.
- Significant improvement through Oct-22 and Nov-22 in reducing the >62-day Cancer PTL volume and percentage of >62-day as a proportion of the overall wait list.
- Recognition from regional and national teams on improving trend in >62 Day PTL and Tumour Site specific improvements in Breast.
- South West region have now made a recommendation to remove NBT from Tier 1 and Tier 2 status; we are awaiting the national outcome from the recommendation.

What further actions are being taken to improve?

- Focus remains on sustaining the absolute >62-day Cancer PTL volume and the percentage of >62-day breaches as a proportion of the overall wait list.
- Having achieved the improved 62-Day cancer PTL target, the next phase will be to ensure the revised actions and processes are embedded to sustain this improvement. At the same time, design work has commenced to fundamentally improve patient pathways, which will improve overall cancer wait time standards compliance.

Safety and Effectiveness

Board Sponsors: Chief Medical Officer and Chief Nursing Officer
Tim Whittlestone and Steven Hams

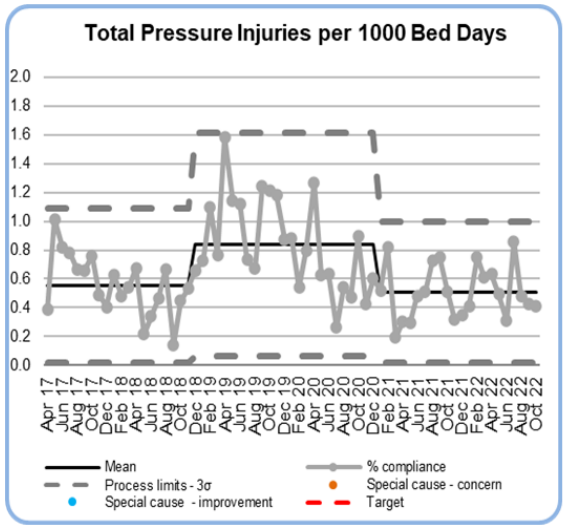
Maternity - Perinatal Quality Surveillance Monitoring (PQSM) Tool (September 2022 data)

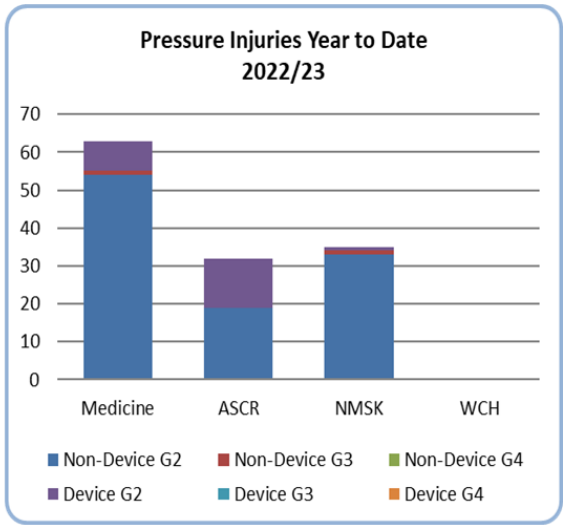
NHS North Bristol NHS Trust

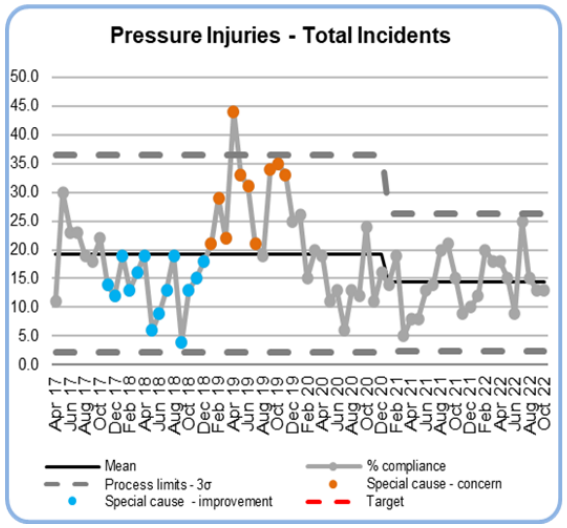
NBT - PQSM	Target	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	YTD Ttal /Avg	Trend	TREND
Activity										
NICU admission rate at term		4.3%	4.4%	6%	5%	4%	4%			
Perinatal Morbidity and Mortality inborn										
Total number of perinatal deaths		4	4	5	4	3	6			
Number of stillbirths 16 to 23+6 weeks excl. TOP		1	2	1	1	1	2			
Number of stillbirths (>=24 weeks excl. TOP)		1	1	1	1	0	1			
Number of neonatal deaths : 0-6 Days		2	1	1	1	2	2			
Number of neonatal deaths : 7-28 Days		0	0	2	1	0	0			
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)		0	0	1	2	0	0			
Maternal Morbidity and Mortality										
Number of maternal deaths (MBRRACE)		2	0	0	0	0	1			
Direct		1	0	0	0	0	0			
Indirect		1	0	0	0	0	1			
Number of women who received level 2 & 3 care		2	1	1	0	1	1			
Insight										
Number of datix incidents graded as moderate or above (total)		1	0	1	3	0	0			
Datix incident moderate harm (not SI, excludes HSIB)		1	0	1	1	0	0			
Datix incident SI (excludes HSIB)		0	0	0	1	0	0			
New HSIB SI referrals accepted		0	1	1	1	0	1			
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0	0			
Coroner Reg 28 made directly to Trust		0	0	0	0	0	0			
Workforce										
Minimum safe staffing in maternity services: Obstetric cover (Resident Hours) on the delivery suite		83	83	83	83	83	83			
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps		DNA	DNA	2	3.2	3.2	2.5			
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps		0	0	0	0	0	1			
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)		1	0	0	0	0	0			
Minimum safe staffing in maternity services: Neonatal Consultants workforce (rota gaps)		1	1	1	1	1	1			
Minimum safe staffing in maternity services: Neonatal Middle grade workforce (rota gaps)		0	0	0	0	0	0			
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled bank shifts).		12%	11%	14%	18%	38%	28%			
Vacancy rate for midwives		6.8%	6.7%	8.1%	6.9%	9.8%	11.8%			
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained)		43%	40%	45%	51%	51%	51%			
Vacancy rate for NICU nurses		11	21	19	15	14	12			
Datix related to workforce (service provision/staffing)		3	2	9	9	5	8			
Consultant led MDT ward rounds on CDS (Day and Night)		DNA	66%	78%	68%	74%				
One to one care in labour (as a percentage)		100%	100%	99%	99%	99%	99%			
Compliance with supernumerary status for the labour ward coordinator	100%	97%	100%	100%	98%	95%	64%			
Number of times maternity unit attempted to divert or on divert		4	6	26	36	34				
in-utero transfers										
in-utero transfers accepted			4							
in-utero transfers declined			0							
ex-utero transfers				11						
ex-utero transfers accepted			9	9	3	6	11			
ex-utero transfers declined				2						
Number of consultant non-attendance to 'must attend' clinical situations		0	0	0	0	0	0			
Involvement										
Service User feedback: Number of Compliments (formal)		57	31	48	58	132	79			
Service User feedback: Number of Complaints (formal)		2	4	5	9	5	13			
Staff feedback from frontline champions and walk-abouts (number of themes)		4	4	4	3	3	4			
Improvement										
Progress in achievement of CNST /10		7	7	7	7	7	8			
Training compliance in maternity emergencies and multi-professional training (PROMPT)	90%	51%	62%	75%	79%	86%	75%			
Fetal Wellbeing and Surveillance	90%	48%	74%	87%	87%	89%	79%			
Trust Level Risks		6	6	5	5	6	6			

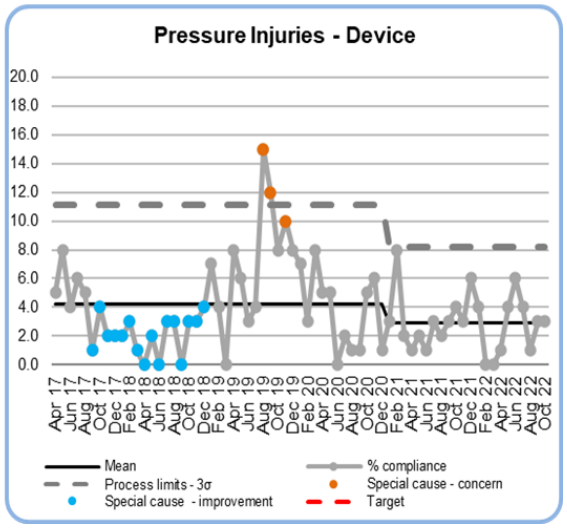
Executive Summary

- The Perinatal Quality Surveillance Matrix (PQSM) report provides a platform for sharing perinatal safety intelligence monthly.
- MSG will receive the quarterly report and approve the safety recommendations from the ATAIN Q2 2022 report.
- Quarterly Term babies admitted to NICU (Neonatal Intensive Care Unit) are reviewed every quarter by a multidisciplinary team; themes are identified and safety recommendations made. The key finding directly contributing to admissions was around inadequate temperature control of birthing rooms and theatres. A new system for monitoring temperature is currently being explored by the clinical leads. A verbal update will be given during this MSG and a full update will be formally provided at December MSG.
- There was 1 admission to ITU following a maternal collapse in the community which resulted in a cardiac arrest and subsequent maternal death at 18 weeks gestation; referred to HSIB.
- 3 cases for full PMRT review - (1 x antenatal stillbirth, 1 x late fetal loss, 1 x early neonatal death).
- Workforce pressures across all staff groups.
- Themes have been identified from staff and service user feedback, and improvement work is ongoing to address these with input from other areas of the Trust and external stakeholders (e.g. Maternity Voices Partnership) as needed. Preliminary findings from the Picker Report 2022 to be formally shared with the Division on 7th December 2022.
- The Maternity Incentive scheme submission date has now been extended to Thursday 2nd February 2023 and guidance has been updated. Following on from the updated guidance there remain 2 areas of concern; Safety Action 6 and Safety Action 8.
- Areas of excellence include the roll out of the Positive Incident Management System (PIMS). The maternity Escalation Phrase Scheme is going live in November 2022 which was coproduced with the Maternity Voices Partnership (MVP). The re-launch of NBT's Homebirth service has been a commendable success with 100% of birth being facilitated by the team.
- There are 6 Trust Level Risks.









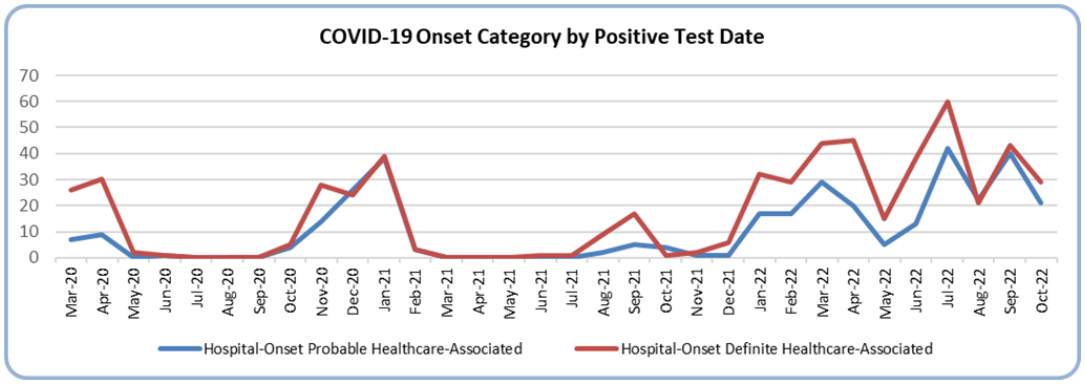
Pressure Injuries

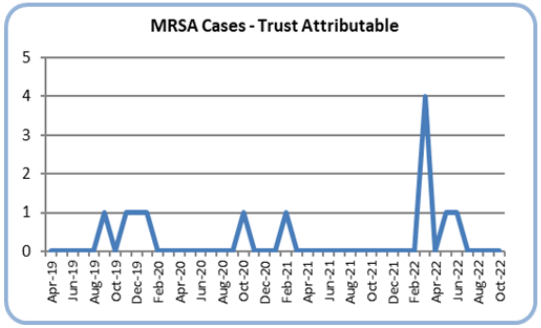
What does the data tell us?

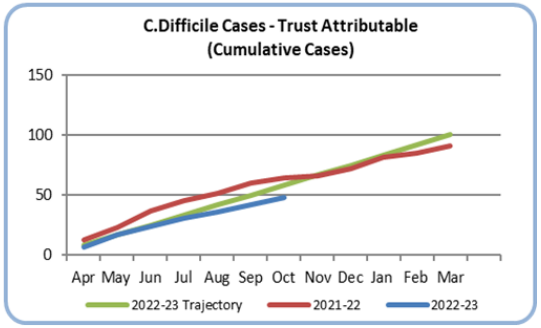
- In October, there was a decrease in the number of Grade 2 pressure injuries. 14 Grade 2 pressure injuries were reported of which 2 related to a medical devices. The 2 medical device injuries were 1 x ear from a nasal cannula and 1 x NIV mask. There were 5 x grade 2s to the sacrum and 7 x grade 2s to the heels.
- The number of DTI injuries remained static in relation to the previous month. There were 20 DTI's, 11 x to heels, 6 x to buttocks/sacrum, 1 x to toe. 2 x DTIs were attributable to medical devices, one from a neck brace and another from a nasal cannula.
- There were 2 x Grade 3 pressure injuries, 1 x NMSK and 1 x Medicine. There were 0 x Grade 4 pressure injuries reported in October.
- There were 4 unstageable pressure injuries reported 4x attributable to 25a from a POP cast.

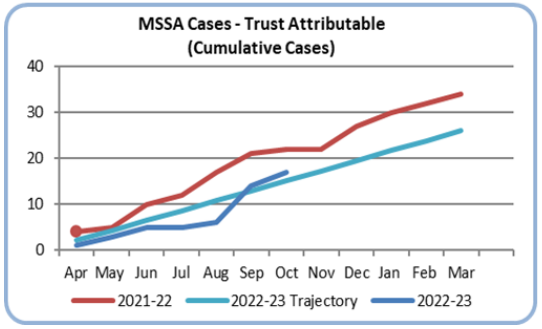
What actions are being taken to improve?

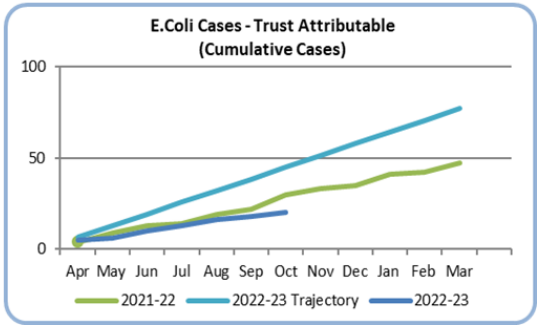
- The Tissue Viability (TV) team continue to support the divisions and wards by working collectively to provide responsive and effective pressure injury prevention and education.
- The TV team hosted the second Tissue Viability Link Ambassador day in collaboration with Medicare Plus to provide training on the prevention and management of moisture associated skin damage. The session also included updates from the team on ongoing projects, and feedback to challenges faced by the ambassadors on the ward to inform future learning and support.
- The focus group creating a pathway and framework on POP care plans to support staff to manage POPs, reduce patient harm and provide effective and responsive care continues to be developed and embedded on 25a through collaborative work and triangulation between the ward, TV team and plaster room.











Infection Prevention and Control

What does the data tell us?

COVID-19 (Coronavirus)

COVID levels followed national levels in September, with an expected fall during October. Outbreaks and asymptomatic cases also declined. Control measures remain in place around risk assessment, use of the ICB Hierarchy of IPC Practice and mask wearing due an expected increase in other respiratory viruses including Influenza A in November.

MRSA – No Further cases noted in October.

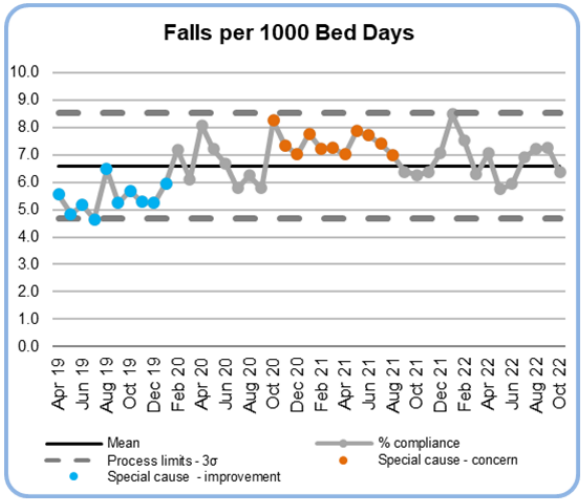
C. Difficile - NBT continues to hold a below trajectory position, the key will now be to maintain this and continue the improvement strategy and educational workstream.

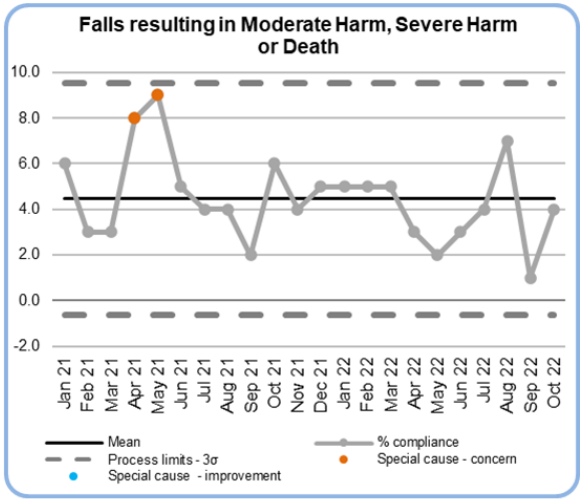
MSSA - Cases increased sharply in September continuing into October, a increase also reflected in the wider region. Few cases before September have contributed to ward learning but some cases are awaiting review at the Steering Group. NBT will be joining regional work aimed at early device removal and AMS principles, looking a development of a tool kit and shared learning

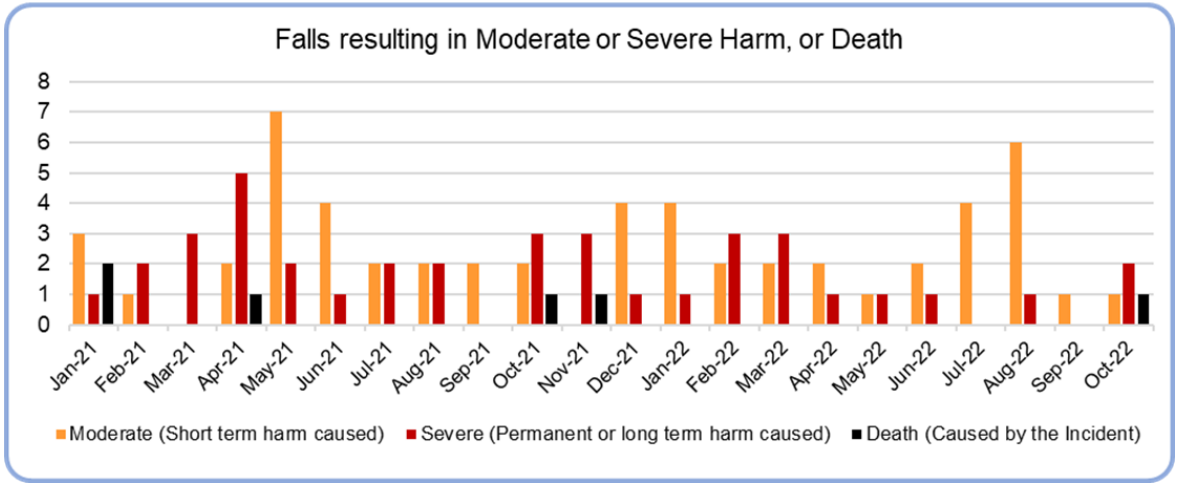
Gram –ve - NBT is reporting a position below trajectory

What actions are being taken to improve?

- Divisional work continues. Link ambassador meetings planned for November / December, specifically focusing on Back to Basics, resetting after Covid, risk assessments and winter planning. IPC remains involved in shared learning platforms with the ICB and regional work targeting C Diff and MSSA planned.
- IPC will collaborate with NBT colleagues to support World Antimicrobial Awareness week in November focusing on IPC prevention measures including Hand Hygiene and other proactive measures.
- COVID and other respiratory viruses support continues across the trust with case management and IP risk assessment including patient placement in bays. Influenza case / contact management is being process mapped and agreed.
- IPC trials – Currently trialling many products with good results . Air purification ceiling units in EEU with Four portable units available. New soap / Emollient products agreed for role out and Neptune / Stryker system in Theatres continues.







Falls

What does the data tell us?

Falls incidents per 1000 bed days

During October 2022, NBT had a rate of 6.35 falls incidents per 1000 bed days. This figure is a slight decrease month on month (from 7.25), and also a slight decrease from the mean rate for NBT falls (including prior COVID-19 pandemic) which is 6.8 falls per 1000 bed days.

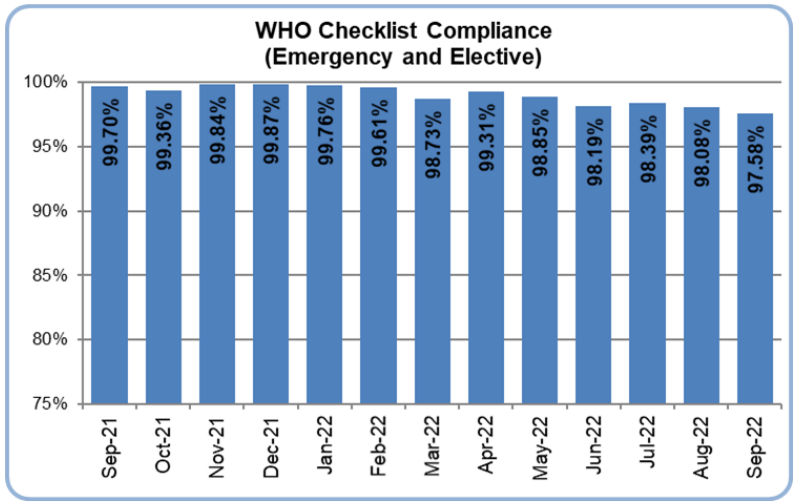
Falls harm rates

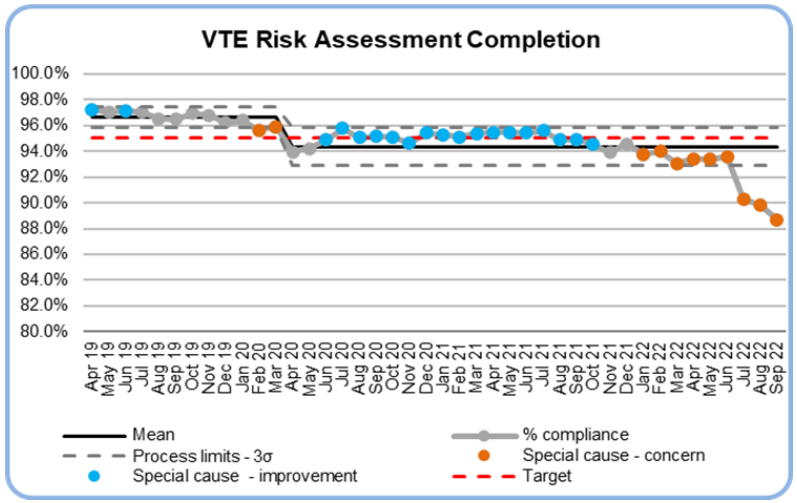
During October 2022, 2 falls were recorded and validated as causing severe harm, 1 fall as a fall resulting in death and 1 fall as causing moderate harm. Moderate and severe harm falls were below the mean rate in October 2022. Falls remain one of the top 3 reported patient safety incidents, therefore there is confidence that the practice of appropriately and safely responding to falls is well embedded at NBT.

What actions are being taken to improve?

The Falls Academy was formed in September 2020 overseeing falls improvement at NBT. This monitors themes and trends through incident reporting, thematic analysis and review of completed audits through the National Audit for Inpatient Falls. The Academy is reviewing the falls prevention policy, training and electronic patient records falls risk assessments.

A continuous improvement project is in progress to implement a robust falls care plan and risk assessment tool across NBT. Additionally, the Falls Academy has a continuous education programme linked to themes identified through thematic analysis, emergent risk and national guidance.





N.B. VTE data is reported one month in arears because coding of assessment does not take place until after patient discharge.

WHO Checklist Compliance

What does the data tell us?

In October, WHO checklist compliance was 97.58%. The Board expects that a WHO surgical safety checklist will be completed and documented prior to each operation in theatres.

The IPR report of less than 100% is due to issues with data capture and solely indicates a failure to 'sign out' on completion of the list. All cases where WHO was not recorded electronically are reviewed to ensure that checklist compliance was recorded in the paper medical records, therefore meaning that the correct checks were undertaken in practice. When a manual check confirms that the WHO check list was not completed a Datix is recorded.

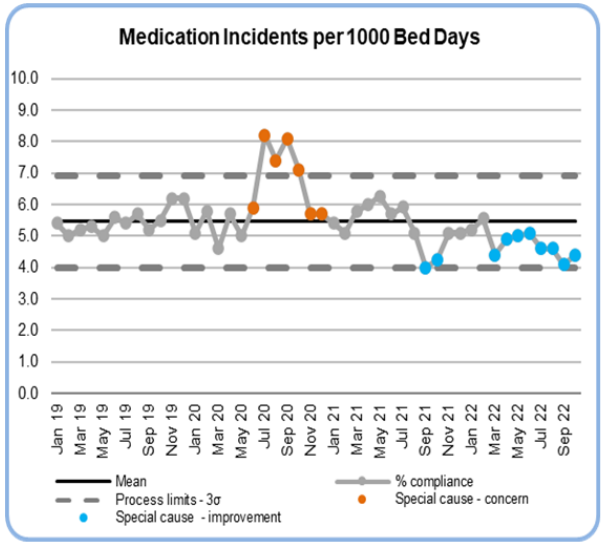
VTE Risk Assessment

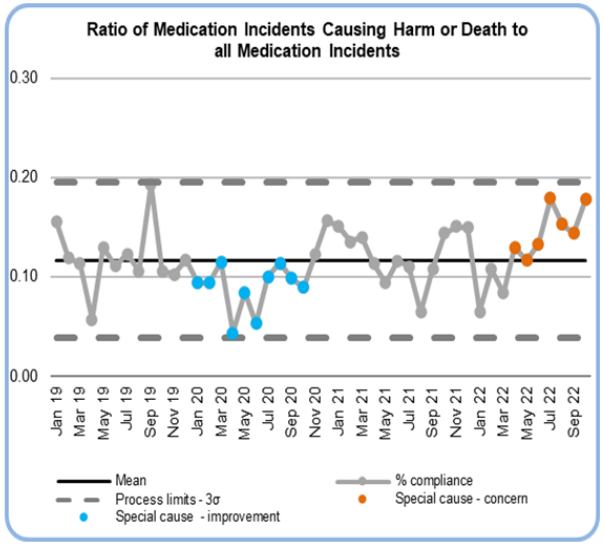
What does the data tell us?

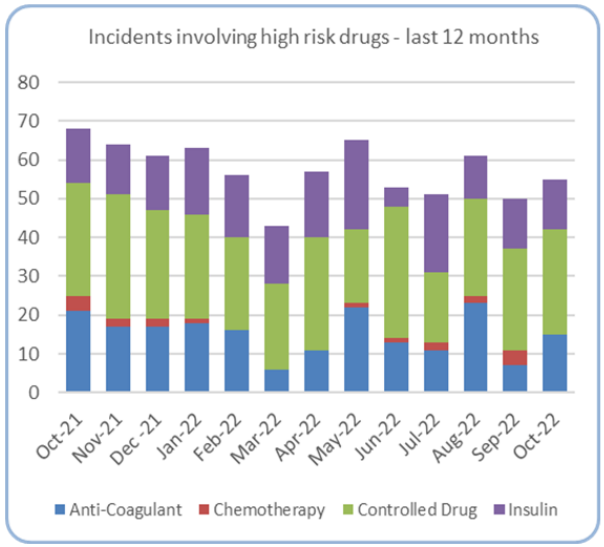
In September, the rate of VTE Risk Assessments (RA) performed on admission was reported as 88.69%. VTE risk assessment compliance is targeted at 95% for all hospital admissions. This is a deteriorating trend over past few months, exacerbated by the CareFlow changeover but this is not the primary factor.

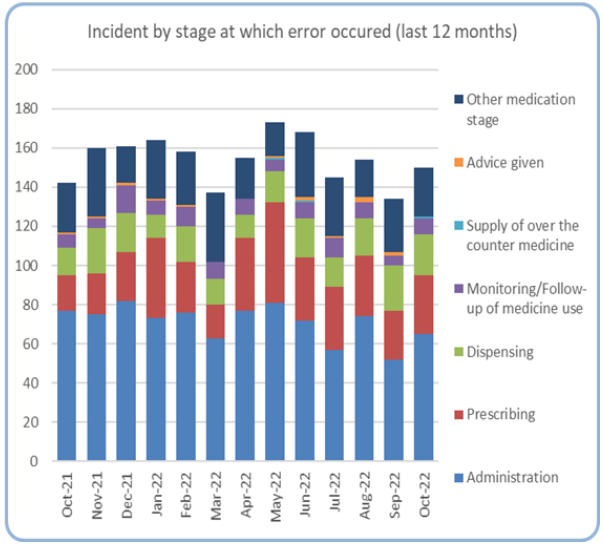
What actions are being taken to improve?
An overarching improvement plan has been developed, clinical leadership responsibilities agreed with direct oversight of the CMO and the Thrombosis Committee reconvened to engage and drive actions across the Trust.

Specifically;
- Introduce VTE RA digitally on Acute Medical admission Unit, supported by digital team and VTE nurses
- Regular ward level audits are now in progress independent of each area
- Ward pharmacists review notes & locate VTE form when checking the thromboprophylaxis prescribed
- Recommence training for clinicians at induction, and FY1/2 protected days – starting next w/c 21 Nov.
- Recommence ad hoc training on the wards and VTE training in L&R
- Add new VTE modules to LEARN, to support OPD staff regarding signs and symptoms of VTE
- Arrange a study day regarding VTE
- Promotional table in the atrium regarding VTE prevention









Medicines Management Report

What does the data tell us?

Medication Incidents per 1000 bed days
During October 2022, NBT had a rate of 4.4 medication incidents per 1000 bed days. This is below the 6 month average for this figure.

Ratio of Medication Incidents Reported as Causing Harm or Death to all Medication incidents
During October 2022, c.17.8 % of all medication incidents are reported to have caused a degree of harm (depicted here as a ratio of 0.178). This is slightly above the average seen over the last 6 months.

High Risk Medicines
During October 2022, c.37% of all medication incidents involved a high risk medicine a figure comparable with data for the last 6 months. The number of incidents involving Controlled Drugs – has reduced from the high seen in in June to a level in keeping with the results for the year to date.

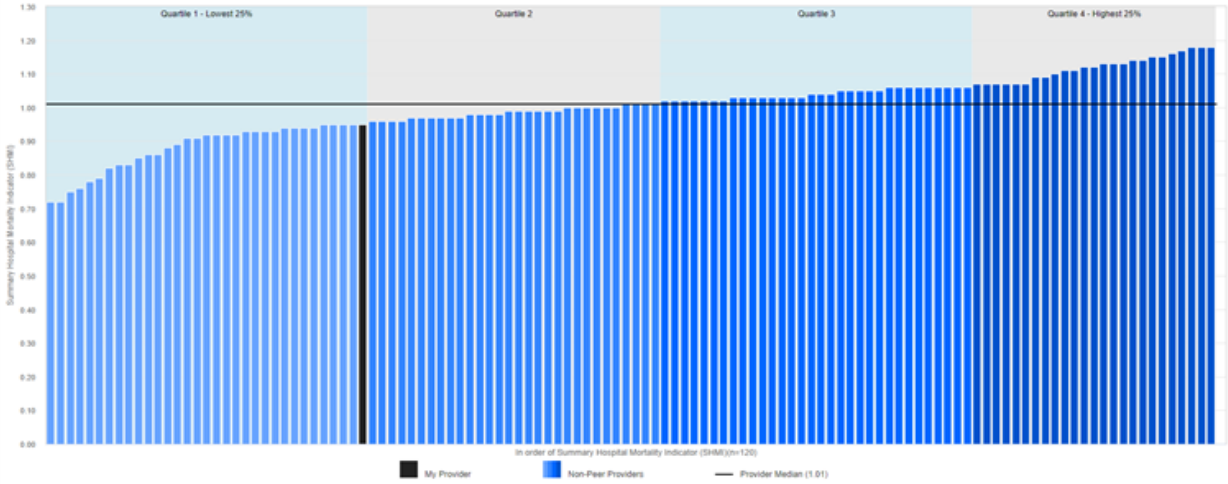
Incidents by Stage
In keeping with the picture seen over the last 6 months most incidents are reported to occur during the 'administration' stage. We have however been looking into the coding of incidents and this work has identified that in some cases nurses designate incidents as 'administration errors' even when the cause was unclear prescribing (this is likely to be in part due to the way the incident coding options are presented on Datix). More work on this subject will be undertaken as part of the 'Medicines Academy' project.

What actions are being taken to improve?

The Medicines Governance Team encourage reporting of all incidents to develop and maintain a strong safety culture across the Trust, and incidents involving medicines continue to be analysed for themes and trends.

The learning from incidents causing moderate and severe harm is to be presented to, and scrutinised by, the Medicines Governance Group on a bi-monthly basis in order to provide assurance of robust improvement processes across the Trust.

Summary Hospital Mortality Indicator (SHMI), National Distribution

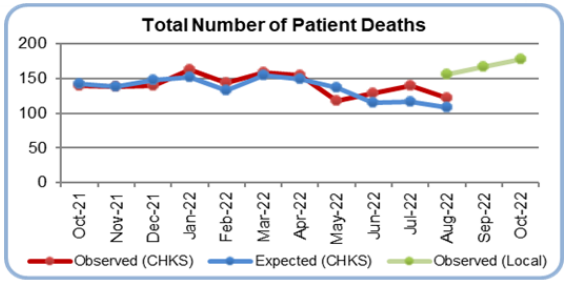


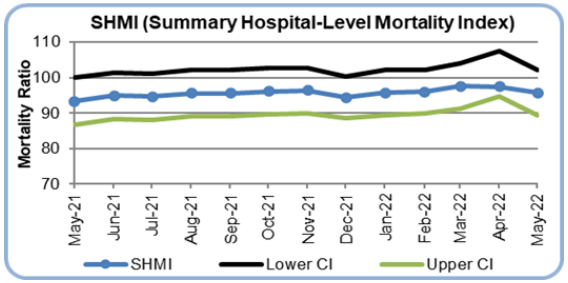
Mortality Review Completion

Sep 21 – Aug 22	Completed	Required	% Complete
Screened & excluded	165		
High priority cases	246		
Other cases reviewed	1604		
Total reviewed cases	2015	2104	96%

Overall Score	1 (very poor)	2	3	4	5 (excellent)
Care received	0%	3%	27%	41%	29%

Date of Death	Sep 21 – Aug 22
Scrutinised by Medical Examiner	1897
Referral to Quality Governance Team	165





Mortality Outcome Data

What does the data tell us?

Mortality Outcome Data
NBT remains in the lowest quartile for SHMI at 0.95 when compared to the national distribution indicating a lower mortality rate than most other Trusts for the latest available data on the Model Health System.

Mortality Review Completion
The current data captures completed reviews from Sep 21 – Aug 22. In this time period 96% of all deaths had a completed review, which includes those reviewed through the Medical Examiner system

Of all "High Priority" cases, 88% completed Mortality Case Reviews (MCR), including 24 of the 25 deceased patients with Learning Disability and 22 of the 27 patients with Serious Mental Illness. The recent drop in completion rate is due to the requirement of all cases of probable and definite hospital associated COVID to be reviewed. These include historic cases that were not previously classified as 'high priority'.

Mortality Review Outcomes
The percentage of cases reviewed by MCR with an Overall Care score of adequate, good or excellent is 97% (score 3-5). There have been 7 mortality reviews with a score of 1 or 2 indicating potentially poor, or very poor care which undergo a learning review through divisional governance processes.

What actions are being taken to improve?

We attended NMSK Quality Governance day and raised awareness of the mortality review process highlighting outstanding cases for review.
Through discussions held at this meeting; specialties and divisions have been informed of outstanding cases. Completion of these cases has seen a rise in high priority case completion since last month.
This has highlighted how important it is for specialties and divisions to have oversight of their cases. Dashboards are being developed to provide this.
Investigations and responses have been requested from divisions that are alerting for mortality to try and understand a recent rise in SHMI.

COVID-19 Weekly Scorecard

Current COVID Status: Level 2

Input date: 31/10/22

Metric	12/09/2022	19/09/2022	26/09/2022	03/10/2022	10/10/2022	17/10/2022	24/10/2022	31/10/2022	Trend
New patients last 24 hours – admitted	1	2	2	4	4	3	1	1	
New Patients Diagnosed in last 24 hours	**1**	**12**	**6**	**6**	**3**	**6**	**3**	**2**	
Of these, in-patients diagnosed <48 hours after admission (Community Acquired)	1	2	2	3	1	2	1	1	
Of these, in-patients diagnosed 3-7 days after admission (Indeterminate)	0	2	0	1	1	2	0	0	
Of these, in-patients diagnosed 8-14 days after admission (Hospital Acquired)	0	4	1	0	1	1	1	0	
Of these, in-patients diagnosed 15+ days after admission (Hospital Acquired)	0	4	2	2	0	1	1	0	
Number of confirmed patients admitted from care or nursing home	0	0	0	0	0	0	0	0	
Blue discharges in past 24 hours	2	3	7	8	4	5	4	3	
Number of COVID positive patients as at 08:00	**13**	**41**	**81**	**56**	**44**	**45**	**35**	**23**	
Of these, patients admitted for primary COVID	10	29	64	39	31	36	27	18	
Of these, patients admitted with incidental COVID	3	12	17	17	14	9	8	6	
COVID positive patients in ICU	1	3	2	2	1	1	2	1	
COVID positive patients outside of ICU	12	38	79	54	43	43	34	22	
Query patients	0	0	0	0	0	0	0	0	
Closed and empty beds due to IPC	0	4	10	8	3	2	0	0	
NIV COVID	0	0	0	0	0	0	0	2	
Deaths	0	0	0	1	0	0	0	0	
Pathology lab positivity rate – rolling 7 day mean	0	0	0	0	0	0	0	0	
Patient Total positivity - detected - number	1	6	3	4	2	3	1	0	
Patient Total positivity - detected - %	0	0	0	0	0	0	0	0	

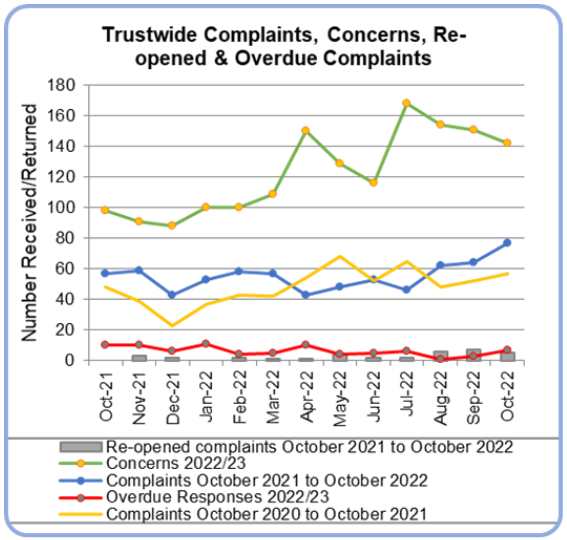
Metric	05/09/2022	12/09/2022	19/09/2022	26/09/2022	03/10/2022	10/10/2022	17/10/2022	24/10/2022	Trend
Bristol cases per 100,000 – 7 days	24	27	42	63	69	75	66	45	
South Gloucestershire cases per 100,000 – 7 days	40	44	69	103	112	123	108	73	
North Somerset cases per 100,000 – 7 days	24	27	42	63	69	75	66	45	

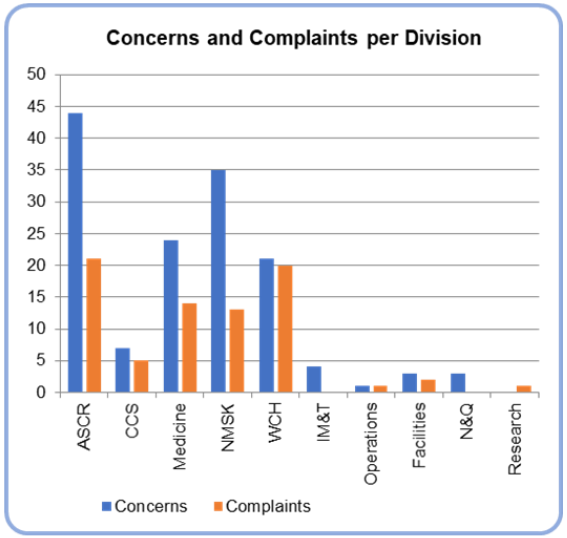
Key:

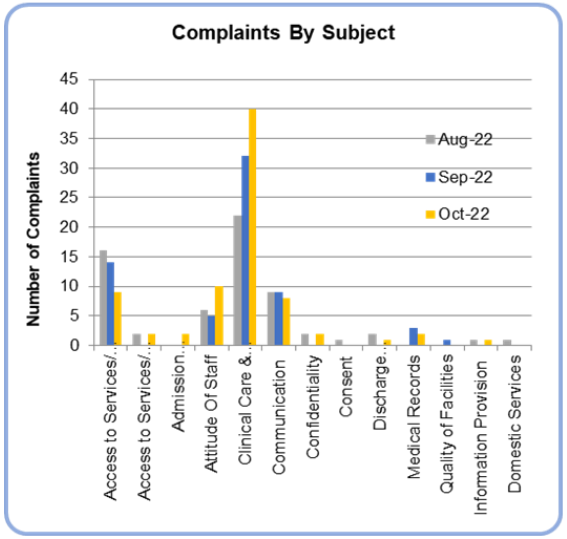
- Decrease from previous day
- Increase from previous day
- Step down to 10 days

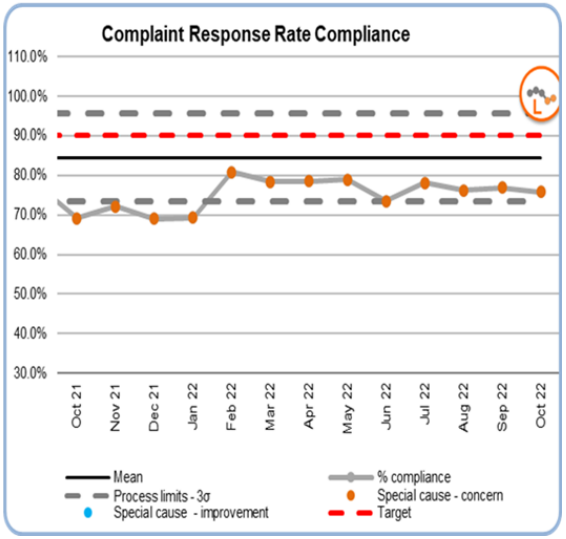
Patient Experience

Board Sponsor: Chief Nursing Officer
Steven Hams









Complaints and Concerns

What does the data tell us?

In October 2022, the Trust received 77 formal complaints. This is 13 more than the previous month and 20 more than the same period last year.

The most common subject for complaints is 'Clinical Care and Treatment'.

In October, the second most common subject is 'Attitude of Staff. This is a change from the previous five months when this was not one of the top three subjects of complaints.

There were 5 re-opened complaints in October, 3 for NMSK, 1 for Medicine and 1 for ASCR.

The 77 formal complaints can be broken down by division: (the previous month's total is shown in brackets)

ASCR	21 (18)	CCS	5 (4)	Facilities	2 (0)
Medicine	14 (19)	NMSK	13 (11)	Research	1 (0)
WCH	20 (11)	Operations	1 (1)		

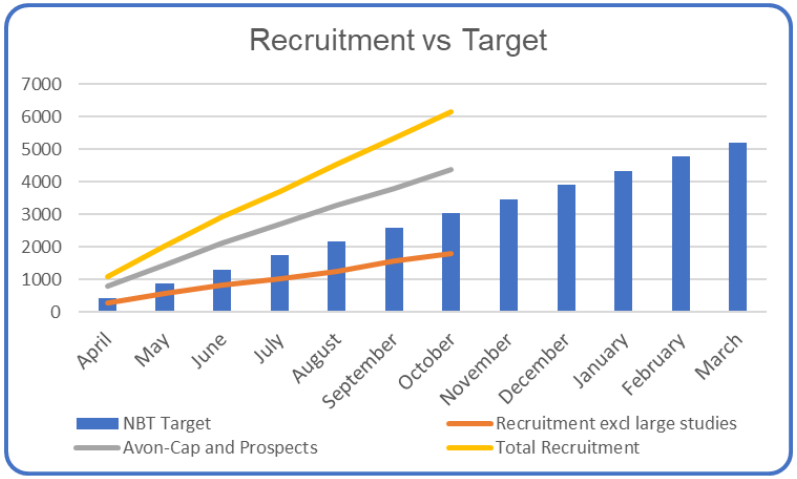
The number of PALS concerns received by the Trust has fallen slightly from 151 in September to 142 in October. The number of enquiries has increased to 105.

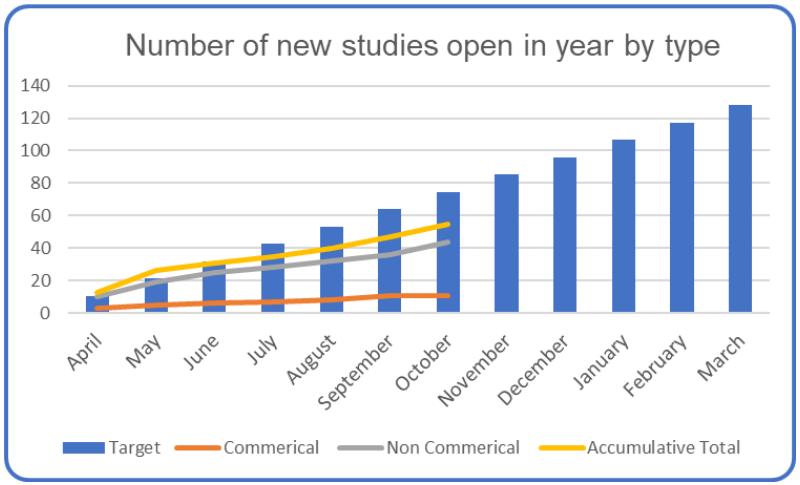
The response rate compliance for complaints decreased marginally from 76.9% in September to 75.8% in October.

The number of overdue complaints at the time of reporting has increased to 7 from 3 in September. There are 3 in ASCR, 2 in Facilities, 1 in NMSK and 1 in CCS.

What actions are being taken to improve?

- Ongoing weekly validation/review of overdue complaints by the Patient Experience Manager and/or Complaints Manager.
- Weekly meetings with Medicine, ASCR, WaCH and NMSK Patient Experience Teams.
- Recovery plans and a trajectory for improvement continue in ASCR and Medicine. Due to staff sickness in the ASCR patient experience team, ASCR has not achieved its targets again.
- Review of main reasons for re-opened cases across all divisions as it appears to be a Trust-wide issue, not isolated to one area/division.





Research and Innovation

What does the data tell us?

Our Research activity
In this financial year we will strive to offer as many research opportunities to our NBT patients and local communities as we can whilst continuing to provide the patients with a positive research experience and high quality care.

We will aim to recruit 5200 participants to our research studies; this reflects our baseline pre COVID ambitions. At present 6153 participants have consented to our research. This exceeds our current YTD target (203%)however is reflective of 2 large studies we are involved in (AVONCAP and PROSPECTS). We are monitoring our activity with and without these studies- which is shown in graph 1.

The NBT portfolio of research remains strong; at present we have 222 studies open to new participants and have set up and opened 55 new studies since April (Graph 2), these are predominantly non commercial studies. We pleased to see a small growth in the number of collaborations with commercial partners which enables us to offer our patients access to clinical trial therapies; this is something we are keen to grow over the coming years.

Our grants
NBT currently holds 71 externally funded research grants, to a total value of £33.5m. This includes 36 prestigious NIHR grants totalling £32m. In addition, NBT is a partner on 58 externally-led research grants, to a total value of £10.3m to NBT.

The Southmead Hospital Charity generously funds two SHC Research Fund calls per annum, run by R&I. The **SHC Research Fund** welcomes research applications from all NBT staff members to undertake small pump-priming research projects (up to a maximum of £20k) in any subject area. We are pleased to announce that we received 11 Expressions of Interest to our recent Round 14 Research Fund call, of which 6 have been shortlisted for Stage 2.

In addition to the SHC Research Fund, R&I is planning to introduce a new process for awarding mentorship and funding to NBT staff who are new to research but have a great idea for a research project '**Early Stage Research Funding**'. The application form will follow a simple SBAR structure and will not require any prior knowledge of, or expertise in, research. R&I will launch this new funding stream across the Trust in due course.

Our Successes:
Over the last quarter we have been reassessed as part of the Investors in People accreditation programme, despite all the challenges over the proceeding years we are extremely pleased to report that we maintained our investors in people silver accreditation. The assessment helps us to understand our current position in terms of how we lead and support our teams to build capabilities to create and sustain success. We will continue to use this leadership and engagement platform to continue to drive improvements for our team members and through them enhance patient/participant experiences.

NHS North Bristol NHS Trust

Well Led

Board Sponsors: Chief Medical Officer, Director of People and Transformation
Tim Whittlestone and Jacqui Marshall

Well Led Introduction

Vacancies
Trust vacancy factor increased from 8.66% in September to 8.69% in October with current vacancies at 774.03 wte. Vacancy rates increased in additional clinical services and registered nursing and midwifery staff groups, driven by a reduction in staff in post, predominantly in Imaging, Outpatients, Pathology, Pharmacy and Therapies for additional clinical services. The increased registered nursing and midwifery vacancy factor was, driven by a reduction in staff in post in Maternity Services, NICU and across the Medicine Division.

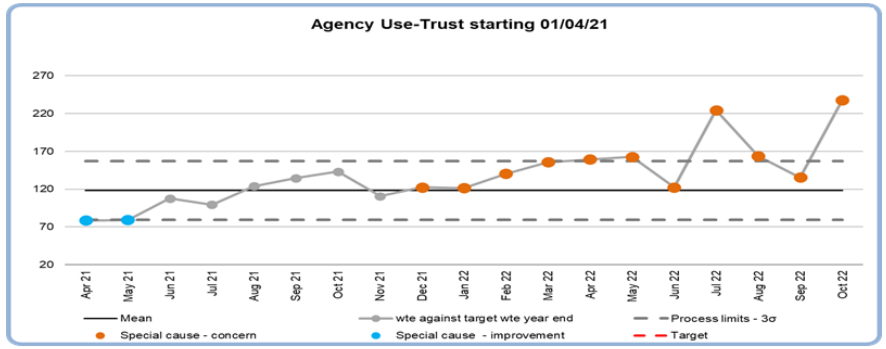
Turnover
NBT's Rolling 12-month staff turnover decreased from 17.22% in September to 17.17% in October. Additional clinical services remains the staff group with highest turnover position and saw an increase from 22.9% in September to 23.4% in October. Allied health professional and healthcare scientists both saw increases in turnover in October both however remain under the trust average.

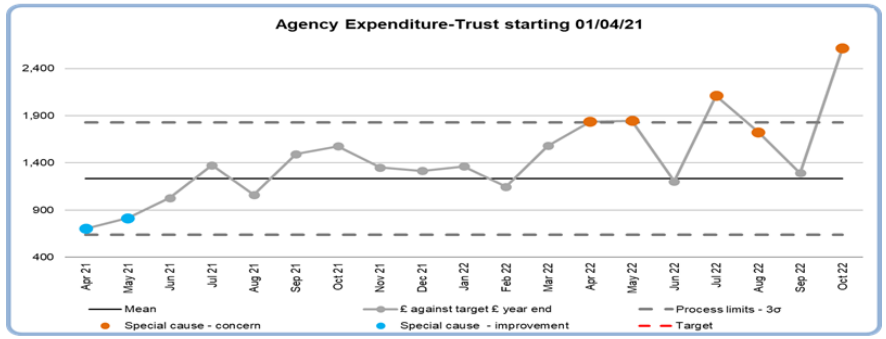
Prioritise the wellbeing of our staff
Rolling 12 month sickness absence increased from 5.42% in September to 5.49% in October. The most affected staff groups are additional clinical services and estates and ancillary staff with absence rates of 8.21% and 9.36% respectively. COVID-19 sickness and *stress/anxiety/depression/other psychiatric illness* continue to be the leading causes of days lost to sickness absence, with *cold, cough, flu – influenza* also seeing an increase in wte days lost, from 938.6wte days (7.7%) in September to 1334.2wte days lost (9.8%) in October. By comparison October 2021, 1543.5 wte days (11.6%) were lost to *cold, cough, flu – influenza.*

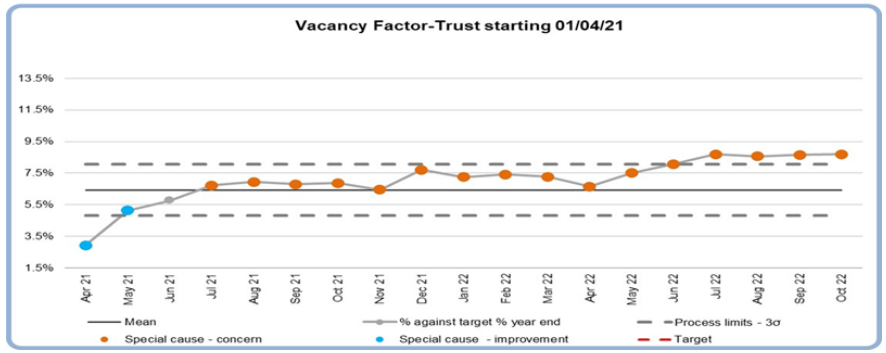
Continue to reduce reliance on agency and temporary staffing
Temporary staffing demand increased by 1.88% (23.52wte) from September to October, while Agency use decreased by 0.81% (-1.38 wte). However, as bank use increased (3.49%, 23.76wte), unfilled shifts increased by only 0.29% (1.14wte). Unregistered nursing and midwifery, and add prof scientific and technical staff saw the greatest increase in demand for temporary staff (5.69% and 10.37% respectively).
Total agency RMN Use decreased by 39.06% (-9.33wte), driven by decreased use in Medicine Division wards; tier 4 RMN use decreased by 2.23wte (-173.91%).

Theme	Action	Owner	By When
Vacancies	Initiated review of recruitment process using which will use Patient First A3 methodology to delivery 'Faster, Fairer Recruitment'	Associate Director for Strategic Workforce Planning and Resource	Ongoing
Turnover	Implementing the agreed agile working principles in a Trust-wide action plan and the developing a toolkit to support staff and managers to work in agile ways. Increasing flexible working across the Trust to improve work life balance and reduce turnover.	Associate Director of People	Ongoing
Wellbeing	Implementing financial wellbeing projects to support our staff; Salary linked finance and savings provider, £7.50 payment to all bands 2-5 and F1 doctors to buy a Blue light card discount card and reduced cost meals in the Vu	Associate Director Culture, Leadership & Development	Dec-22
Temporary Staffing	Tighter focus on Tier 4 reduction - with increased governance and control over usage at point of escalation	Associate Director for Strategic Workforce Planning and Resource	Oct-22

Workforce







What Does the Data Tell Us – Vacancies Nursing and Midwifery

Unregistered Nursing

- October was a positive month for recruitment with far more applications received. 47 offers were made for healthcare support worker (HCSW) roles across the Trust. 23 for band 2 roles and 24 for band 3 roles
- October saw 19.9 wte new band 2 starters this month, band 3 starters were 14.6 wte for the month
- Vacancies in October for unregistered nursing increased slightly. Band 2 vacancies are now at 78.7 wte (down from 79.4 wte) and band 3 vacancies are currently 60.4 wte (Up from 57.1 wte)

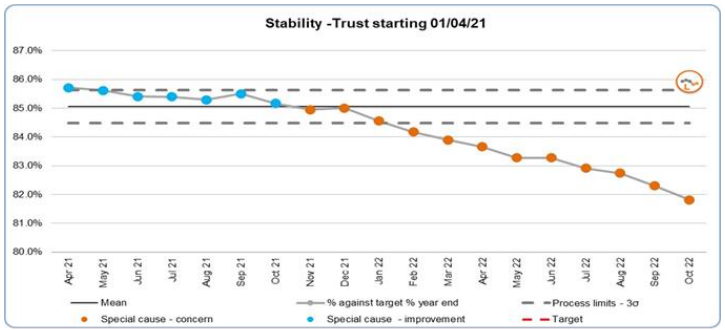
Registered Nursing

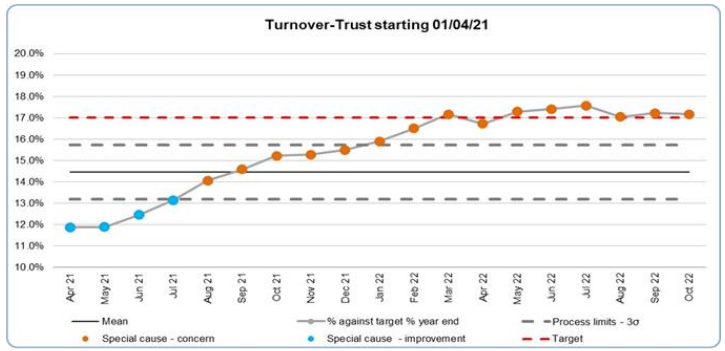
- Applications bounced back this month and a record number of offers were made for band 5 nursing and midwifery candidates – 53 in total. 28 of which were offered during our Autumn Nursing, Midwifery and ODP open day on the 15th October.
- October saw a further 20.6 wte band 5 starters in September and leavers were 21.9 wte. Our overall registered nursing and midwifery vacancies increased to 287.2 wte
- The Trust was represented at four job fair events in, Newport, Central Bristol and our own internal nursing exhibition. .
- Eight international nurses arrived in October to start their OSCE training with the Trust

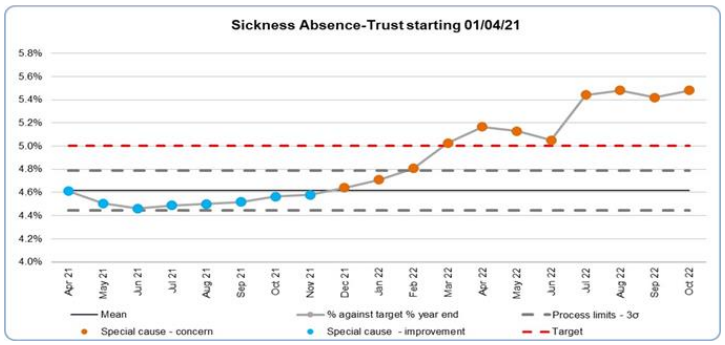
Temporary Staffing

- Agency worked wte and expenditure increased in October due to invoices being paid in month for work completed in other months – this has meant the position in the financial ledger in the SPC charts on this page do no demonstrate the position of agency hours worked in October.

Engagement and Wellbeing







What Does the Data Tell Us - Turnover and Stability

Turnover while remaining high, decreased in October to 17.17% with unregistered clinical professions driving the position and in particular HCA band 2 roles. Other clinical staff groups saw an increase in October but remain under the average turnover rate for the Trust.

Actions delivered: (Associate Director of People)

- The National Nursing and Midwifery self-assessment tool has been completed with stakeholders to assess our strengths and opportunities in nursing retention areas. This has produced an action plan of actions we will take that will support higher levels of retention
- Backpay negotiations with trade unions concerning Band 2 HCAs have now concluded and have improved career opportunities for all our colleagues in HCSW roles

Actions in Progress:

- Further development of career coaching for all staff, with an initial focus on N&M, AHPs and admin staff in response to leaver's data which cites reasons for leaving linked to promotion and career progression **(August – Dec 22)**
- Piloting Exit Questionnaires using MS Forms with a data feed into Qlik **(October – December 22)** to improve ease of use and data interrogation
- Extend the use of buddy support for international nurses to all new starters on ward areas **(Oct – Dec 2022)**
- An internal business case is under consideration to increase pay rates offered to apprentices, which could improve HCA retention rates **(Nov 22)**,
- Targeted interventions in high turnover areas such as Theatres with 'stay conversations' help to understand engagement levels and people's intentions around leaving (Nov- Jan 2023)
- Business case to review pay rates for apprentices for approval (Dec 22)
- Community career events planned with Stepping Up targeting youth groups & BAME women's groups (Dec 22)

What Does the Data Tell Us - Health and Wellbeing

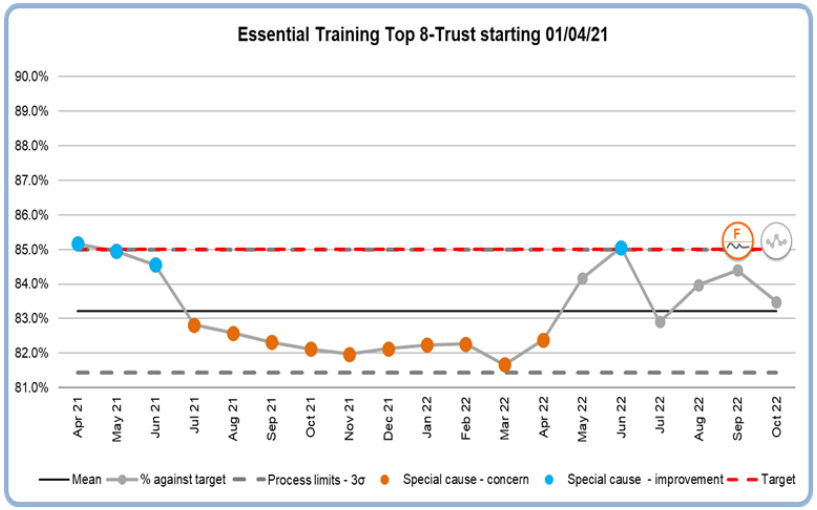
October saw an increase in sickness.

Actions Delivered: (Associate Director of People/Associate Director Culture, Leadership & Development)

- Black History Month events held throughout October led by our B.A.M.E. staff network
- Pensions Recycling Scheme launched October & Blue Light Card payments in October salaries to Bands 2-5 & FY1 staff
- Subsidised staff food introduced across 3 staff sites introduced in November (£1 soup & roll)
- Wellbeing Deep Dive held with Joint Union Committee to review current wellbeing offer and consider areas for enhancement, action plan to be taken through Wellbeing Task & Finish Group
- Staff survey continues to be live, 49% participation rate 16/11 ahead of survey close date 25/11

Actions in Progress: (Associate Director of Culture, Leadership & Development)

- New Reasonable Adjustment toolkit is being finalised and then comms plan and engagement events are being scheduled to align to Disability History Month 2022 (Nov- Dec 22)
- Proposal for new Leadership Development Programme & new managers training developed ahead of business case.
- Revised Trust-wide induction programme proposed for implementation from January 2023.
- Contract for salary advance / credit agreements via third party close to completion ahead of January launch.



Training Topic	Variance	Sep-22	Oct-22
Child Protection	-0.2%	82.8%	82.6%
Adult Protection	0.1%	83.1%	83.2%
Equality and Diversity	0.1%	85.6%	85.7%
Fire Safety	0.5%	84.5%	85.0%
Health and Safety	-0.2%	85.4%	85.2%
Infection Control	0.1%	86.0%	86.1%
Information Governance	0.0%	82.0%	82.0%
Manual Handling	0.2%	82.8%	83.0%
Waste	-0.1%	85.5%	85.4%
Total	**1.1%**	**82.38%**	**83.49%**

What Does the Data Tell Us - Essential Training

MaST compliance is trending upwards, meaning that more people are engaging with their MaST. Trust compliance is hovering around 85%.

L&OD are working with 5 divisions to encourage completion of outstanding training.

Actions – Essential Training (*Head of Learning and Development)*

- People Partners are sent reports to encourage completion of MaST for areas below the 85% target.

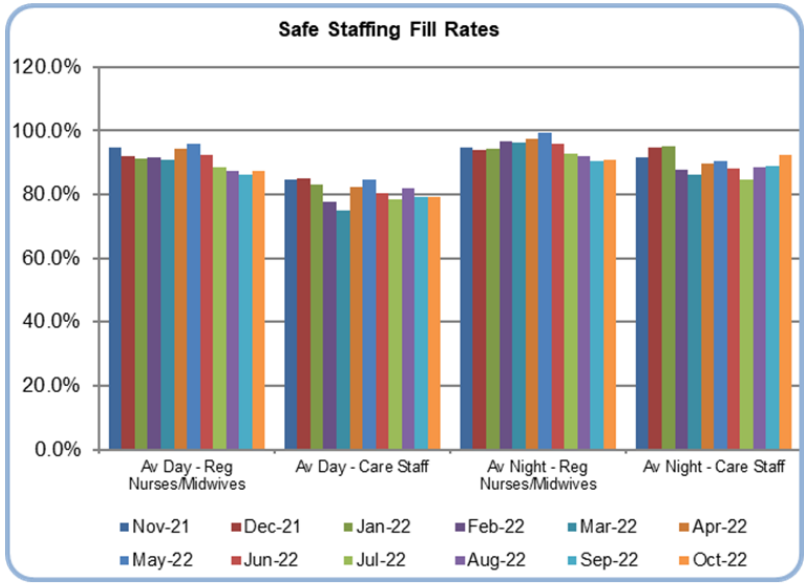
Other Wider Actions

Leadership & Management Learning

- Our range of face-to-face Management Skills Modules continue to be delivered, whilst we are carrying out a review of our modules to include Bitesize events and resources and virtual sessions.
- The previous OneNBT Programme has officially been closed, and we are working to review, rebrand and relaunch this in collaboration with NHS Elect in April 2023, along with a relaunch of the NBT Induction and a Management Refresher training programme available for Managers across NBT.
- Coaching CPD Events are being organised to develop and support our NBT Coaching Faculty, (6 new coaches have joined the NBT coaching community) and Mentoring training will be available in 2023 to create a Faculty to further support development requests.
- We are working on creating a comms and engagement plan and calendar, with the aim of sending out our first monthly Newsletter to staff across the Trust in December 2023.
- The Specialty Leads Programme continues to be delivered, however due to low attendance rates we are looking to refresh this offer in early 2023, which may see this offered to additional roles including General Managers across the Trust.
- The Conversations with Compassion Module, jointly developed by the Psychology Team and Leadership and Management is being run in to support clerical and administrative staff in NMSK and ASCR on 15.11.22 and 29.11.22

Apprenticeships

- Levy utilisation from 1st April 22 is 92%, with zero expired levy funds for October. NBT also continued to commit to transferring 10% of levy funds to healthcare providers within the BNSSG, however, this is currently on pause for new transfer requests as allocation for the year has been met.
- The apprenticeship centre has since had its final Ofsted report, which will be live to view on the Ofsted report website within the next eight days.
- Apprenticeship centre completions for October - 6 L2 HSCW have passed their apprenticeship and 2 L4 SHCSW apprentices have passed. Enrolments for HCSW apprentices have significantly reduced compared to this time last year, this is mainly due to HCSW eligibility to meet apprenticeship requirements.
- Team leader apprentices' success stories we have had a B6 radiographer gain a promotion to a B7 practice education and radiographer A previous learner within facilities, also secured a promotion last week from a B4 to B5 Manager in facilities.



Oct-22	Day shift		Night Shift	
	RN/RM Fill rate	CA Fill rate	RN/RM Fill rate	CA Fill rate
Southmead	87.4%	79.2%	90.7%	92.5%

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

What Does the Data Tell Us

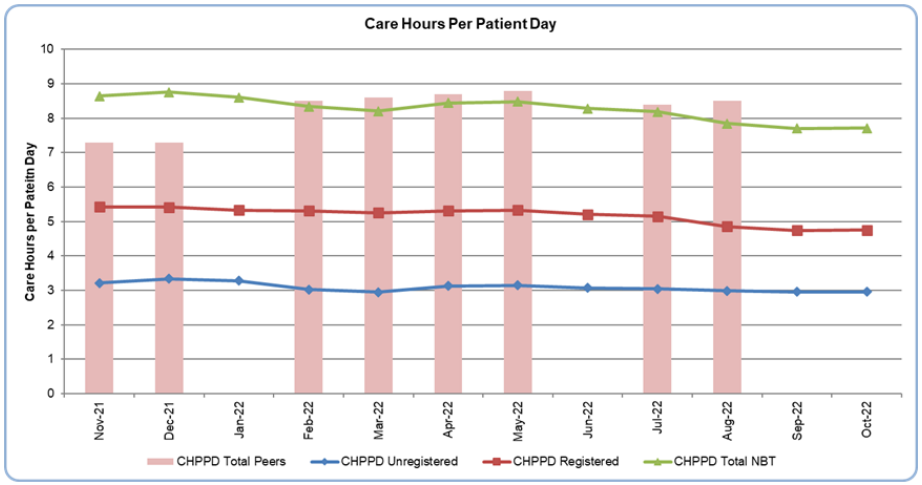
There is an organisational focus on recruiting to Care Staff (HCSW) vacancies with a successful BNSSG recruitment event supported by NHS England during May 2022 with 82.00 wte starting up to the end of October.

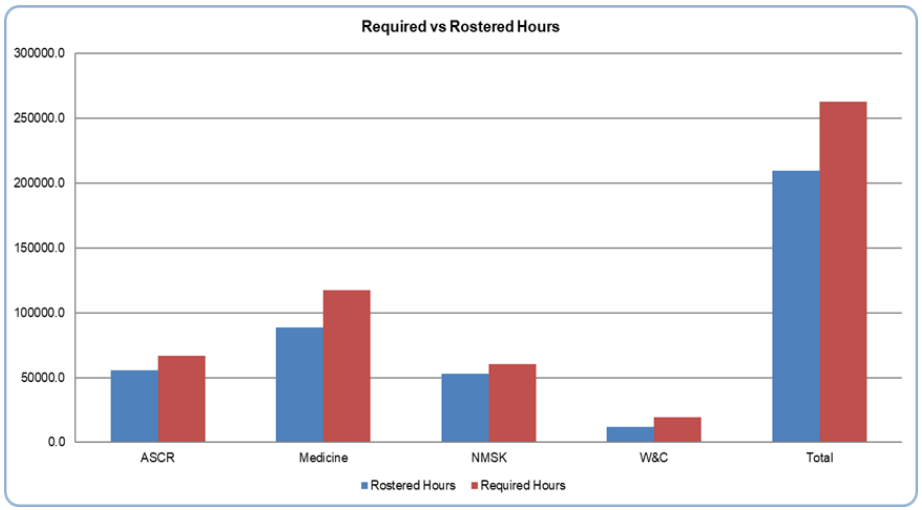
September's Nursing & Midwifery safe staffing summit has led to some key actions to review and improve the care assistant recruitment process.

Safe staffing is maintained through daily staffing reviews and registered staff and unregistered staff are deployed as required to meet the needs of patients across the service. Where staffing fill rates exceed 100% this is predominantly related to caring for patients with enhanced care needs.

Of the 34 units reports safer staffing data:

- 17.6% of units had a registered fill rate of less than 80% by day and 8.8% by night with hotspots in maternity, NMSK wards, Medirooms and SAU.
- 50.0% had an unregistered fill rate of less than 80% by day and 17.6% by night. Data shows an extremely high unfilled rate across all divisions which is reflected in the daily overall staffing sitrep.





What Does the Data Tell Us – Care Hours per Patient Day (CHPPD)

The chart shows care hours per patient day for NBT total and is split by registered and unregistered nursing. The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital).

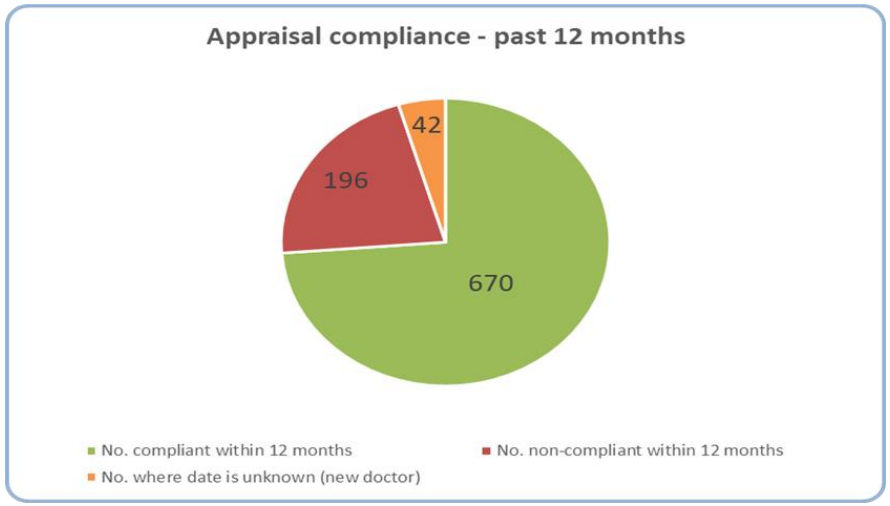
Safe Care Live (Electronic Acuity Tool)

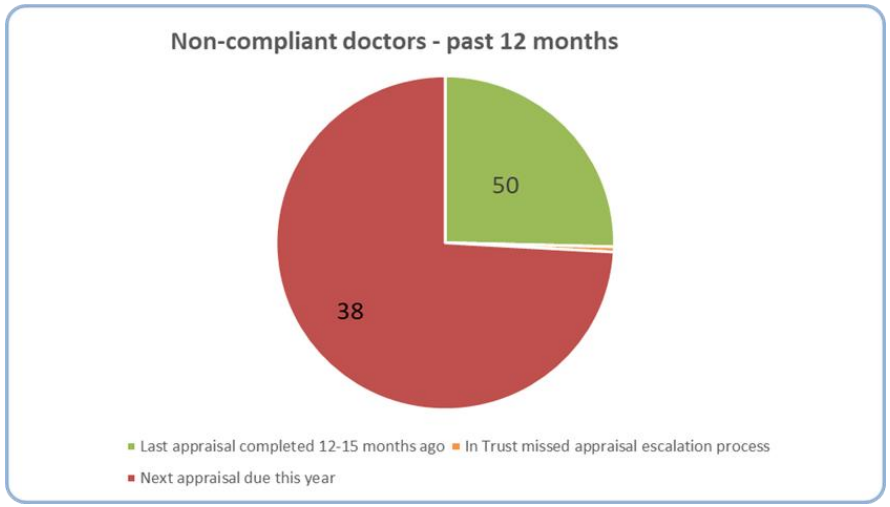
The acuity of patients is measured three times daily at ward level. The Safe Care data is triangulated with numbers of staff on shift and professional judgement to determine whether the required hours available for safe care in a ward/unit aligns with the rostered hours available.

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

What does the data tell us

This month the required hours have been augmented using the completion rate for SafeCare patient census data. Where the census completion was less than 100% the required hours have been supplemented by an assumption that for the census periods not completed the patient mix would have been the same on average.





Medical Appraisal

What does the data tell us?

Medical appraisals returned to a mandatory process for all doctors from the 1st April 2021 using a nationally agreed light touch approach. The Fourteen Fish system has been adapted for this process. Appraisals unable to be completed prior to April 2021 will be marked as an approved missed appraisal due to the pandemic.

The information in this page refers to appraisal compliance within the last 12 months. Doctors without an appraisal in the last 12 months includes doctors completing their last appraisal earlier than when it was due, doctors having missed an appraisal while being employed with another organisation, or doctors who are simply overdue their current appraisal (some of which have a meeting date set).

All revalidations prior to the 16th March 2021 were automatically deferred by the GMC for 12 months. The process restarted in full in March 2021.

What actions are being taken to improve?

Doctors who are overdue their appraisal from the last 12 months which should have taken place at NBT will fall under the Trusts missed appraisal escalation process. Doctors with an acceptable reason for not completing an appraisal in the last 12 months will have a new appraisal date set this year.

Where possible, the revalidation team are making revalidation recommendations early for those doctors who were automatically deferred in order to reduce the number that will be due in 2022/23.

Finance

Board Sponsor: Chief Financial Officer
Glyn Howells

Statement of Comprehensive Income at 31st October 2022

	Month 7			Year to Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Contract Income	58.3	61.4	3.1	406.9	422.7	15.7
Other Income	5.3	7.6	2.3	42.8	47.7	5.0
Pay	(38.6)	(42.9)	(4.3)	(275.5)	(290.8)	(15.3)
Non-Pay	(25.1)	(26.6)	(1.5)	(179.9)	(190.7)	(10.7)
Surplus/(Deficit)	**(0.1)**	**(0.6)**	**(0.5)**	**(5.7)**	**(11.1)**	**(5.3)**

Assurances

The financial position for October 2022 shows the Trust has delivered a £0.6m actual deficit against a £0.1m planned deficit which results in a £0.5m adverse variance in month, with a £5.3m adverse variance year to date.

Contract income is £3.1m favourable in month and £15.6m favourable year to date. The in month position is driven by the additional income recognised relating to the pay award (£1.3m favourable), ESRF (£0.7m favourable) and additional funding relating to SDEC, Demand and Capacity funding and Service Developments (£1.4m favourable).

Other Income is £2.3m favourable in month and £5.0m favourable year to date. The Trust has recognised new income streams since the plan was signed off, the new income streams have a net-neutral impact on the financial position. The favourable position is driven by increased income in finance due to private patient activity and post graduate funding.

Pay expenditure in month is £4.3m adverse in month and £15.3m adverse year to date. The in month position is driven by overspends on bank and agency (£1.9m), CIP under-delivery (£0.8m) and overspends on admin and ancillary driven by delays in delivery of savings as well as increased bank usage to cover sickness. In September, the Trust paid the backdated pay award to agenda for change and consultant employees. The additional 1.66% pay award announced in August is greater than the initial 2% included within the June plan. This is driving a £0.8m adverse variance in October.

Non-pay expenditure in month is £1.5m adverse and £10.7m adverse year to date. The in month position is driven by increased spend on medical and surgical supplies in ASCR, drug and blood product spend (pass-through), unidentified CIP and increased spend in Corporate areas offset by income. This is partially offset by £1.5m favourable variance in cost of capital from delayed depreciation and a review of IFRS 16 leases treatment.

Statement of Financial Position at 31st October 2022

	21/22 M12 £m	22/23 M06 £m	22/23 M07 £m	In-Month Change £m	YTD Change £m
Non Current Assets					
Property, Plant and Equipment	605.0	609.2	610.3	1.0	5.3
Intangible Assets	13.7	12.3	12.3	0.1	(1.4)
Non-current receivables	1.5	1.5	1.5	0.0	0.0
Total non-current assets	**620.2**	**623.0**	**624.1**	**1.1**	**3.9**
Current Assets					
Inventories	9.1	9.4	9.5	0.1	0.4
Trade and other receivables NHS	19.0	22.0	18.8	(3.2)	(0.2)
Trade and other receivables Non-NHS	20.5	25.6	25.2	(0.4)	4.7
Cash and Cash equivalents	116.2	89.2	99.4	10.1	(16.8)
Total current assets	**164.8**	**146.3**	**153.0**	**6.6**	**(11.8)**
Current Liabilities (< 1 Year)					
Trade and Other payables - NHS	10.6	5.5	6.1	0.6	(4.5)
Trade and Other payables - Non-NHS	102.6	98.3	99.6	1.3	(3.0)
Deferred income	16.4	17.9	26.5	8.6	10.1
PFI liability	15.2	15.7	15.7	0.0	0.4
Finance lease liabilities	2.1	4.1	3.1	(1.0)	1.0
Total current liabilities	**147.0**	**141.4**	**150.9**	**9.5**	**4.0**
Trade payables and deferred income	7.1	7.8	7.7	(0.1)	0.6
PFI liability	359.3	354.1	353.4	(0.8)	(5.9)
Finance lease liabilities	2.0	6.7	6.2	(0.4)	4.2
Total Net Assets	**269.7**	**259.3**	**258.8**	**(0.4)**	**(10.9)**
Capital and Reserves					
Public Dividend Capital	456.9	456.9	456.9	0.0	(0.0)
Income and expenditure reserve	(372.4)	(371.3)	(371.3)	0.0	1.1
Income and expenditure account - current year	1.1	(10.4)	(10.9)	(0.4)	(11.9)
Revaluation reserve	184.1	184.1	184.1	0.0	(0.0)
Total Capital and Reserves	**269.7**	**259.3**	**258.8**	**(0.4)**	**(10.9)**

Assurances and Key Risks

Capital – Total capital spend for the year to date was £14.1m, compared to an initial plan of £12.7m. The total planned spend for the year is £22.1m. The Capital Planning Group (CPG) has reviewed the year to date position, together with the forecast for the remainder of the year and the associated risks.

Receivables - There was a net increase of £4.5m in receivables, of which £4.6m is related to income from the commissioners offset by a net decrease in other receivables (including year-end accruals for Mass Vaccination and Nightingale Surge Ward).

Cash – The cash balance decreased by £16.8m for the year to date due to the in-year deficit and higher than average payments made during the period, including significant amounts of capital spend cash relating to the March 2022 capital creditor and partially funded pay award. This is offset by deferred commissioning and research income received to date. Despite the reducing cash balance, the Trust is still expected to be able to manage its affairs without any external support for the 2022/23 financial year.

Payables -Year to date NHS payables have reduced by £4.5m due to post year end actions. Non-NHS payables have decreased by £3.0m, of which £5.9m relates to the reduction of accrued capital expenditure because of post year end payments, offset by net increases of £2.9m across invoiced and accrued liabilities. The above payments patterns are reflected in the reduced cash balance.

Deferred income - There is a year to date increase of £10.1m in deferred income, of which £3.8m represents deferral of contract income for delayed service developments, and the remainder is linked with timing of funding received from Health Education England and research.

Regulatory

Board Sponsor: Chief Executive
Maria Kane

Monitor Provider Licence Compliance Statements at November 2022
Self-assessed, for submission to NHSI

Ref	Criteria	Comp (Y/N)	Comments where non compliant or at risk of non-compliance
G4	Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)	Yes	A Fit and Proper Person Policy is in place. All Executive and Non-Executive Directors have completed a self assessment and no issues have been identified. Further external assurance checks have been completed as appropriate and no issues have been identified.
G5	Having regard to monitor Guidance	Yes	The Trust Board has regard to NHS Improvement guidance where this is applicable. The Organisation has been placed in segment 3 of the System Oversight Framework, receiving mandated support from NHS England & Improvement. This is largely driven be recognised issues relating to cancer wait time performance and reporting.
G7	Registration with the Care Quality Commission	Yes	CQC registration in place. The Trust received a rating of Good from its inspection reported in September 2019. A number of mandatory actions were identified which are being addressed through an action plan. The Trust Board receives updates on these actions via its Quality Committee.
G8	Patient eligibility and selection criteria	Yes	Trust Board has considered the assurances in place and considers them sufficient.
P1	Recording of information	Yes	A range of measures and controls are in place to provide internal assurance on data quality, including an annual Internal Audit assessment.
P2	Provision of information	Yes	The trust submits information to NHS Improvement as required.
P3	Assurance report on submissions to Monitor	Yes	Scrutiny and oversight of assurance reports to regulators is provided by Trust's Audit Committee and other Committee structures as required.
P4	Compliance with the National Tariff	Yes	NBT complies with national tariff prices. Scrutiny by CCGs, NHS England and NHS Improvement provides external assurance that tariff is being applied correctly. It should be noted that NBT is currently receiving income via a block arrangement in line with national financial arrangements.
P5	Constructive engagement concerning local tariff modifications	Yes	Trust Board has considered the assurances in place and considers them sufficient. It should be noted that NBT is currently receiving income via a block arrangement in line with national financial arrangements.
C1	The right of patients to make choices	Yes	Trust Board has considered the assurances in place and considers them sufficient.
C2	Competition oversight	Yes	Trust Board has considered the assurances in place and considers them sufficient.
IC1	Provision of integrated care	Yes	Range of engagement internally and externally. No indication of any actions being taken detrimental to care integration for the delivery of Licence objectives.

Appendix 1: Glossary of Terms

Unless noted on each graph, all data shown is for period up to, and including, 31 October 2022 unless otherwise stated.

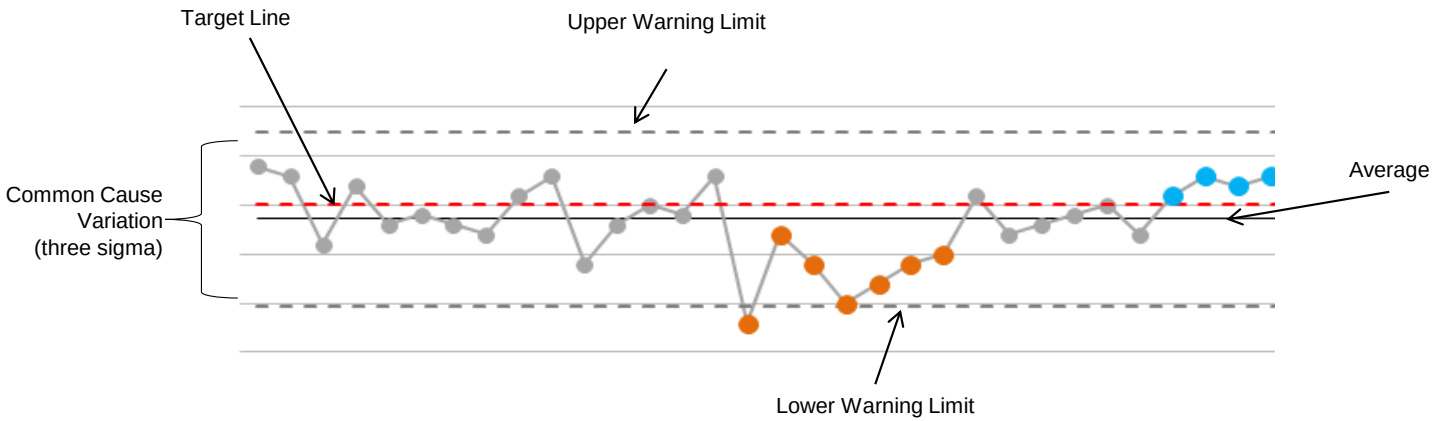
All data included is correct at the time of publication.
Please note that subsequent validation by clinical teams can alter scores retrospectively.

NBT Quality Priorities 2022/23

QP1	Enabling Shared Decision Making & supporting patients' self-management
QP2	Improving patient experience through reduced hospital stays ('right to reside') & personalised care
QP3	Safe & excellent outcomes from emergency care
QP4	Safe & excellent outcomes from maternity care
QP5	Providing excellent cancer services with ongoing support for patients and their families
QP6	Ensuring the right clinical priorities for patients awaiting planned care and ensuring their safety

Abbreviation Glossary	
AMTC	Adult Major Trauma Centre
ASCR	Anaesthetics, Surgery, Critical Care and Renal
ASI	Appointment Slot Issue
CCS	Core Clinical Services
CEO	Chief Executive
CIP	Cost Improvement Programe
Clin Gov	Clinical Governance
CT	Computerised Tomography
CTR/NCTR	Criteria to Reside/No Criteria to Reside
CQUIN	Commissioning for Quality and Innovation
D2A	Discharge to assess
DDoN	Deputy Director of Nursing
DTOC	Delayed Transfer of Care
EPR	Electronic Patient Record
ERS	E-Referral System
GRR	Governance Risk Rating
HSIB	Healthcare Safety Investigation Branch
HoN	Head of Nursing
ICS	Integrated Care System
IMandT	Information Management
IPC	Infection, Prevention Control
LoS	Length of Stay
MDT	Multi-disciplinary Team
Med	Medicine
MRI	Magnetic Resonance Imaging
NMSK	Neurosciences and Musculoskeletal
Non-Cons	Non-Consultant
Ops	Operations
PDC	Public Dividend Capital
P&T	People and Transformation
PTL	Patient Tracking List
qFIT	Faecal Immunochemical Test
RAP	Remedial Action Plan
RAS	Referral Assessment Service
RCA	Root Cause Analysis
SI	Serious Incident
TWW	Two Week Wait
UEC	Urgent and Emergency Care
VTE	Venous Thromboembolism
WCH	Women and Children's Health
WTE	Whole Time Equivalent

Appendix 2: Statistical Process Charts (SPC) Guidance



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

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

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

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

Report To:	Trust Board – Public		
Date of Meeting:	24 November 2022		
Report Title:	Finance & Performance Committee Upward Report		
Report Author & Job Title	Aimee Jordan, Interim Senior Corporate Governance Officer and Policy Manager		
Executive/Non-executive Sponsor	Tim Gregory, Non-Executive Director and Committee Chair		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Committee recommends that Trust Board receive the report for assurance and note its content.		
Report History:	The report is a standing item to each Trust Board meeting following a Finance and Performance Committee. The last report was received at the September 2022 private Board meeting.		
Next Steps:	The next report to Trust Board will be to the January 2023 meeting.		

Executive Summary	
The following report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the 17 November 2022 F&PC.	
Risk	Reports received at the meeting support the mitigation of various BAF and Trust Level risks, particularly those relating to patient flow, access to elective care and IMT/Cyber security risks.
Financial implications	Business cases approved by the Committee are within the delegated limits as set out in the Trust's Standing Financial Instructions and Scheme of Delegation.
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No as this is not a strategy or policy or change proposal
Appendices:	Appendix 1: Finance Report Month 7

1. Purpose

1.1 To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Finance and Performance Committee meeting held on 17 November 2022.

2. Background

2.1 The Finance and Performance Committee is a sub-committee of the Trust Board. It meets bi-monthly and reports to the Board after each meeting. The Committee was established to provide assurance to the Trust Board that there are robust and integrated systems in place overseeing the Trust's finance, IM&T, transformation, and performance and that they are in line with the organisation's objectives.

3. Key Assurances & matters for the attention of Trust Board

3.1. NBT Performance Report

The Committee received an update on the organisation's operational performance, which confirmed:

- That the performance against trajectory for long-waiting patients has deviated but it remained within the delivery tolerance. It was noted that monthly trajectories have been developed and targeted plans were in place to ensure delivery of the planned care trajectories, including outsourcing to the Independent Sector for a range of General Surgery procedures.
- That the diagnostic trajectories had significantly improved and were driven by a reduction in the backlog position across the modalities. It was noted that the performance was in the best position since July 2021.
- That there was significant improvement in the Cancer performance and that actions to sustain the performance were being embedded. It was highlighted that the South West region has made a recommendation to the National team to remove NBT from Tier 1 and Tier 2 status.

The system plans to combat capacity issues such as the No Right to Reside (NR2R) patients were discussed and the Committee recognised that the Trust was fully engaged with the system's plans, but more work was required to find solutions.

The Committee discussed the Emergency Department's long waiting times and requested that the impact of 'worried well' patients be investigated.

The Committee were informed that activity levels remained an issue (despite the positive planned care performance) and that the business planning process will give visibility of the impact of the decreased activity levels driven by the NR2R position.

3.2. EPR Performance Risks

The Committee received an update on the EPR Performance Risks that have occurred following the go-live including the resulting impacts and current resolution status. The key issues centred around outpatients particularly clinic building, electronic outcoming and

the waiting list. The ongoing work to implement solutions and resolve issues with the divisional performance teams was noted.

The revalidation reporting risks as a result of the issues were discussed and the Committee noted the ongoing work to mitigate the risk through additional resourcing.

The Committee raised concerns regarding the impact on the patient and were informed there was a reduction in outpatient capacity due to booking inefficiencies. The Committee were reassured that this issue had now been resolved and there were minimal clinical challenges.

Following discussions on the level of engagement during the process mapping, the Committee noted that governance had been established to ensure clinical leaders were included in the workstream and programme governance but noted that this would be further investigated in the post-programme analysis.

The Committee agreed to receive a further update at January's meeting on the status of the stabilisation and were reassured that learning would be shared with other organisations.

3.3. Finance Report (Month 7) & CIP update

The Committee received the Month 7 finance report (see Appendix 1), which detailed that the year to date position at Month 7 was that the Trust had delivered a £11.1m deficit, which was £5.3m worse than plan. This was predominately driven by the non-delivery of savings in the first seven months of the year and high levels of premium pay spend, including on agency and incentives, offset by slippage on service developments and investments. It was noted that the rate of deterioration against plan had significantly improved following actions taken to mitigate the issues and that a route to breakeven for the year had been developed and agreed with Executives and Trust Management Team.

The Committee noted that the Capital Plan was in a favourable position in year which will give the Trust the opportunity to capitalise on any slippage elsewhere in the system or region.

The full finance report is attached as Appendix 1.

3.4. Theatres Stock Management update

The Committee received an update on the progress against the agreed actions to mitigate the risks from the August 21 Theatres Stock Management Audit.

It was recognised that digitalising the whole of the Theatres Stock Management process would provide significant benefits, particularly costs benefits, and should be considered during the investment prioritisation process for 2023/24.

The Committee were assured that appropriate actions are being taken to address the risks identified in the Internal Audit Report and that the Executive team saw this as a step towards a final solution rather than the end of the piece of work.

3.5. BCRG

The Committee received an update from the Business Case Review Group outlining business cases reviewed and approved since the last Committee meeting.

The Committee were assured that all agreed business cases had an identified funding source.

3.6. Operational Performance IM&T Update

The Committee received an update on IM&T performance and noted the conclusion of the tap-and-go implementation and the progress of the Digital Maternity and the Digital Patient programmes.

The Committee received assurance that the Server Room Cooling Systems solution had been delivered and installed, and that the corresponding risk of overheating would therefore be reduced once the new equipment had been evidenced to run for a period with no issues.

The Committee were reassured that progress was being made with the new electronic Procurement system and that the cultural challenges to bring the Digital Maternity system into a single IT system were recognised.

The Committee were also reassured that there was support from operational colleagues to release staff to undertake the relevant training for the digital transformation projects, noting the intention to create a nursing digital fellow post for each ward to provide direct support for staff.

3.7. Risk Report

The Committee noted the Trust Level Risks and Board Assurance Framework (BAF) risks within its purview. The Committee noted the mitigating actions for the overheating and air handling unit risks and acknowledged the potential increase in the BAF risk relating to respiratory illness and Covid-19 as a result of the winter period.

3.8. Other Updates:

- The Committee noted the F&PC Work Programme for 2022/23.
- The Committee discussed the Level 6 Conversion Update, the Community Diagnostics Centre Update and the contract awards.

4. Summary and Recommendations

4.1 The Committee recommends that Trust Board receive the report for assurance, note its content and approve the contract recommendations at section 3.5.

NHS North Bristol NHS Trust

Report To:	Finance & Performance Committee (F&PC)		
Date of Meeting:	November 2022		
Report Title:	Finance Report for October 2022		
Report Author & Job Title	Simon Jones, Assistant Director of Finance – Financial Management		
Executive/Non-executive Sponsor (presenting)	Glyn Howells, Chief Finance Officer		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Disucssion**	**To Receive for Information**
			X
Recommendation:	F&PC is asked to note: • the revised financial framework that the Trust is operating in • the financial performance for the month and year end position • the spend on Mass Vaccinations and Covid-19 expenditure areas • the delivery of Cost Improvement Plan (CIP) savings and how they compare with divisional targets • the Cash position and Capital spend levels for the financial year • the Risks and Mitigations for the forecast position, including the actions required to deliver breakeven		
Report History:	N/A		
Next Steps:	N/A		

Executive Summary
2022/23 has seen the end of the interim financial regime implemented by NHSE/I during the Covid-19 pandemic, which saw trusts deliver a break-even plan, with support from non-recurrent funds. Whilst the new regime is not a return to pre-pandemic Payment by Results, there is a mix of block and variable elements. The basis for funding is on 2019/20 levels of activity and spend, adjusted for inflation and savings over the period since then, as well as service developments and service transfers. There is also the ability to earn additional funds through Elective Services Recovery Funding (ESRF). The Trust submitted a phased plan for 2022/23 in June 2022 that requires it to deliver a breakeven position in the current financial year. This was consolidated into a system breakeven plan.

14.1

This plan includes additional funding to cover some of the inflationary pressures recurrently, in addition to further non-recurrent support. Funding to cover the impact of Covid-19 pressures on Quarter 1 has now been removed and will be funded by the Trust.

The financial plan for 2022/23 at Month 7 (October) was a deficit of £5.8m. The Trust has delivered a £11.1m deficit, which is £5.3m worse than plan. This is predominately driven by the non-delivery of savings in the first seven months of the year and high levels of premium pay spend, including on agency and incentives, partially offset by slippage on service developments and investments.

In month the Trust has recognised £0.7m of ESRF funding in addition to that assumed in the plan. Whilst the Trust has not reached the required activity levels to receive this, there has been a national approach of no clawback from commissioners in Months 1 to 7 for non-delivery. In BNSSG this has been recognised in provider positions in month.

The Trust completed a detailed forecast in September. At month 7 the Trust has seen a £0.1m deterioration against the expected in month position.

The Month 7 CIP position shows £3.4m schemes fully completed, with a further £3.4m schemes on track and £1.6m in pipeline. There is a £8.8m shortfall between the 2022/23 target of £15.6m and the schemes on the tracker. If pipeline schemes are included this reduces to a £7.2m shortfall.

Given the position at Month 7, the Risks and Mitigations impacting on the delivery for the year end position have been reviewed.

Cash at 31 October amounts to £99.4m, an in-month increase of £10.1m which is linked with receipt of pay award funding and reduction in payables.

Total capital spend year to date was £14.1m compared to a plan of £12.1m.

Risks	N/A
Financial implications	N/A
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No
Appendices:	Appendix 1: BNSSG System Finance Report Month 6

1. Purpose

This report is to inform and give an update to F&PC on the financial position and performance for Month 7, the year-to-date position, and the year-end forecast outturn.

2. Financial Performance

2.1 Total Trust

Overall, the Trust delivered a £0.5m adverse position in Month 7, with a £5.3m adverse position to plan for the year-to-date for the 2022/23 financial year.

The table below summarises the Trust financial performance for Month 7 and the year-to-date.

	Month 7			Year to Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Contract Income	58.3	61.4	3.1	406.9	422.7	15.7
Other Income	5.3	7.6	2.3	42.8	47.7	5.0
Pay	(38.6)	(42.9)	(4.3)	(275.5)	(290.8)	(15.3)
Non-Pay	(25.1)	(26.6)	(1.5)	(179.9)	(190.7)	(10.7)
Surplus/(Deficit)	**(0.1)**	**(0.6)**	**(0.5)**	**(5.7)**	**(11.1)**	**(5.3)**

For Month 7 the Trust has delivered a £0.5m adverse position against the £0.1m planned deficit. Underperformance on CIP is the key driver of the position, alongside overspends on pay for agency and bank against substantive vacancies, however this is partially offset by delays in the delivery of recurrent and non-recurrent service developments. The Trust has seen an improvement in its adverse position in month against the year-to-date run rate, with further details of the drivers in the Core narrative.

Nationally, there is no written confirmation that there will be no clawback of ESRF for non-delivery in 2022/23. However, the Trust and the System continue to work to the assumption that there will be no clawback for the remainder of the financial year as verbally instructed by NHSEI. The Trust recognised £10.2m of ESRF income in Month 7 for the year-to-date period and will continue to recognise an additional £0.7m per month in relation to this.

2.2 Core Trust

The table below summarises the Core Trust including ESRF activity (excluding Mass Vaccination, Research and Education) financial performance for Month 7.

	Month 7			Year to Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Contract Income	58.3	61.4	3.1	406.9	422.7	15.7
Other Income	4.2	6.0	1.8	31.3	38.5	7.2
Total Income	**62.5**	**67.4**	**4.9**	**438.2**	**461.2**	**22.9**
AHP's and STT's	(6.0)	(5.9)	0.1	(42.2)	(39.8)	2.4
Medical	(12.2)	(11.7)	0.5	(81.9)	(83.1)	(1.2)
Nursing	(13.6)	(14.9)	(1.4)	(93.1)	(99.2)	(6.1)
Other Non Clinical Pay	(5.9)	(9.3)	(3.4)	(49.6)	(61.8)	(12.2)
Total Pay	**(37.7)**	**(41.9)**	**(4.2)**	**(266.8)**	**(283.9)**	**(17.1)**
Drugs	(4.1)	(4.4)	(0.3)	(29.5)	(33.3)	(3.7)
Clinical Supplies (Incl Blood)	(4.9)	(5.3)	(0.4)	(33.7)	(34.7)	(1.0)
Supplies & Services	(5.8)	(6.5)	(0.7)	(39.9)	(42.4)	(2.5)
Premises Costs	(3.3)	(3.2)	0.1	(22.5)	(23.8)	(1.3)
Other Non-Pay	(6.9)	(6.7)	0.2	(51.8)	(54.1)	(2.4)
Total Non-Pay Costs	**(25.0)**	**(26.0)**	**(1.0)**	**(177.4)**	**(188.3)**	**(10.9)**
Surplus/(Deficit)	**(0.2)**	**(0.4)**	**(0.3)**	**(5.9)**	**(11.1)**	**(5.2)**

The core Trust position in month is £0.3m adverse. This highlights the impact of the under-achievement of CIP and overspends on agency and bank offset by delayed spend against funding for new investments and service developments and the recognition of ESRF funding in month.

2.2.1 Core In Month

The in month performance for Trustwide Contract Income shows a favourable variance of £3.1m. This is largely driven by the 1.66% pay uplift recognised in month (£1.3m) which was not in the original budget plan, along with £1.4m of additional funding including for SDEC and Demand & Capacity funding with the balance relating to several Service Development items (Ageing Well, Long Covid, Breast Recovery and Heart Failure).

Following the update in Month 4 with respect to additional ESRF funding per the revised guidance, £0.7m of incremental income has been recognised creating a further favourable variance. In addition, an improved performance against High Cost Drugs and Devices of £0.4m has been seen which is offset by additional non-pay expenditure.

In terms of financial value at a Divisional level, Contract Income in October is £3.5m adverse shown in the table below.

Divisional Contract Income by POD	Price Plan	Price Actual	Variance
AandE	1.7	1.3	(0.4)
Critical Care	3.5	3.9	0.3
Direct Access	1.3	1.4	0.0
Elective	8.3	8.4	0.1
High Cost Drugs & Devices	4.8	4.8	(0.0)
Non Elective	14.0	12.0	(2.0)
Outpatients	6.6	5.0	(1.5)
Rehab	0.9	0.4	(0.5)
Other	8.4	8.9	0.4
Total	**49.7**	**46.1**	**(3.5)**

Month 7 contract income for Divisions shows actual activity, whereas the Trust wide position has been set to the expected block amounts except for variable items (e.g. high-cost drugs). Any variances on drugs and devices income are countered by an increase/decrease in expenditure on drugs and devices in non-pay.

Actual activity delivered is behind plan in month by £3.5m. This is driven predominately by underperformances in Outpatients and Non-elective activity partially countered by over performance in Elective activity and Critical Care. The drop in Outpatient activity continues to be investigated with the lower levels of expected income being driven, at least in part, by delays in processing activity and subsequently recording it on the new electric patient record system.

Other income is £1.8m favourable to plan. The Trust has recognised new funding in the year-to-date position since the final plan was signed off in June due to new funding streams. A monthly adjustment is undertaken to align this with the plan. This adjustment is net neutral on the Trust position and if removed shows other income to be £0.2m favourable to plan. This is driven by increased income in Finance due to private patient activity and for postgraduate funding. Both these income streams have corresponding offsetting costs in non-pay in month.

Pay expenditure is £4.2m adverse to plan. In Month 6 the Trust has paid the backdated pay award to agenda for change and consultant employees. The additional 1.66% pay award announced in August was greater than the initial 2% included within the June plan. The costs have been offset by additional income to the Trust within the contract income position above. In month 7 the Trust is seeing a £0.8m impact of this.

The remaining adverse variance on pay of £3.3m is driven by overspends in Nursing and HCA (£1.4m) due to higher agency and bank spend, sickness and continued Registered Mental Nurse (RMN) agency usage in Medicine. The Trust has seen the impact in month of £0.5m of backdated charges relating to the usage of a new agency for nursing staffing. An offsetting improvement in run-rate from reduced spend through Thornbury was seen within prior months. In month, the Trust has seen a further reduction in run-rate for RMN spend within Medicine. This is driven by increased scrutiny within Divisions over shift bookings and a reduction in complexity of patients from September.

In month unidentified pay CIP is causing a £0.8m adverse variance from continued underperformance, £0.4m adverse variance in administration due to delayed delivery of the IM&T clinical coding saving and backdated charges for cancer trackers within the Operations directorate, and £0.3m adverse in ancillary driven by increased sickness amongst domestics within Facilities.

Non-pay spend is £1.0m adverse to plan which is driven by increased spend on medical and surgical supplies in ASCR, drug and blood product spend (pass-through), unidentified CIP and increased spend in Corporate areas offset by income. The is partially offset by £1.5m favourable variance in cost of capital from delayed depreciation and a review of IFRS 16 leases treatment.

CIP under delivery is causing a £1.1m adverse variance to plan in month split between pay and non-pay.

2.2.2 Core Full Year

The year-to-date position is £5.2m adverse.

The year-to-date Trustwide contract income variance is £15.7m favourable. This is driven by the additional income recognised relating to the pay award (£5.9m favourable), ESRF income clawback

not included within the plan (£4.7m favourable) and high cost drugs and devices (£4.2m favourable) offset within non-pay.

Pay expenditure is £17.1m adverse to plan driven by the pay award, premium pay costs and non-delivery of CIP.

Non-pay spend is £10.9m adverse driven mainly bypass-through drugs costs. The Trust has also seen underperformance on CIPs, increased medical supplies spend, and additional Pathology costs within Core Clinical.

CIP delivery year-to-date is driving a £4.4m adverse variance to plan split between pay and non-pay.

2.3 Mass Vaccination

The table below summarises the Mass Vaccination Programme income and expenditure for Month 7.

	Month 7			Year to Date		
	Budget	Actual	Variance	Budget	Actuals	Variance
	£m	£m	£m	£m	£m	£m
Other Income	0.0	0.9	0.9	4.5	4.9	0.4
Total Income	**0.0**	**0.9**	**0.9**	**4.5**	**4.9**	**0.4**
AHP's and STT's	(0.0)	(0.4)	(0.4)	(0.2)	(0.9)	(0.7)
Medical	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)
Nursing	(0.0)	0.0	0.0	(1.5)	(1.1)	0.5
Other Non Clinical Pay	(0.0)	(0.1)	(0.1)	(0.9)	(1.1)	(0.3)
Total Pay	**(0.0)**	**(0.5)**	**(0.5)**	**(2.7)**	**(3.2)**	**(0.5)**
Drugs	0.0	(0.0)	(0.0)	(0.1)	(0.1)	(0.1)
Premises Costs	0.0	(0.4)	(0.4)	(1.1)	(1.4)	(0.3)
Other Non-Pay	0.0	(0.0)	(0.0)	(0.6)	(0.1)	0.6
Total Non-Pay Costs	**0.0**	**(0.4)**	**(0.4)**	**(1.8)**	**(1.6)**	**0.2**
Surplus/(Deficit)	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**

A plan was agreed and signed-off at Trust level for funding to support the Mass Vaccination programme up until September 2022. An extension of this plan was agreed at September Trust Board for the period to March 2023. This extension plan has not been included in budgets at Month 7. In month the Trust has seen a reduction in spend due to reduced activity. The plan has been set based on 2021/22 activity and hence this has tailed off in 2022/23. The programme is pass-through so any correction in future months will not impact the Trust overall position.

2.4 Research and Education

The table below shows the research and pass-through education positions. This has been excluded from the core position to remove the impact of variances that have minimal impact on the Trust bottom line position.

	Month 7			Year to Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Other Income	1.0	0.6	(0.4)	7.0	4.4	(2.6)
Total Income	**1.0**	**0.6**	**(0.4)**	**7.0**	**4.4**	**(2.6)**
AHP's and STT's	(0.0)	(0.0)	(0.0)	(0.1)	(0.2)	(0.0)
Medical	(0.4)	(0.0)	0.3	(2.6)	(0.2)	2.4
Nursing	(0.2)	(0.3)	(0.0)	(1.7)	(1.8)	(0.1)
Other Non Clinical Pay	(0.2)	(0.2)	0.0	(1.5)	(1.4)	0.1
Total Pay	**(0.9)**	**(0.5)**	**0.3**	**(6.0)**	**(3.7)**	**2.4**
Other Non-Pay	(0.1)	(0.2)	(0.1)	(0.8)	(0.7)	0.1
Total Non-Pay Costs	**(0.1)**	**(0.2)**	**(0.1)**	**(0.8)**	**(0.7)**	**0.1**
Surplus/(Deficit)	**0.1**	**(0.1)**	**(0.2)**	**0.2**	**0.0**	**(0.2)**

The research position is underspent on pay, offset with income, due to delays with trials starting.

2.5 Trust Trends

The table below sets out the income, pay and non-pay trends for the Trust over the last 12 months. This position removes the impact of Mass Vaccination, Nightingale, and the impact of one-off items such as the pension and pay awards. Once these items have been removed, the position shown is relatively consistent over recent months.

Pay has seen a £2m increase in actuals between September and October. This is driven by items discussed in the in month position – increased nursing costs caused by the catch-up in invoicing, increase domestic costs within Facilities, and the transfer of administration costs back from capital to revenue within Operations.

£m	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Income	64.4	64.2	70.8	62.9	89.9	62.5	64.2	66.1	68.8	67.1	72.8	69.0
Pension					(18.1)							
Pay award											(5.0)	(0.8)
Net Income	64.4	64.2	70.8	62.9	71.8	62.5	64.2	66.1	68.8	67.1	67.8	68.1
Pay	(39.1)	(37.4)	(39.3)	(39.0)	(55.9)	(39.7)	(39.4)	(41.7)	(42.2)	(39.8)	(45.1)	(42.9)
Pension					18.1							
Pay award											5.0	0.8
Net Pay	(39.1)	(37.4)	(39.3)	(39.0)	(37.8)	(39.7)	(39.4)	(41.7)	(42.2)	(39.8)	(40.1)	(42.1)
Non-pay	(25.2)	(26.8)	(31.5)	(23.9)	(28.8)	(25.2)	(27.9)	(26.4)	(27.3)	(28.5)	(28.7)	(26.6)

2.6 Divisional Breakdown

		Month 7			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
ASCR	Contract Income	12.9	13.5	0.6	88.5	82.1	(6.4)
	Other Income	0.7	0.7	0.0	3.3	3.2	(0.1)
	Pay	(10.1)	(10.4)	(0.2)	(68.3)	(70.7)	(2.4)
	Non-Pay	(2.4)	(2.9)	(0.5)	(16.6)	(18.3)	(1.7)
	Surplus/(Deficit)	**1.0**	**1.0**	**(0.1)**	**6.9**	**(3.7)**	**(10.6)**
CCS	Contract Income	5.5	6.1	0.6	38.1	39.4	1.3
	Other Income	1.5	1.0	(0.5)	9.7	9.5	(0.2)
	Pay	(7.0)	(6.9)	0.1	(49.4)	(46.9)	2.5
	Non-Pay	(3.8)	(4.2)	(0.5)	(25.4)	(27.7)	(2.3)
	Surplus/(Deficit)	**(3.8)**	**(4.0)**	**(0.2)**	**(27.1)**	**(25.8)**	**1.3**
MED	Contract Income	14.3	6.9	(7.4)	97.8	88.7	(9.1)
	Other Income	0.2	0.3	0.1	1.4	1.7	0.3
	Pay	(7.7)	(9.1)	(1.3)	(54.1)	(58.7)	(4.5)
	Non-Pay	(2.6)	(2.8)	(0.2)	(18.6)	(20.6)	(2.1)
	Surplus/(Deficit)	**4.2**	**(4.7)**	**(8.9)**	**26.5**	**11.1**	**(15.4)**
NMSK	Contract Income	11.6	12.0	0.3	82.4	82.1	(0.3)
	Other Income	0.3	0.3	0.1	1.7	1.9	0.2
	Pay	(5.3)	(5.5)	(0.1)	(37.5)	(37.0)	0.5
	Non-Pay	(4.1)	(4.1)	(0.0)	(27.7)	(29.8)	(2.0)
	Surplus/(Deficit)	**2.5**	**2.7**	**0.2**	**18.9**	**17.2**	**(1.7)**
W&CH	Contract Income	4.9	4.2	(0.6)	33.6	30.7	(2.9)
	Other Income	0.1	0.1	0.0	0.4	0.5	0.0
	Pay	(3.1)	(3.2)	(0.1)	(21.8)	(21.9)	(0.1)
	Non-Pay	(0.3)	(0.5)	(0.2)	(2.5)	(3.0)	(0.5)
	Surplus/(Deficit)	**1.5**	**0.6**	**(0.9)**	**9.7**	**6.2**	**(3.5)**
MASS VACCINATION	Contract Income	0.0	0.0	0.0	0.0	0.0	0.0
	Other Income	0.0	0.9	0.9	4.5	4.9	0.4
	Pay	(0.0)	(0.5)	(0.5)	(2.7)	(3.2)	(0.5)
	Non-Pay	0.0	(0.4)	(0.4)	(1.8)	(1.6)	0.2
	Surplus/(Deficit)	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**
TOTAL CLINICAL DIVISIONS		**5.3**	**(4.4)**	**(9.8)**	**34.9**	**5.1**	**(29.8)**
NON-CLINICAL AREAS	Contract Income	9.1	18.7	9.6	66.6	99.7	33.1
	Other Income	2.6	4.3	1.7	21.8	26.1	4.4
	Pay	(5.2)	(7.4)	(2.2)	(41.7)	(52.4)	(10.7)
	Non-Pay	(11.9)	(11.7)	0.3	(87.3)	(89.6)	(2.3)
	Surplus/(Deficit)	**(5.4)**	**3.9**	**9.3**	**(40.7)**	**(16.2)**	**24.5**
TRUST TOTAL		**(0.1)**	**(0.6)**	**(0.5)**	**(5.7)**	**(11.1)**	**(5.3)**

Key Divisional variances have been discussed in the main narrative of this report. A brief commentary on the year-to-date position of the clinical divisions is shown below.

ASCR

Underperformance on contract income of £6.4m, largely due to lower levels of Outpatient activity (£4.5m) than planned as well as due to lower levels of Non-elective activity (£1.5m). Pay is £2.4m overspent due to undelivered CIP, locum costs in Renal, RMN spend and additional costs to cover junior doctor gaps in General Surgery. The Division has seen a reduction in Month 7 in RMN spend due to increased scrutiny. Non-Pay is £1.7m adverse due to CIP under delivery and increase medical supplies partially offset by improvement private patient income.

CCS

Divisional pay is £2.5m underspent due to vacancies across consultants in Cellular Pathology and delayed recruitment to weekend working posts. The Division saw a deterioration in run-rate in month due to the impact of backdated charges for an agency consultant in Histopathology. Non-pay is £2.3m adverse driven by increased spend in Pathology due to external tests to support consultant vacancies in Cellular Pathology and increased non pay from activity related work. The Division has seen increased drug costs year-to-date which are offset within contract income.

Medicine

Contract income is £9.1m adverse due to reduced Respiratory Critical Care income following reduction in Covid-19 patients, Outpatient activity being behind plan due to reduced volumes and A&E attendances being behind plan due to uncoded activity, while Rehab activity continues to perform at levels above plan. Pay is £4.5m adverse due to RMN spend, increased agency nursing spend, agency consultant use to cover vacancies, and increased junior doctor spend to cover A&E mid-shifts and outliers. The Division has seen a reduction in RMN agency spend in month against year-to-date run-rate due to increased scrutiny booking shifts, change in casemix, and increased use of Engagement Support Workers on Elgar ward. The Division saw a £0.5m charge in month for backdated invoices due to a new agency being used from August 2022.

NMSK

The contract income position is £0.3m adverse to plan due to a reduction in Elective and Outpatient activity, countered by increased activity levels in Non-Elective and increased use of high cost drugs (offset with overspend on non-pay). Non-pay (including pass-through drugs) is £2.0m adverse driven by high cost drugs (offset in contract income) and backdated charges from suppliers being received in Month 5 and Month 6 for non pass through devices.

W&CH

Contract income is £2.9m adverse caused by a reduction in activity across NICU and Maternity. Non-pay is £0.5m adverse to plan from unidentified CIP and increased medical consumables and drugs spend.

Non-clinical Areas

Contract income is £33.1m favourable. This value brings the Divisional contract income positions back with the Trust block value. Pay is £10.7m adverse of which £6.8m is the impact of the pay award where the 1.66% additional funding has been provided to Divisions leaving a negative reserve within corporate finance. The Trust is receiving additional contract income to offset this.

Divisional level contract income is currently being reviewed and refined given the challenges around CareFlow implementation. This does not impact the Trustwide contract income due to the block contract.

2.7 Year-end forecast outturn

The Trust has completed a detailed forecast in Month 6 that shows a year end breakeven position. This position shows an improvement against the £15m potential deficit forecasted in Month 4, with improved Divisional (£5m) and central Trust (£10m) actions helping to deliver the breakeven position. The Trust is currently in communication with Divisions about the necessary actions required to ensure delivery of this forecast.

The table below shows the Core Trust position excluding Mass Vaccination, research and education.

	Month 7			Year to Date		
	Forecast £m	Actual £m	Variance £m	Forecast £m	Actuals £m	Variance £m
Contract Income	61.0	61.4	0.4	422.2	422.6	0.4
Other Income	5.3	6.0	0.7	37.8	38.5	0.7
Total Income	**66.3**	**67.4**	**1.1**	**460.0**	**461.1**	**1.1**
AHP's and STT's	(5.8)	(5.9)	(0.1)	(39.7)	(39.8)	(0.1)
Medical	(11.9)	(11.7)	0.2	(83.4)	(83.1)	0.2
Nursing	(14.4)	(14.9)	(0.5)	(98.7)	(99.2)	(0.5)
Other Non Clinical Pay	(7.9)	(9.3)	(1.5)	(60.3)	(61.8)	(1.5)
Total Pay	**(40.0)**	**(41.9)**	**(1.9)**	**(282.1)**	**(283.9)**	**(1.9)**
Drugs	(4.8)	(4.4)	0.5	(33.7)	(33.3)	0.5
Clinical Supplies (Incl Blood)	(4.9)	(5.3)	(0.4)	(34.3)	(34.7)	(0.4)
Supplies & Services	(5.9)	(6.5)	(0.6)	(41.9)	(42.4)	(0.6)
Premises Costs	(3.5)	(3.2)	0.3	(24.1)	(23.8)	0.3
Other Non-Pay	(7.6)	(6.7)	0.9	(55.1)	(54.1)	0.9
Total Non-Pay Costs	**(26.7)**	**(26.0)**	**0.7**	**(189.0)**	**(188.3)**	**0.7**
Surplus/(Deficit)	**(0.4)**	**(0.5)**	**(0.1)**	**(11.0)**	**(11.1)**	**(0.1)**

In month the Trust was forecast to deliver a £0.4m deficit, with the actual position being a £0.5m deficit, £0.1m worse than the forecast position.

Contract income is £0.4m better than forecast due to additional monies being received in relation to the pay award from HEE.

Other income is £0.7m better than forecast due to increased training monies from HEE (£0.3m), additional private patient work in ASCR (£0.2m) and finance (£0.2m). The private patient work is offset by increased costs in non-pay.

Pay is £1.9m worse than forecast. Medicine is £0.8m worse due to the backdated nursing invoice received in month and other medical costs not reducing in line with expectations within the Emergency Department. ASCR is £0.2m worse due to enhanced rates for Operating Department Practitioners (ODP) and anaesthetics assistants being signed off in Month 7 but not being reflected in the Divisional forecast. Other Divisional issues £0.5m from backdated locum invoices (CCS), increased winter costs (NMSK) and increased domestic sickness (Facilities).

Non-pay is £0.7m better than forecast due to cost of capital (£1.2m improvement) from delayed depreciation and impact of IFRS 16 leases review. This is offset by deteriorations in clinical and corporate Divisional non-pay spend.

3. Balance Sheet, Cash Flow, Capital, and Better Payment Practice Code ("BPPC")

	21/22 M12 £m	22/23 M06 £m	22/23 M07 £m	In-Month Change £m	YTD Change £m
Non Current Assets					
Property, Plant and Equipment	605.0	609.2	610.3	1.0	5.3
Intangible Assets	13.7	12.3	12.3	0.1	(1.4)
Non-current receivables	1.5	1.5	1.5	0.0	0.0
Total non-current assets	**620.2**	**623.0**	**624.1**	**1.1**	**3.9**
Current Assets					
Inventories	9.1	9.4	9.5	0.1	0.4
Trade and other receivables NHS	19.0	22.0	18.8	(3.2)	(0.2)
Trade and other receivables Non-NHS	20.5	25.6	25.2	(0.4)	4.7
Cash and Cash equivalents	116.2	89.2	99.4	10.1	(16.8)
Total current assets	**164.8**	**146.3**	**153.0**	**6.6**	**(11.8)**
Current Liabilities (< 1 Year)					
Trade and Other payables - NHS	10.6	5.5	6.1	0.6	(4.5)
Trade and Other payables - Non-NHS	102.6	98.3	99.6	1.3	(3.0)
Deferred income	16.4	17.9	26.5	8.6	10.1
PFI liability	15.2	15.7	15.7	0.0	0.4
Finance lease liabilities	2.1	4.1	3.1	(1.0)	1.0
Total current liabilities	**147.0**	**141.4**	**150.9**	**9.5**	**4.0**
Trade payables and deferred income	7.1	7.8	7.7	(0.1)	0.6
PFI liability	359.3	354.1	353.4	(0.8)	(5.9)
Finance lease liabilities	2.0	6.7	6.2	(0.4)	4.2
Total Net Assets	**269.7**	**259.3**	**258.8**	**(0.4)**	**(10.9)**
Capital and Reserves					
Public Dividend Capital	456.9	456.9	456.9	0.0	(0.0)
Income and expenditure reserve	(372.4)	(371.3)	(371.3)	0.0	1.1
Income and expenditure account - current year	1.1	(10.4)	(10.9)	(0.4)	(11.9)
Revaluation reserve	184.1	184.1	184.1	0.0	(0.0)
Total Capital and Reserves	**269.7**	**259.3**	**258.8**	**(0.4)**	**(10.9)**

3.1 Property, Plant and Equipment and Intangibles

The year-to-date increase of £3.9m in Non-current assets includes capital spend additions of £14.2m, together with the £5.6m additions as a result of the IFRS 16 implementation, offset by depreciation and amortisation of £15.9m. The impact of implementation of IFRS 16 is also recognised in an increase in finance lease liabilities.

3.2 Receivables

There was a net increase of £4.5m in receivables, of which £4.6m is related to income from the commissioners offset by a net decrease in other receivables (including year-end accruals for Mass Vaccination and Nightingale Surge Ward).

The total value of invoiced debt outstanding is £20.4m, of this £7.5m relates to Non-NHS individuals and organisations and is over 365 days old. £4.3m of the non-NHS debt older than 365 days relates to private and overseas patients and has been fully provided for. There are actions to be taken in November to write-off some outstanding debt deemed no longer economic to pursue.

	Outstanding invoiced debtors	Total £m	Up to 30 days	30-60 days	60-90 days	90-180 days	180-365 days	365 + days
Oct-22	NHS	7.0	2.6	1.6	0.3	0.6	1.3	0.7
	Non-NHS	13.4	3.2	0.7	0.3	0.6	1.1	7.5
	Total	**20.4**	**5.8**	**2.3**	**0.6**	**1.2**	**2.4**	**8.2**
Mar-22	NHS	6.4	4.8	0.0	0.3	0.6	0.6	0.1
	Non-NHS	12.0	1.8	0.7	0.4	0.9	1.5	6.7
	Total	**18.4**	**6.6**	**0.7**	**0.7**	**1.5**	**2.1**	**6.8**
Change	NHS	0.6	(2.3)	1.5	0.0	0.0	0.7	0.6
	Non-NHS	1.4	1.4	(0.0)	(0.1)	(0.3)	(0.3)	0.8
	Total	**2.1**	**(0.9)**	**1.5**	**(0.1)**	**(0.3)**	**0.4**	**1.4**

3.3 Payables

Year to date NHS payables have reduced by £4.5m due to post year end actions.

Non-NHS payables have decreased by £3.0m, of which £5.9m relates to the reduction of accrued capital expenditure because of post year end payments, offset by net increases of £2.9m across invoiced and accrued liabilities. The above payments patterns are reflected in the reduced cash balance.

3.4 Deferred Income

There is a year to date increase of £10.1m in deferred income, of which £3.8m represents deferral of contract income for delayed service developments, and the remainder is linked with timing of funding received from Health Education England and research.

3.5 Cash

The cash balance decreased by £16.8m for the year to date due to the in-year deficit and higher than average payments made during the period, including significant amounts of capital spend cash relating to the March 2022 capital creditor and partially funded pay award. This is offset by deferred commissioning and research income received to date. Despite the reducing cash balance, the Trust is still expected to be able to manage its affairs without any external support for the 2022/23 financial year.

The in month cash balance has increased by £10.1m, which is linked with backdated funding from pay award from commissioners (£5.9m), and upfront payments from commissioners and other funders for services to be delivered later in the financial year.

	Oct-22 £m	Nov-22 £m	Dec-22 £m	Jan-23 £m	Feb-23 £m	Mar-23 £m
Cash brought forward	**89.2**	**99.4**	**96.6**	**98.3**	**105.6**	**107.4**
Forecast in-month cash movement	10.1	(2.7)	1.6	7.4	1.8	0.3
Forecast cash balance	**99.4**	**96.6**	**98.3**	**105.6**	**107.4**	**107.8**

3.6 Capital Spend

Total capital spend for the year to date was £14.1m, compared to an initial plan of £12.7m. The total planned spend for the year is £22.1m.

In addition to this initial plan, £19.8m of capital funding is expected to be available through national funding sources, grants, and the use of historic receipts taking the potential total capital funding envelope to £41.9m. The Capital Planning Group (CPG) has reviewed the year to date position, together with the forecast for the remainder of the year and the associated risks.

The CPG was content that plans were in place to ensure that the Trust will meet its planned expenditure for the year up to the total £41.9m level. This will be reviewed again at Month 8 and any mitigations required will also be assessed. Final confirmation of the total level of national funding available is still outstanding and the CPG will manage the position to ensure the Trust delivers against the final target once it is known.

The plan was developed on a straight line basis, however, the IM&T spend relating to the EPR project has been higher at the start of the year, driving the overspend shown above. There are several sources of external funding expected which will be reflected in the position once funding has been received.

New IFRS16 leases are now being captured in the capital expenditure following the work undertaken during August to recognise these, however, due to slower than anticipated introduction of new equipment under the Pathology Manged Equipment Service the impact has been minimal.

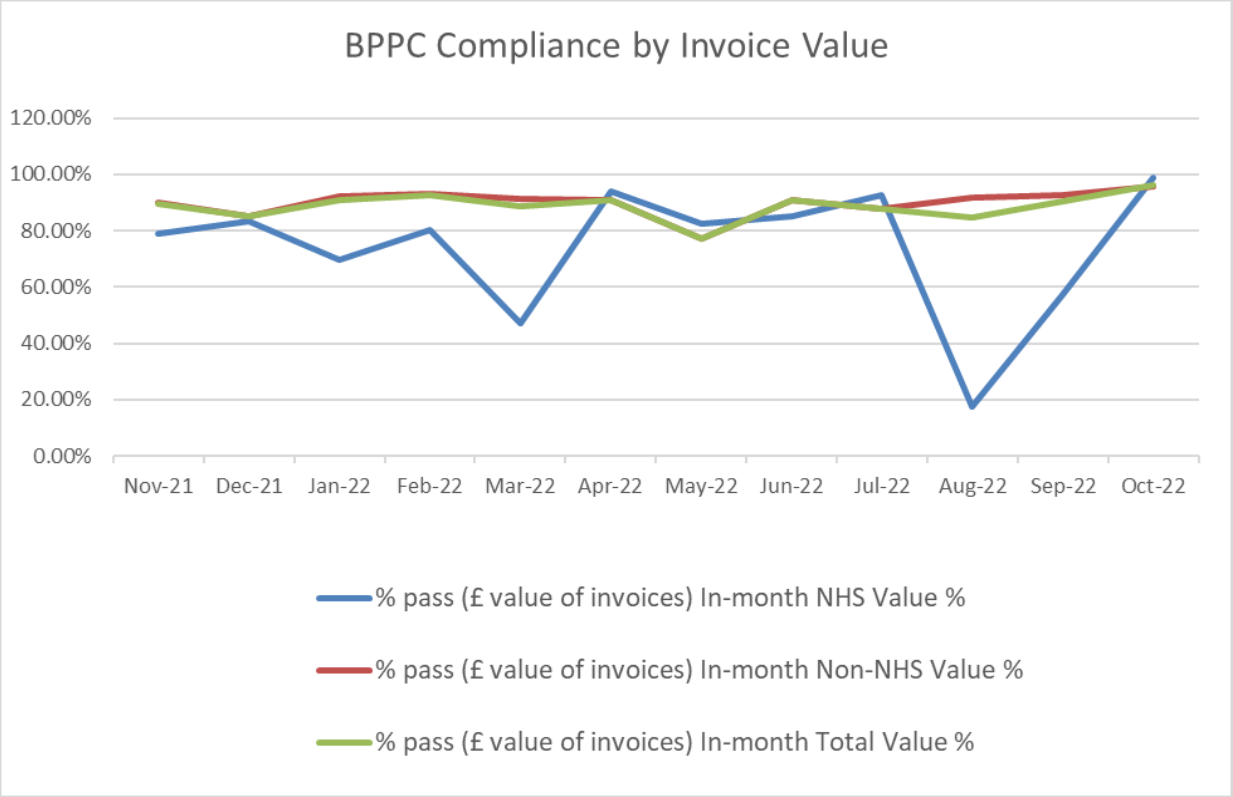
2022/23 Capital Expenditure	2022/23 plan £m	Year to date Plan £m	Year to date Actual £m	Year to date Variance from plan £m
Divisional Schemes	7.4	4.1	1.7	-2.4
CRISP	4.6	2.7	3.6	0.9
Medical equipment	4.6	2.7	2.1	-0.6
IM&T	4.2	2.4	6.2	3.8
Charity and grant funded	0.2	0.1	0.4	0.3
PFI lifecycle	1.1	0.7	0.1	-0.6
Total Core Plan	**22.1**	**12.7**	**14.1**	**1.4**
Expected National Funding	5.8			
Additional internal funding (provision release and use of historic receipts)	9.6			
PSDS Grant	4.4			
Total Expected available funding	**41.9**			

14.1

3.7 BPPC

The Better Payment Practice Code (BPPC) achievement of invoices paid within 30 days by value was 88.1% for the first seven months of 2022/23, compared to 87.8% for 2021/22. BPPC achievement by volume of invoices has increased from 83.7% in 2021/22 to 87.0% for the first seven months of 2022/23.

There was a deterioration in performance in August, which was cause by two factors – a cyber-attack on the company that host the Procurement system resulting in the lack of access to EROS (procurement system) for a short period of time, and delays in processing consolidated provider-to-provider (P2P) invoices. Work is ongoing within the Trust to improve the performance against BPPC metrics.



4. Cost Improvement Programme

The CIP plan for 2022/23 is for savings of £15.6m. At Month 7 the Trust has £3.4m of completed schemes on the tracker. There are a further £3.3m of schemes in implementation and planning, creating a £8.8m shortfall against the annual target of £15.6m. The Trust has a further £1.6m of schemes in pipeline. Further schemes, including around agency reduction and procurement savings are currently being worked up.

Summary Division	FYE Target	Completed Schemes	Schemes in Implementation	Schemes in Planning	Total FYE	Variance FYE	Schemes in Pipeline	Total FYE inc Pipeline
£m	£m	£m	£m	£m	£m	£m	£m	£m
ASCR	3.7	0.3	0.0	0.3	0.6	(3.1)	0.1	0.7
CCS	3.2	1.3	0.4	0.1	1.8	(1.4)	0.1	1.9
FAC	1.0	0.4	0.9	0.0	1.4	0.4	0.2	1.6
MED	2.6	0.3	0.0	0.2	0.5	(2.1)	0.0	0.5
NMSK	2.6	0.7	0.1	1.0	1.8	(0.8)	0.1	1.9
WCH	1.1	0.1	0.1	0.0	0.3	(0.8)	0.3	0.5
CORP/ TRUSTWIDE	1.4	0.3	0.0	0.2	0.5	(0.9)	0.8	1.3
Total	**15.6**	**3.4**	**1.6**	**1.8**	**6.8**	**(8.8)**	**1.6**	**8.4**

The Trust is monitoring the CIP position on a weekly basis and meeting regularly with teams. Governance includes a monthly CIP review between finance and Divisions, a monthly Financial Sustainability Group (FSG), and a bi-monthly CIP Board with representation from Trust Executives.

The table below shows the movement of Divisional CIP plans between Month 6 and Month 7 excluding pipeline. Divisions will be tasked with working up schemes to close the gap in Quarter 3.

Division	Total FYE (Month 6) £m	Total FYE (Month 7) £m	Movement FYE £m
ASCR	0.6	0.6	0.0
CCS	1.4	1.8	0.4
MED	0.5	0.5	0.0
NMSK	1.5	1.8	0.3
WCH	0.3	0.3	0.0
FAC	1.4	1.4	0.0
CORP	0.4	0.5	0.1
Grand Total	**5.9**	**6.8**	**0.8**

5. System position

For Month 7, the System has delivered a breakeven position year-to-date. This has been driven by providers being £5.3m adverse to plan offset by a positive variance within the ICB. The themes

underlying the providers adverse position across the System are the same as NBT – non delivery of savings and increased spend on agency to cover vacancies. The Month 6 ICB report is attached at Appendix 1 (one month in arrears due to time taken to consolidate the position).

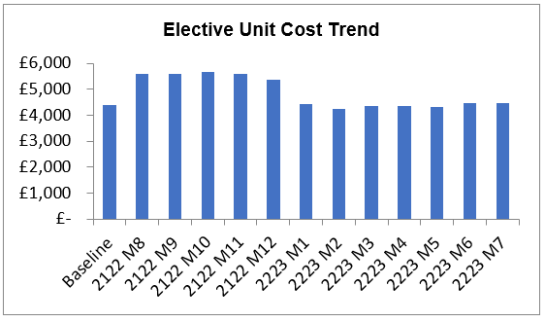
6. Productivity

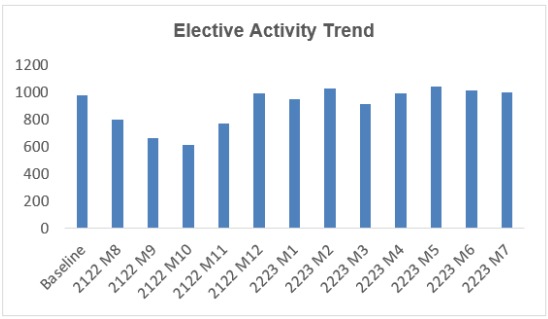
The impact of Covid-19 has been felt differently by different organisations which has meant more traditional forms of benchmarking have become less useful when assessing the Trust's performance. As a result, starting in early 2021/22 a new measure of performance has been captured. The calculation of unit costs allows for productivity to be measured at a point of delivery (POD) / speciality level. Unit costs have been calculated going back to 2019/20 and so trends can then be analysed and compared to pre-pandemic levels.

While the hospital has been focusing on the response to the pandemic full analysis involving crucial Divisional input has not been carried out. Now, as part of the recovery process, productivity analysis is to be launched at a Divisional level.

Productivity as shown in the below graphs sources cost data from service line reporting and activity data from patient access systems and aims to understand the relationship between activity and expenditure.

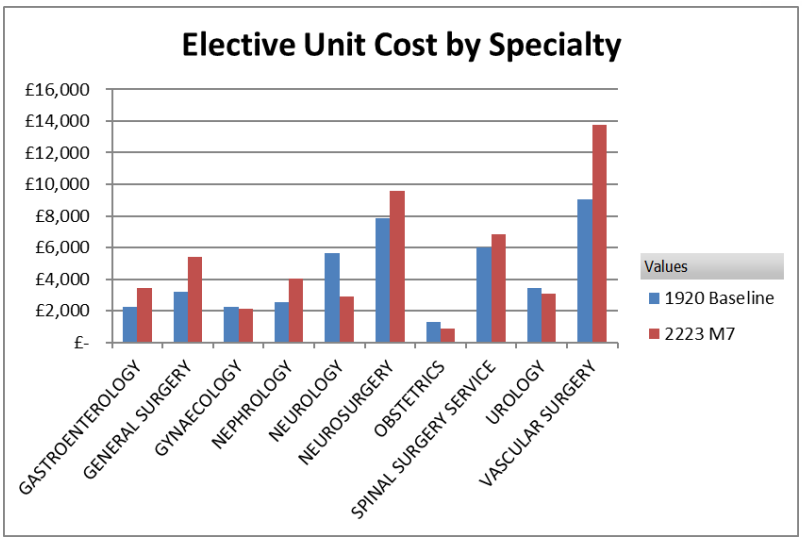
In areas where there is a high proportion of fixed costs movements in activity have a greater effect on unit costs. This can be seen in the elective unit costs below where low levels of activity during the Covid-19 pandemic greatly increased the unit cost and rising levels of activity in this financial year have seen the unit cost move closer to pre-pandemic levels.



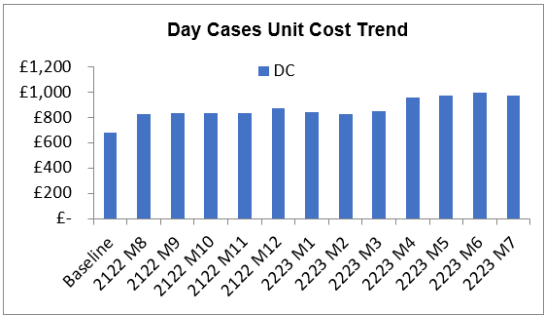


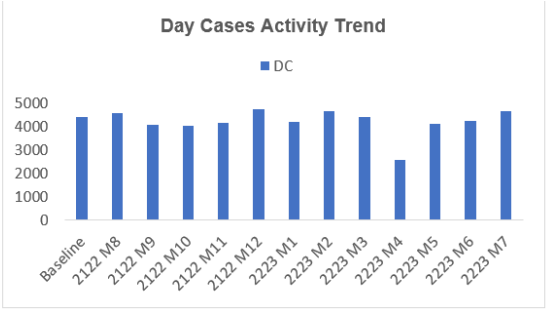
It should be noted that the 2019/20 baseline has not been adjusted for inflation. Tariff inflation when compared to 2019/20 is currently 8.4% however this includes the inflationary effect of overhead items such as utilities. As unit cost data does not include overheads applying this level of inflation is not appropriate. Detailed work is ongoing to calculate an appropriate level of inflation.

The below graph shows elective unit costs at a speciality level. When compared to the 2019/20 baseline unit costs performance differs across specialties. With some specialties such as Neurology, Obstetrics and Urology operating at a unit cost lower than the 2019/20 baseline even before inflation is considered.

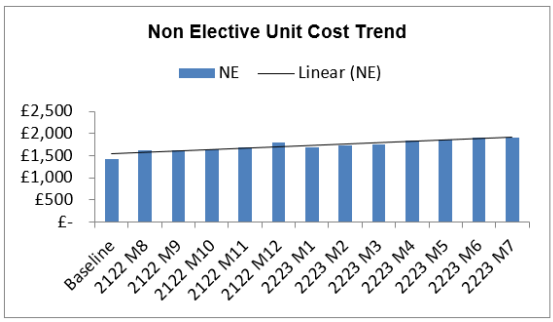


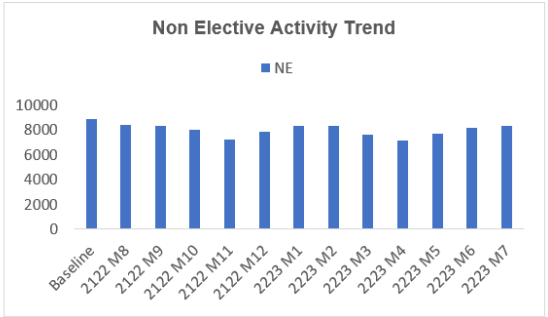
In terms of day cases, where activity has been very volatile recently, the unit cost is less correlated to activity.

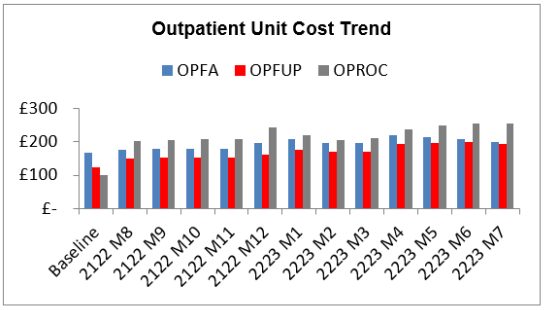


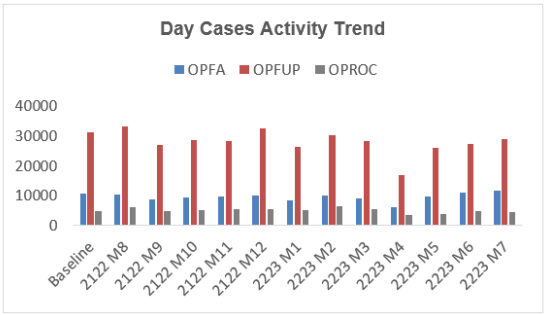


Non-elective activity levels have remained reasonably stable, however, there is a clear trend of increased unit costs over the last twelve months. The same could be said for outpatients, particularly when looking at outpatient procedures.









Unlocking the real value of this data requires additional intelligence as a result of clinical engagement and Divisional input. For this reason, a Costing for Value steering group, which will be clinically chaired, is in the process of being setup and Divisions now have access to monthly productivity data which will be included as part of the Divisional review process.

7. Risk and mitigations to plan

The Month 7 forecast is being consolidated, however, the below table highlights the current risks and mitigations within the Trust position at Month 7.

Risks	£m	Mitigations	£m	Actions
Inflationary Impact over & above funded levels	(3)	Contract management around inflation	3	Proactive review of contract management with Procurement – **Procurement review of inflation underway**
Continuation at current levels of Registered Mental Health Nurse agency spend	(5)	Task and finish group to understand drivers, introduce further control and decrease spend led by Execs	2	Work underway to reduce spend. Impact seen in September and October position.
Continuation at current levels of non-RMN agency spend	(4)	Task and finish group to understand drivers, introduce further control and decrease spend led by Execs	1	**Task and finish group to be set up.** New role looking at nursing agency under Chief Nurse.
Continuation at current levels of locum costs spend	(4)	Task and finish group to understand drivers, introduce further control and decrease spend led by Execs	1	'Root and branch' review in Medicine underway
		Delays in recruitment to investments	3	**Divisions to review recruitment profile**
		Non-recurrent savings	2	**Finance Business Partners to identify opportunities with divisions**
		ESRF Month 7-12	4	**Distribution of expected ESRF clawback in H2**
Total	**(16)**		**16**	

Whilst there are a number of actions underway to mitigate risks and deliver a financial balanced position, the continuing high level of spend on agency and locums, in addition to the gap in the delivery of savings is resulting in a significant risk.

Management actions are required to bring down the level of spend on Registered Mental Health nurse agency, other agency, and medical locums. Without these actions the Trust will not deliver a breakeven position and will result in a greater pressure for 2023/24.

8. Underlying Position

The key drivers of the underlying position are:

- Inflation for 2022/23 not funded recurrently of £7.1m
- Efficiencies not delivered in H2 2021/22 £5.3m
- Pressures including incremental drift above funded levels £6.1m
- Elective Recovery actions invested recurrently £2.0m

This is being covered in 2022/23 by

- Non-recurrent income from ICB and NSHE £7.1m to cover inflation
- Non-recurrent actions from the Trust £11.4m
- Elective Recovery Funding £2.0m

This gives an underlying position of £20.5m off set by non-recurrent actions. As savings have not been delivered recurrently in 2022/23 and spend continues around agency at a higher level the underlying position has deteriorated to around £30m. This will have the impact of driving a higher efficiency target for 2023/24.

9. Recommendation

The F&PC are asked to note:

- the revised financial framework that the Trust is operating in
- the financial performance for the month and year to date position
- the spend on Mass Vaccination areas
- the Cash position and Capital spend levels for the financial year
- the delivery of Cost Improvement Plan savings and how they compare with divisional targets
- the Risks and Mitigations for the forecast position, including the actions required to deliver breakeven.

Report To:	Trust Board		
Date of Meeting:	24 November 2022		
Report Title:	Elective Recovery Self-Certification		
Report Author & Job Title	Lisa Whitlow, Associate Director of Performance and Sustainability		
Executive/Non-executive Sponsor (presenting)	Nick Smith, Deputy Chief Operating Officer		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	That Trust Board note the "next steps on elective care for Tier One and Tier Two providers" self-certification signed off by the Chair and Chief Executive in November 2022		
Report History:	N/A		
Next Steps:	The self-certification has been signed off and returned to NHS England as required.		

Executive Summary
On 25 October 2022 NHS England wrote to all provider Chairs and Chief Executives setting out immediate next steps for tier one and tier two of the national elective recovery programme to ensure that objectives around long waiting patients (for elective and cancer care) were achieved. As part of this exercise, providers were required to undertake a self-certification by 11 November 2022, to be signed off on behalf of the Board by the Chair and Chief Executive. This was to confirm to NHS England that the Board had appropriate oversight of the organisation's plans for elective care recovery, and that it receives appropriate levels of assurance on performance, risks to delivery, and opportunities. NBT's self-certification is appended to this coversheet.

Risks	There are a number of Trust Level Risks relating to non-elective, elective, and cancer care on Datix, including: Risk ID 663 – impact of poor flow

15

	Risk ID 988 – insufficient cancer capacity (aggregating 5 risks across multiple divisions) Risk ID 1242 – diagnostic and elective care wait times
Financial implications	No specific financial implications outlined in the paper
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No
Appendices:	Appendix 1 – NBT Self-Certification

NHS North Bristol NHS Trust

Appendix A
Elective Recovery Self certification
The Chair and CEO are asked to confirm that the Board:

Confirmation required	NBT response
a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services performance and recovery.	Yes, Chief Operating Officer (COO)
b) That the Board and its relevant committees (F&P, Safety and Quality etc) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.	The Board receives a monthly update through the Integrated Performance Report (IPR), including peer performance/ benchmarking and the Finance and Performance Committee (F&PC) receives a bi-monthly F&PC report. In addition to the narrative contained within the report, in presenting the report, the COO also provides a verbal update on performance and progress against plans. In addition to the regular reports provided, the COO has also delivered 'deep dive' presentations to the Board on each of the areas - elective, diagnostic and cancer.
c) Has an agreed plan to deliver the required 78ww and 62-day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.	Yes, there is an agreed plan in place to deliver the required 78ww and 62-day trajectories – both are on track. The Board has met the ICS to discuss the system initiatives to support confirmed elective recovery through Winter and has been given headlines on what the NCTR flow support will be. We await confirmation of details, contractual values and start dates. The Board understands the risks to delivery and support needed through written narrative in the regular reports provided, the COO's

Confirmation required	NBT response
	verbal overview and the 'deep dive' presentations as outlined in b) above.
d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.	Assurance on cancer is provided through the Board and sub-committees with detail being supplied by the COO and CMO. Early focus has been on the successful reduction of 62-day breaches. The detailed pathway elements will be picked up in the next phase of work to improve patient pathways. This will be reported through to Board and sub-committees as the work progresses. In relation to the specific progress against actions in Lower GI, Skin and Prostate: • FIT testing has already been used to review the routine backlog Endoscopy patients. Plans to rollout FIT pathway prior to Christmas with pathway proposal being reviewed by the Shared Care Board in November. • Trust is fully engaged in the regional and system work with regards to Skin pathways – rollout of dermatoscopes requires a system-wide response in liaison with Primary Care. The Trust has mechanisms in place to receive dermoscopic quality images. • Previous demand/capacity analysis has been undertaken in relation to provision of Hot mpMRI. The mpMRI demand exceeds the **dedicated** capacity, but the Trust has additional slots it can utilise to meet demand. An audit is being undertaken to better understand demand and will feed into the 2023/24 business planning round.
e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other	Yes, the Trust is pursuing the opportunities and monitoring impacts presented by Outpatient Transformation. Outpatient Transformation is one of the five programmes in NBT's Reset and Recovery portfolio. The governance and work programme for Outpatient Transformation

Confirmation required	NBT response
productivity, performance and benchmarking data and opportunities.	has recently been revised and implemented, with defined objectives and monitoring in place. Assurance on delivery will be reported through to the Finance and Performance Committee and on to the Board during 2023. The Board is also aware of, and is being kept updated, on the impact on outpatients of a new EPR and the clear plan to resolve the issues (with a detailed update scheduled for the Finance and Performance Committee on 17 November 2022).
f) Have received a report on Super September and have reviewed the impact of this initiative for their Organisation	The Trust was not involved with this initiative and will not be reporting any non-admitted >78ww capacity breaches at the end of March 2023.
g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.	The impact of validation is implicit to the performance reported to the Board. Board performance reports reflect periods where nationally validated data has been agreed and submitted. The Trust has eliminated >104ww capacity breaches and has clear plans to eliminate any >78ww capacity breaches by the end of March 2023. Having written to all long-waiting admitted patients earlier in the year the Trust has plans to repeat this process to include >52ww non-admitted patients.
h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.	The Board has received detailed information with regards to clinical prioritisation and other aspects of the Trust's Elective Recovery plans through periodic deep dives and regular IPR reports. The Board is aware that funding has been received from NHSE/I (£120k) to support improvements in diagnostic reporting turnaround times. Cancer specific imaging reporting turnaround times are reviewed every month at the Divisional Review meetings with assurance and escalation reflected through to the Executive Team. This and

Confirmation required	NBT response
	component pathway work in the Trust's Cancer plans allows exception reporting to the Board and to sub-committee levels.
i) Discuss theatre productivity at every Trust Board; we suggest with the support of a non-executive director to act as a sponsor	Theatre productivity has been discussed as part of the elective recovery deep dive and plans (see under J) to repeat more regularly will be picked up, as will the support of a NED sponsor. Activity and productivity compared to 2019/20 baseline and annual operational plans are reviewed bi-monthly at F&PC. Business planning outputs make reference to these in the annual business planning process. Following a GIRFT review in November, a deep dive on Theatres Productivity is planned for the F&PC meeting scheduled for January 2023.
j) Routinely review Model Health System theatre productivity data, as well as other key information such as day-case rates across trusts.	The Trust reviews theatre productivity data from the Model Health System, GIRFT, BADS, Four-Eyes diagnostic and CHKS benchmarking data.
k) Confirm your SROs for theatre productivity.	Deputy Chief Operating Officer, Deputy Chief Medical Officer.
l) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.	There are plans in place to deliver the national requirements of no more than 25% of patients waiting longer than 6-weeks for their diagnostic test and zero patients waiting >26-weeks. The Board monitors progress against plans – as outlined in the response to b) above.

Signed by CEO: Date:

Signed by Chair: Date:

Report To:	Trust Board Meeting		
Date of Meeting:	24 November 2022		
Report Title:	Audit & Risk Committee Report		
Report Author & Job Title	Aimee Jordan, Senior Corporate Governance Officer & Policy Manager		
Non-executive Sponsor (presenting)	Richard Gaunt, Non-Executive Director (Committee Chair)		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is recommended to: • Receive the Audit & Risk Committee Upward report for assurance • Approve the Standing Orders and SFIs • Approve the changes and addition to the BAF risks • Approve the revised Terms of Reference		
Report History:	The report is a standing item to each Trust Board meeting following an Audit & Risk Committee meeting.		
Next Steps:	The next report to Trust Board will be to its meeting in March 2022.		

Executive Summary	
The report provides assurances received, issues escalated to the Trust Board and any new risks identified from the Audit and Risk Committee Meeting held on 10 November 2022.	
Risks	The Committee is now the Audit & Risk Committee, with oversight of the Trust's overall risk management systems and processes.
Financial implications	None within this report.
Does this paper require an Equality, Diversity and Inclusion Assessment (EIA)?	No
Appendices:	Appendix 1: Standing Orders and SFIs Appendix 2: Board Assurance Framework Terms of Reference Appendix 3: Terms of Reference

North Bristol NHS Trust

Purpose

1.1 To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Audit & Risk Committee meeting held on 10 November 2022.

1. Background

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

2. Meeting of 10 November 2022

3.1 External Audit Progress Plan

The Committee received the External Audit Progress Plan report which set out the position against the 2021/22 and 2022/23 audits. It was noted that the 2022/23 Charity audit report had positive findings and would be presented for approval at the Corporate Trustee meeting at the end of the month.

The Committee received assurance that plans were in place to avoid delays with next year's audit sign-off process and were informed that the 2022/23 external audit plan would be brought to March's meeting.

3.2 Internal Audit Progress Report

The Committee received a progress report and the recommendation tracker from the Internal Auditors. The progress report includes a summary of the work completed and a programme of work for the current financial year and it was noted that six reviews had commenced.

3.2.1 Internal Audit - Learning from Incidents – Patient Safety Incident Response Framework (PSIRF) Implementation

The Committee noted that the report was given a 'significant assurance with minor improvements opportunities' rating with two medium findings identified, relating to monitoring and evaluation of learning from Patient Safety Investigations and a lack of recording of Duty of Candour on Datix. It was explained that the review considered the implementation of PSIRF rather than the processes, compliance and embeddedness of PSIRF across the Trust.

The Committee raised concerns regarding the duty of candour recording findings and agreed that Quality Committee would be given the internal audit report to review and to particularly focus on the duty of candour recording concern.

It was recognised that NBT were an early adopter of the PSIRF system, and the Committee agreed that a further review should be undertaken once it has been fully embedded.

3.2.2 Local Clinical Excellence Award (LCEA)

The Committee noted that the report was given a 'significant assurance with minor improvements opportunities' rating. Three medium findings were identified including documentation of approval of calculation, documentation of approval of eligible consultants and Formalisation of reconciliations. It was detailed that the process for calculating and approving the LCEA calculation was well-designed and that management actions following the internal review in May 2021 had been implemented.

The Committee were reassured that there was a strong process in place and highlighted the importance of having correct documentation to provide evidence for assurance.

The Committee were reassured that there were only four outstanding overpayments relating to the 2020/21 Local Clinical Excellence Awards and noted that debt collection would become involved to recover any outstanding payments from December 2022.

3.3 Counter Fraud Progress Report

The Committee received an update from the Local Counter Fraud Specialist. It was noted that a proactive review into sickness absence fraud had been completed and the Bank and Agency and National Fraud Incentive reviews were ongoing. The sickness absence fraud review was positive with the recommendation to amend the return-to-work forms to include a signed confirmation that staff have not worked elsewhere whilst off sick. The Committee were reassured that the Trust benchmarked well against other Trust for the review.

The Committee were informed of the ongoing activities to promote Fraud awareness month including the circulation of posters and information on the Trust's intranet and the Fraud Insider newsletter. The importance of the Fraud Triangle framework (pressure, opportunity, and rationalisation) was also discussed.

The Committee agreed that the People Committee would be given the internal audit report to review with a focus on data analytics, particularly on the ability to have visibility on patterns of sickness within staffing groups.

3.4 External Auditor Recommendations 2021/22 Update Report

The Committee received an update against the various findings and recommendations arising from the 2022/23 External Auditor Audit of the accounts and Value for Money audit.

The Committee received assurance that the findings and recommendations continued to be progressed and closed as required.

3.5 Patient Property Internal Audit Report – Update on progress against actions

The Committee received an update on the progress against the actions from the Patient Property Internal Audit Report noting that:

- Patient Property Policy would be rewritten and launched by the end of December 2022 and would include staff training requirements.
- Communications have been increased to encourage patients to be responsible for their valuables.
- Work was ongoing to enhance the audit trail over patient values including the introduction of the new Electronic Patient Record digital documentation.

The Committee noted the importance of focusing the communication on the patient's experience and the impact of the personal loss where property was lost or misplaced, rather than focusing on the financial impact to the Trust.

3.6 BWPC Procurement Report

The Committee received the BWPC Procurement Report which detailed:

- the findings of recent assessments of NBT's procurement financial governance and controls including NBT's performance in comparison to other NHS organisations
- the activity underway, and timescales, to close the specific findings arising from the KPMG Fraud controls audit.
- the proposed KPI dashboard to monitor actions for improvement.

The Committee raised concerns regarding the volume of non-PO spend and the timescale for improvement and requested that a regular update be brought to the Committee to report on the route back to compliance.

3.7 Standing Orders and SFIs

The Committee endorsed the proposed updates to the Standing Orders (SO), Standing Financial Instructions (SFI), and Scheme of Delegated Authority (SoDA), and recommend them to Trust Board for approval (see Appendix 1).

The Committee requested further understanding on how the BNSSG Integrated Care System's emerging financial controls intersected with the Trusts governance framework. It was acknowledged that this was still in a formative stage.

3.8 Risk Report

The Committee reviewed the Risk Report that incorporated the Trust Level Risk (TLR) Report and Board Assurance Framework and an update on the risk management process.

The Committee approved the updated Risk Management Strategy & Policy and noted the ongoing work to review the TLRs, provide further clarity on the timeline of mitigating actions and to improve the consistency of risk scoring.

The Committee noted the changes to the BAF and endorsed the additional BAF risk linked to the Trust's underlying financial deficit.

The BAF is attached to this report for Board review (Appendix 2).

3.9 Policies Update Report

The Committee received a report which showed that positive progress had been made to reduce the backlog of policies past review date. The Committee approved the updated Losses and Special Payments Policy.

3.10 Committee Self-Evaluation Proposal & Terms of Reference Review
The Committee approved the Self-Assessment questions which would be distributed via Survey Monkey for committee members to complete and endorsed the revised Terms of References for Trust Board approval (see Appendix 3).

3.11 Losses And Salary Overpayments
The Committee received an update on Losses and Salary Overpayments as part of its standing agenda items and agreed to write off six invoices totalling £532.6k that related to historic, unrecoverable debt from overseas patients. The Committee received assurance that the debt would be cleared on the balance sheet but that the patients would still be chased for payment.

3.12 Other items
The Committee also received the following items for information:

- The Bi-Annual Declarations of Interest Report
- The Audit Committee Work Plan 2022/23

3. New risks or items for escalation

3.1 The Board is asked to note the changes to the BAF.

4. Summary and Recommendations

4.1 The Trust Board is recommended to:

- Receive the Audit & Risk Committee Upward report for assurance
- Approve the Standing Orders and SFIs
- Approve the changes and addition to the BAF risks
- Approve the revised Terms of Reference

North Bristol NHS Trust

Trust Standing Orders, including Standing Financial Instructions, Schedule of Reservations of Powers

Internal Policy Number: CO12

Specific staff groups to whom this policy directly applies	Likely frequency of use	Other staff who may need to be familiar with policy
All individuals employed or engaged by the Trust who have been given resource management and decision making authorities need to have a reasonable understanding of the extended SOs.		All should be aware that the SOs exist and what they contain

Main Author(s):	Chief Executive (for SOs and SRP) Chief Finance Officer (for SFIs and SoDA) Director of Corporate Governance/Trust Secretary
Consultation:	Executive Team Audit & Risk Committee Trust Board
Ratifying Committee:	Trust Board
Executive Lead:	Xavier Bell, Director of Corporate Governance/Trust Secretary
Date of Approval:	~~31 March 2022~~24 November 2022
Next Review Due:	March 2023 – or earlier if required by legislation or regulatory change
Version:	~~8.3~~ 9.0

Version history	V3.1 April 2010 – Programmed update V4.0 May 2014 – Programmed update, plus update for the NHS Act, 2006 (2012 provisions) and other new legislation V5.0 April 2015 – Annual Review V6.0 January 2017 – Annual Review V7.0 November 2018 – Annual Review V8.0 January 2020 – Annual Review V8.1 November 2020 – Annual Review V8.2 November 2021 – Annual Review

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	V8.3 January 2022 – update following discontinuation of the role of Executive Director of Estates, Facilities & Capital Planning (referred to as 'Director of Facilities' in previous versions of this document). V9.0 November 2022 – Annual Review. Key changes provide clarity on use of seal, electronic signature of documents, procurement processes and approval routes and business case approval routes.~~...~~

Trust Standing Orders

Contents

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North Bristol NHS
NHS Trust

Foreword to Standing Orders

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

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

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

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

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

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

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

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North Bristol NHS Trust

Introduction

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

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

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

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

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

VI. The Membership and Procurement Regulations required the Trust to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individual officers of the Trust and must establish audit and remuneration committees with formally agreed terms of reference.

VII. The Freedom of Information Act, 2000 and the Environmental Information Regulations, 2004 sets out the requirements for public access to information on the NHS.

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

Interpretation

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

X. The following definitions apply for this document.

Legislation definitions:

- the **2006 Act** is the National Health Service Act, 2006
- the **2012 Act** is the Health and Social Care Act, 2012

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

Other definitions:

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

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

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

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

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

Part I – Membership

1. Name and business of the Trust

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

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

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

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

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

2. Composition of the Trust Board

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

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

- 2.2.1. one appointee nominated to be the Vice-Chair
- 2.2.2. one appointee nominated to be the (shadow) Senior Independent Director.
- 2.2.3. in accordance with the Establishment Order, one appointee from the University of Bristol, in recognition of the Trust's status as a teaching hospital
- 2.2.4. one or more appointees who have recent relevant financial experience.

Appointees can fulfil more than one of the roles identified.

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2.3. The Executive Directors shall include:

2.3.1. Chief Executive

2.3.2. Chief Finance Officer, or equivalent

2.3.3. ~~Medical Director~~Chief Medical Officer

2.3.4. ~~Director of Nursing~~Chief Nursing Officer, or equivalent

2.3.5. Chief Operating Officer

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

3. *Appointment of the Chair and directors*

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

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

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

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

4. *Vice-Chair*

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

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

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

5. *Tenure of office*

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

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

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

6.1. All directors shall subscribe and adhere at all times to the principles described within these Standing Orders and any other relevant Trust policies, including but not limited to the Declarations of Interests Policy and the Counter Fraud Policy.

7. *Functions and roles of Chair and directors*

7.1. The function and role of the Chair and members of the Trust Board is described within these Standing Orders and within those documents that are incorporated into these Standing Orders.

Part II – Meetings

8. *Ordinary meetings of the Trust Board*

8.1. All ordinary meetings of the Trust Board shall be held in public and shall be conducted in accordance with relevant legislation, including the Public Bodies (Admission to Meetings) Act 1960, as amended and guidance issued by the Secretary for State for Health. Members of the public and representatives of the press shall be afforded facilities to attend.

8.2. Ordinary meetings of the Trust Board shall be held at regular intervals at such times and places as the Trust Board may from time to time determine. A minimum of six meetings shall be held each year.

8.3. The Chair shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press; to ensure that the Trust Board's business may be conducted without interruption and disruption.

8.4. Without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public and representatives of the press will be required to withdraw upon the Trust Board resolving as follows: "That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public"

8.5. Business proposed to be transacted when the press and public have been excluded from a meeting as provided in Standing Order 8.4, shall be confidential to members of the Board.

8.6. Members and Officers or any employee or representative of the Trust in attendance at a private meeting or private part of a meeting, shall not reveal or disclose the contents of papers, discussions or minutes of the items taken in private, outside of the Trust Board meetings without the express permission of the Trust Board.

8.7. Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner

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whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Trust Board.

8.8. The Chair may invite any member of staff of North Bristol NHS Trust, any other NHS organisation, an officer of the local council(s), or any other individual acting in an advisory capacity to attend meetings. These invitees shall not count as part of the quorum or have any right to vote at the meeting.

8.9. An annual public meeting shall be held on or before 30th September in each year for the purpose of presenting audited accounts, annual reports and any report on the accounts.

8.10. The Trust Board may, by resolution, exclude the public from a part or the whole of a meeting whenever publicity would be prejudicial to public interest by reason of the confidential nature of the business to be transacted

8.11. The provisions of these Standing Orders relating to meetings of the Trust Board shall refer only to formal Trust Board meetings, whether ordinary or extraordinary meetings. The provisions shall not apply to seminars or workshops or other meetings attended by members of the Trust Board.

9. Extraordinary meetings of the Trust Board

9.1. The Chair may call a meeting of the Trust Board at any time. Directors may ask the Chair to call a meeting of the Trust Board at any time.

9.2. A meeting may be called forthwith, by the directors who are eligible to vote, if the Chair refuses to call a meeting after such a request has been presented to the Chair, signed by at least one third of the whole number of directors who are eligible to vote (including at least one executive and one Non-Executive Director); and has been presented to the Chair at the Trust's principal place of business. The directors who are eligible to vote may also call a meeting forthwith, if, without refusing, the Chair does not call a meeting within seven days after receipt of such request.

10. Notice of meetings

10.1. The Trust shall set dates and times of regular Trust Board meetings for the forthcoming calendar year by the end of November of each year.

10.2. A notice of the meeting, specifying the business proposed to be transacted, shall be posted before each meeting of the Trust Board. This notice shall be signed by the Chair, or by a director or officer of the Trust authorised by the Chair to sign on their behalf. The notice shall be delivered to every director, by the most effective route, including being sent by post to the usual place of residence of the director, sent electronically to the usual e-mail address of the director, or circulated via an agreed online board paper portal. The notice shall be delivered to each director at least three working days before the meeting. Notice shall be presumed to have been served two days after posting and one day after being sent out via email or portal.

10.3. Lack of service of such notice on any individual director shall not affect the validity of a meeting. However, failure to serve such a notice on at least three directors who are eligible to vote will invalidate the meeting.

10.4. In the case of a meeting called by directors in default of the Chair, see Standing Order 9, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

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10.5. Where a part or the whole of a meeting is to be open to the public, official notice of the time, place and agenda of the meeting shall be announced in public. Notice will be given by one or more of: an announcement in the local press, on the Trust's internet website, displaying the notice in a conspicuous place in the Trust's hospitals or other facilities, or displaying the notice in other public places. The Trust Board may decide to limit publication to details of the items on the meeting agenda that will be considered in the part of the meeting to be held in public. A copy of the notice including the agenda may also be sent to local organisations that will have an interest in the decisions of the Trust Board. These organisations include bodies responsible for commissioning acute NHS services locally, patient and public representative groups and local councils.

10.6. Notice will be given at least three working days before the meeting. Failure to do so will render the meeting invalid.

11. The agenda and Supporting Papers

11.1. The Trust Board may determine that certain matters will appear on every agenda for an ordinary meeting of the Trust Board; and that these will be addressed prior to any other business being conducted at the discretion of the Chair. On agreement by the Trust Board, these matters may change from time to time.

11.2. A director may request that a matter is included on an agenda. This request should be made in writing, including by electronic means, to the Chair, Chief Executive, or the Trust Secretary at least seven working days before the meeting, subject to Standing Order 10. Requests made less than seven working days before the meeting may be included on the agenda at the discretion of the Chair, or to the extent that this discretion is delegated to the Chief Executive and the Trust Secretary.

11.3. Notwithstanding Standing Order 17 a director may with the consent of the Chair of the meeting, add to the agenda of any meetings any item of business relevant to the responsibilities of the Trust, under "Any Other Business".

11.4. The Agenda will be sent to Directors five working days before the meeting and supporting papers, whenever possible, shall accompany the Agenda but will certainly be despatched no later than three clear working days before the meeting, save in an emergency.

12. Chair of meetings

12.1. The Chair shall preside at any meeting of the Trust Board, if present. In their absence, the Vice Chair shall preside.

12.2. If the Chair and Vice-Chair are absent, the directors present, who are eligible to vote shall choose a Non-Executive Director who shall preside. An Executive Director may not take the chair.

12.3. The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and the Chair's interpretation of the Standing Orders shall be final. In this interpretation the Chair shall be advised by the Chief Executive and the Trust Secretary and in the case of Standing Financial Instructions the Chair shall be advised by the Chief Finance Officer.

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13. Voting

13.1. It is not a requirement for decisions to be subject to a vote. The necessity of a vote shall be indicated by the agreement of at least one third of those attending and eligible to vote. The Chair shall be responsible for deciding whether a vote is required and what form this will take.

13.2. Where it is necessary to take a vote to determine an issue, the decision shall be determined by a majority of the votes of the directors' present and eligible to vote. If the result of the vote is equal, the Chair of the meeting shall have a second or casting vote.

13.3. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may be held, if a majority of the directors' present and eligible to vote so request. Unless specifically agreed beforehand, the voting record of each individual director in a paper ballot will not be made public or recorded.

13.4. The voting record, other than by paper ballot, of any question will be recorded to show how each director present voted or did not vote, if at least one-third of the directors' present and eligible to vote so request.

13.5. If a director so requests, their vote will be recorded by name. Such a request will not be accepted if doing so would reveal the votes of other directors that do not wish to have their vote recorded.

13.6. In no circumstances may an absent director vote by proxy.

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

13.8. Where the office of a director who is eligible to vote is shared jointly by more than one person:

- 13.8.1. either or both of those persons may attend and take part in the meetings of the Trust Board.
- 13.8.2. if both are present at a meeting, they will cast one vote if they agree.
- 13.8.3. in the case of disagreement, no vote will be cast.
- 13.8.4. the presence of either or both of those persons will count as the presence of one person for the purpose of establishing a quorum.

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

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14. Quorum

14.1. No business shall be transacted at a meeting unless at least six of the directors who are eligible to vote (including at least three Executive Director with voting powers and three Non-Executive Director) are present

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

14.3. A director will not count towards the quorum on a matter where they are ruled to be ineligible to participate in the discussion, or vote, due to the declaration of a conflict of interest, see Standing Order 21 and 22. If a quorum is not available for the passing of a resolution on any matter, that matter may be discussed further at the meeting, but no resolution can be made. That position shall be recorded in the minutes of the meeting. The meeting shall then proceed to the next business.

15. Record of attendance

15.1. The names of the directors and others invited by the Chair, in accordance with Standing Order 8, present at the meeting, shall be recorded in the minutes.

15.2. If a director is not present for the entirety of the meeting, the minutes shall record the items that were considered whilst they were present.

16. Minutes

16.1. The minutes of the proceedings of a meeting shall be drawn up, entered in a record kept for that purpose and submitted for agreement at the next meeting.

16.2. There should be no discussion on the minutes, other than as regards their accuracy, unless the Chair considers discussion appropriate.

16.3. Any amendment to the minutes as to their accuracy shall be agreed and recorded at the next meeting and the amended minutes shall be regarded as the formal record of the meeting.

17. Notice of motion

17.1. Subject to the provision of Standing Order 20, a director of the Trust desiring to move a motion shall give notice of this, to the Chair, at least seven working days before the meeting. The Chair shall insert all such notices that are properly made in the agenda for the meeting. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

18. Motions

18.1. When a motion is under discussion or immediately prior to the discussion it shall be open to a director to move:

18.1.1. an amendment to the motion.

18.1.2. the adjournment of the discussion or the meeting.

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18.1.3. that the meeting proceeds to the next item of business.

18.1.4. the appointment of an ad hoc committee to deal with a specific item of business.

18.1.5. that the motion be now put

18.1.6. a motion resolving to exclude the public (including the press).

18.2. The proposer may withdraw a motion or amendment once moved and seconded with the concurrence of the seconder and the consent of the Trust Board.

19. Right of reply

19.1. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment to it.

20. Motion to rescind a decision of the Trust Board

20.1. Notice of a motion to rescind any decision of the Trust Board (or general substance of any decision) which has been passed within the preceding six calendar months, shall bear the signature of the director who gives it and also the signature of four other directors who are eligible to vote.

20.2. When the Trust Board has debated any such motion, it shall not be permissible for any director, other than the Chair to propose a motion to the same effect within a further period of six calendar months.

21. Declaration of Interests and Register of Interests

Declaration of Interests

21.1. In addition to the statutory requirements relating to pecuniary interests dealt with in Standing Order 22, the Trust's Declarations of Interest Policy requires directors to declare interests which are relevant and material to the Trust Board. All existing directors and decision-making staff as set out in the Policy should declare such interests on an annual basis, or as otherwise recommended in the Policy. Any directors and decision-making staff appointed subsequently should declare these interests on appointment.

21.2. Interests are:

21.2.1. Financial interests, where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

21.2.2. Non-financial professional interests, where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

21.2.3. Non-financial personal interests, where an individual may benefit personally in ways which are not linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

21.2.4. Indirect interests, where an individual has a close association with another individual who has a financial interest, a non-financial

professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

21.3. Subject to the requirements stated in Standing Order 22, the interests of directors' spouses, partners, or other family members must be disclosed where these maybe in conflict with the Trust.

21.4. If directors have any doubts about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust Secretary. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that the potential level of influence, rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

21.5. Declarations of interests should be considered by the Trust Board and retained as part of the record of each Trust Board meeting. Any changes in interests should be declared at the next Trust board meeting following the change occurring.

21.6. If a conflict of interest is established during the course of a Trust Board meeting, whether arising from a declared interest or otherwise, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The declared conflict of interest should be recorded in the minutes of the meeting. When a Director has declared an interest arising solely from a position with a charity or voluntary body under this Standing Order, the Trust Board may resolve that the director may remain in the meeting and take part in the discussion, but not vote on the relevant item. A record of this decision shall be made in the minutes.

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

Register of Interests

21.8. The Trust Secretary will ensure that a Register of Interests is established and maintained to record formally declarations of interests of directors and other decision-making staff. The Register of Interests will include details of all directorships and other relevant and material interests which have been declared by both executive and Non-Executive Directors.

21.9. These details will be kept up to date by means of an annual review of the Register of Interests in which any changes to interests declared during the preceding twelve months will be incorporated.

21.10. The Register of Interests will be available to the public and open to inspection at the Trust's usual place of business at any time during normal business hours (between 09:00am and 17:00pm on any working day).

21.11. With the exception of the requirement to report interests in the Annual Report (Standing Order 21.7), this Standing Order also applies in full to any committee or sub-committee or group of the Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a director).

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22. Disability of directors in proceedings on account of pecuniary interest

22.1. Subject to Standing Order 21 and the provisions of this Standing Order, if a director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

22.2. The Secretary of State may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order, in any case where it appears to them to be in the interests of the NHS that the disability should be removed.

22.3. The Trust Board, or any committee or sub-committee may, if it thinks fit, provide for the exclusion of a director from a meeting while any contract, proposed contract or other matter in which that person has a pecuniary interest, direct or indirect, is under consideration.

22.4. Any remuneration, compensation or allowances payable to a director by virtue of paragraph 233, Part 11 of the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

22.5. For the purpose of this Standing Order a director shall be treated, subject to Standing Order 2 as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

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

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

22.5.3. and in the case of persons living together as a couple, whether married or not, the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

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

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

22.6.2. of an interest in any company, body or person with which they are connected as mentioned in Standing Order 22.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

22.7. This Standing Order shall not prohibit a director from taking part in the consideration or discussion of the contract or other matter, or from voting on any question with respect to it, if:

22.7.1. They have an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, **and**

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

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

This does not affect their duty to disclose the interest

22.8. This Standing Order also applies in full to any committee or sub-committee or group of the Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a director).

23. Standards of Business Conduct

23.1. The Trust considers it to be a priority to maintain the confidence and continuing goodwill of its patients, public and fellow service providers. The Trust will ensure that all staff are aware of the standards expected of them and will provide guidance on their personal and professional behaviour.

23.2. The NHS Constitution 2016 identifies a number of key rights that all staff have and makes a number of further pledges to support staff in delivering NHS services. It goes on to set out the legal duties and expectations of all NHS staff, including:

- to accept professional accountability and maintain the standards of professional practice as set out by the relevant regulatory bodies;
- to act in accordance with the terms of contract of employment;
- not to act in a discriminatory manner;
- to protect confidentiality;
- to be honest and truthful in their work;
- to aim to maintain the highest standards of care and service;
- to maintain training and personal development to contribute to improving services;
- to raise any genuine concerns about risks, malpractice or wrongdoing at work at the earliest opportunity;
- to involve patients in decisions about their care and to be open and honest with them and;
- to contribute to a climate where the truth can be heard and learning from errors is encouraged.

23.3. The Trust adheres to and expects all staff to abide by the seven principles of public life set out by the Parliamentary Committee on Standards of Public Life. These are:

- **Selflessness:** Holders of public office should act solely in terms of the public

interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

- **Integrity:** Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.
- **Objectivity:** Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Accountability:** Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.
- **Openness:** Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.
- **Honesty:** Holders of public office should be truthful.
- **Leadership:** Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

23.4. All staff are expected to conduct themselves in a manner that reflects positively on the Trust and not to act in a way that could reasonably be regarded as bringing their job or the Trust into disrepute. All staff must:

- act in the best interests of the Trust and adhere to its values and this code of conduct;
- respect others and treat them with dignity and fairness;
- seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- be honest and act with integrity and probity;
- contribute to the workings of the Trust and its management and directors in order to help them to fulfil their role and functions;
- recognise that all staff are individually and collectively responsible for their contribution to the performance and reputation of the Trust;
- raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate and;
- accept responsibility for their performance, learning and development.

23.5. All Directors must act in accordance with the Professional Standards Authority's 'Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England' 2012.

23.6. All staff shall declare any relevant and material interest, such as those described in Standing Order 21 and in the Trust's Declarations of Interest Policy. The declaration should be made on appointment to the Executive Director, clinical director, or senior manager to whom they are accountable. If the interest is acquired or recognised subsequently, a declaration should be made via the Trust's online declarations of interest system in line with the Declarations of Interest Policy. The system will then add

the interest to the Trust's Register of Interests.

23.7. Officers who are involved in, have responsibility for, or are able by virtue of their role or functions to influence the expenditure of taxpayer monies, may be required by the Trust to give statements from time to time, or in connection with particular contracts, confirming that they have no relevant or material interest to declare.

23.8. If an officer becomes aware of a potential or actual contract in which they have an interest of the nature described in Standing Orders 21 and 22 and this Standing Order, they shall immediately advise the Chief Finance Officer formally in writing. This requirement applies whether or not the officer is likely to be involved in administering the proposed or awarded contract to which they have an interest.

23.9. Gifts and hospitality shall only be accepted in accordance with the Trust's Declarations of Interest Policy. Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value.

23.10. All gifts and hospitality, other than those that are of clearly minimal value (as determined in the Trust's Declarations of Interest Policy), should be declared via the Trust's online declarations of interest system. Acceptance of gifts by way of inducements or rewards is a criminal offence under the Fraud Act, 2006 and the Bribery Act 2010.

23.11. In addition to Standing Orders 21 and 22 and this Standing Order, an officer must also declare to the Chief Executive or Trust Secretary any other employment, business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with interests of the Trust, unless specifically allowed under that officer's contract of employment.

Part III – Arrangements for the exercise of functions by delegation and committees

24. Exercise of functions

24.1. Subject to Standing Order 3 and any such directions as may be given by the Secretary of State for Health, the Trust Board may delegate any of its functions to a committee or sub-committee appointed by virtue of Standing Order 25, or to a director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the board thinks fit.

Emergency powers

24.2. The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair acting jointly and, if possible, after having consulted with at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Trust Board for ratification.

Delegation to committees

24.3. The Trust Board shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The Trust Board shall approve the constitution and terms of reference of these committees and their specific powers.

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Delegation to officers

24.4. Those functions of the Trust, which have not been retained as reserved by the Trust Board or delegated to a committee of the Trust Board, shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust Board.

Schedule of Decisions Reserved for the Trust Board

24.5. The Trust Board shall adopt a Schedule of Decisions Reserved for the Trust Board setting out the matters for which approval is required by the Trust Board. The Schedule that is current at the date of adoption of these Standing Orders is contained in Appendix 1 and shall be regarded as forming part of these Standing Orders.

24.6. Subject to Standing Order 44, the Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule in Appendix 1 after each review.

24.7. The Schedule of Decisions Reserved for the Trust Board shall take precedence over any terms of reference or description of functions of any committee or sub-committee established by the Trust Board. The powers and functions of any committee or sub-committee shall be subject to and qualified by the reserved matters contained in that Schedule.

Scheme of Delegated Authorities

24.8. The Trust Board shall adopt a Scheme of Delegated Authorities setting out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters; and in a director's or officer's absence, the director or officer who may act for them. The Schedule that is current at the date of adoption of these Standing Orders is contained in Appendix 3 and shall be regarded as forming part of these Standing Orders

24.9. Subject to Standing Order 44, the Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule in Appendix 3 after each review.

24.10. The direct accountability, to the Trust Board, of the Chief Finance Officer and other Executive Directors to provide information and advise the Trust Board in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities.

25. Appointment of committees

25.1. Subject to Standing Order 3 and such directions as may be given by, or on behalf of, the Secretary of State for Health, the Trust may, and if directed by them, shall appoint committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust. Committees will be subject to review by the Trust Board from time to time.

25.2. A committee appointed under Standing Order 25 may, subject to such directions as may be given by, or on behalf of, the Secretary of State for Health or the Trust Board, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the committee (whether or not they include directors of the Trust).

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25.3. The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration, to meetings of any committee or sub-committee.

25.4. The Trust Board shall approve the terms of reference of each such committee. Each committee shall approve the terms of reference of each sub-committee reporting to it. The terms of reference shall include details of the powers vested and conditions, including reporting back to the committee, or Trust Board. Such terms of reference shall have effect as if incorporated into the Standing Orders and be subject to review every two years, at least, by that committee; and adoption by the Trust Board.

25.5. Committees may not delegate their powers to a sub-committee unless expressly authorised by the Trust Board.

25.6. The Board shall approve the appointments to each of the committees and sub-committees that it has formally constituted. Where the Board determines that a committee shall include members who are neither directors nor officers, the Board shall determine the terms of such appointment. The payment of travelling and other allowances shall be in accordance with the rates as may be determined by the Secretary of State for Health, with the approval of the Treasury (see Part 11, paragraph 233 of the 2006 Act).

25.7. Minutes, or a representative summary of the issues considered and decisions taken, of any committee appointed under this Standing Order are to be formally recorded and submitted for inclusion onto the agenda of the next possible Trust Board meeting. Minutes, or a representative summary of the issues considered and decisions taken of any sub-committee shall be submitted for inclusion onto the agenda of the next committee meeting to which it reports.

25.8. The committees to be established by the Trust will consist of statutory and mandatory; and non-mandatory committees.

Statutory and Mandatory Committees

Role of Audit & Risk Committee

25.9. The Trust Board shall appoint a committee to undertake the role of an Audit & Risk Committee. This role shall include providing the Trust Board with a means of independent and objective review of the financial systems and of general control systems that ensure that the Trust achieves its objectives, the reliability of the financial information used by the Trust and of compliance with law, regulations, guidance and codes of conduct. This Committee will pay due regard to good practice guidance, including, in particular, the NHS Audit Committee Handbook.

25.10. The terms of reference of the Audit & Risk Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

Role of Auditor Panel

25.11. The Trust Board shall nominate its Audit & Risk Committee to act as its Auditor Panel in line with schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

25.12. The Auditor panel shall advise the Trust Board on the selection and appointment of the external auditor.

25.13. The terms of reference of the Auditor Panel shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes

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of the Trust Board and may be varied from time to time by resolution of the Trust Board.

Role of Remuneration and Nominations Committee

25.14. The Trust Board shall appoint a committee to undertake the role of a remuneration and nominations committee. This role shall include providing advice to the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (Regulations 17-18, Membership and Procedure Regulations), as well as advising the Trust Board on the terms of service of other senior officers, and ensuring that the policy of the Trust Board on remuneration and terms of service is applied consistently.

25.15. The Committee shall advise the Trust Board on the size, structure and membership and succession plans for the Trust Board and maintain oversight of the performance of the Chief Executive and Executive Directors.

25.16. The terms of reference of the Remuneration and Nominations Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

Charity Committee

25.17. The Trust Board, acting as Corporate Trustee, shall appoint a Committee to be known as the Southmead Hospital Charity Committee, whose role shall be to advise the Trust on the appropriate receipt, use and security of charitable monies.

25.18. The terms of reference of the Southmead Hospital Charity Committee shall have effect as if incorporated into these Standing Orders and shall be recorded in the appropriate minutes of the Trust Board, acting as Corporate Trustee, and may be varied from time to time by resolution of the Trust Board, acting in this capacity.

Non mandatory committees

25.19. The Trust Board shall appoint such additional non-mandatory committees as it considers necessary to support the business and inform the decisions of the Trust Board (Regulations 15-16, Membership and Procedure Regulations).

25.20. The terms of reference of these committees shall have effect as if incorporated into these Standing Orders. The approval of the terms of reference shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

25.21. The membership of these committees may comprise Non-Executive Directors or Executive Directors, or a combination of these. The membership and voting rights shall be set out in the terms of reference of the committee and shall be subject to approval by the Board.

25.22. The current non-mandatory committees in place are (November ~~2021~~2022):

- Quality Committee
- Finance and Performance Committee
- People Committee

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- Patient and Carer Experience Committee
- Acute Provider Collaborative Board (A committee-in-common with University Hospitals Bristol & Weston NHS Foundation Trust)

These are subject to change at the discretion of the Trust Board. All new or amended non-mandatory committees will have the same standing and will be subject to the same standing orders.

26. Proceedings in committee to be confidential

26.1. There is no requirement for meetings of Trust Board committees and sub-committees to be held in public, or for agendas or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act, 2000 and there is no legal justification for non-disclosure.

26.2. Committee members should normally regard matters dealt with or brought before the committee as being subject to disclosure, unless stated otherwise by the Chair of the committee. The Chair shall determine whether specific matters should remain confidential until they are reported to the Trust Board.

26.3. A director of the Trust or a member of a committee shall not disclose any matter reported to the Trust Board, or otherwise dealt with by the committee if the Trust Board resolves that it is confidential.

26.4. Regardless of this Standing Order 26, individual directors and officers of the Trust have a right and a duty to raise with the Trust any matter of concern they may have about health service issues concerned with the delivery of care or services.

27. Election of Chair of committee

27.1. Each committee shall appoint a Chair; and may appoint a vice-Chair from its membership. The terms of reference of the committee shall describe any specific rules regarding who the Chair should be. Meetings of the committee will not be recognised as quorate, if the Chair, or vice Chair, or other suitably qualified, nominated member of the committee is not present to undertake the role.

27.2. Each committee shall review the appointment of its Chair, as part of the annual review of the committee's role and effectiveness.

28. Special meetings of committee

28.1. The Chief Executive shall require any committee to hold a special meeting, on the request of the Chair, or on the request, in writing of any two members of that committee.

Part IV – Custody of seal and sealing of documents

29. Custody of seal

29.1. The common seal of the Trust shall be kept by the Chief Executive in a secure place.

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30. *Sealing of documents*

30.1. The Seal of the Trust shall only be attached to documents where ~~the~~there is a legal requirement for sealing and the subject matter of the relevant document has first been approved in accordance with these Standing Orders and Standing Financial Instructions~~by the Trust Board, or the Chair, or the Chief Executive, or their designated acting replacement, in accordance with the Scheme of Delegated Authorities~~.

30.2. The seal shall be affixed in the presence of the signatories in accordance with Paragraph 33 of Schedule 4 of the 2006 Act:

"33 Instruments etc.
(1) The fixing of the seal of an NHS trust must be authenticated by the signature (a) of the chairman or of some other person authorised (whether generally or specifically) by the NHS trust for that purpose, and (b) of one other director."

31. *Bearing witness to the affixing of the Seal*

31.1. A recommended wording for the witnessing of the use of the Seal is "The Common Seal of the North Bristol National Health Service Trust was hereunto affixed in the presence of…."

32. *Register of sealing*

32.1. An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose. The entry shall be signed by the persons who approved and authorised the sealing of the document; and who attested the seal.

32.2. A report of all sealing shall be made to the Trust Board, or a committee delegated to oversee the register at periods of its discretion. The report shall contain details of the seal number, the description of the document and date of sealing.

Part V – Appointment of directors and officers of the Trust

33. *Canvassing of, and recommendations by, directors*

33.1. Canvassing of any director of the Trust or member of a committee of the Trust directly or indirectly for any appointment under the Trust, shall disqualify the candidate from such appointment. Where the Chair or any such director or committee member is so canvassed, they shall notify the Chief Executive in writing. The purpose of this Standing Order shall be included in any form of application or otherwise brought to the attention of candidates.

33.2. No director of the Trust shall solicit for any person any appointment under the Trust or recommend any person for such appointment; but this shall not preclude a director from sharing knowledge about the availability of potential candidates prior to the commencement of recruitment, nor from giving a written testimonial of a candidate's ability, experience or character for submission to the appropriate panel or committee of the Trust Board.

34. *Relatives of directors or officers of the Trust*

34.1. Candidates for any appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any director or senior officer of the Trust. Failure to disclose such a relationship is likely to disqualify a candidate and, if appointed, render them liable to instant dismissal.

34.2. Every director and senior officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that director or senior officer is aware. It shall be the duty of the Chief Executive to report to the committee with responsibility for oversight of remuneration and terms of service any such disclosure made.

34.3. Where the relationship to the director or senior officer of the Trust is disclosed, Standing Order 21 (~~Interest of directors in contracts and other matters~~Declarations of Interests and Register of Interests) shall apply.

34.4. This Standing Order applies to circumstances where a candidate or candidate's partner or spouse is an immediate family relation or dependent of the director or senior officer of the Trust, or their partner or spouse.

Part VI – Tendering and contracting procedures

35. General

35.1. The Trust use Bristol and Weston Purchasing Consortium (BWPC) otherwise known as its Trust's procurement service supplier.

35.2. Every contract made by or on behalf of the Trust shall comply with the procedures and requirements of:

35.2.1. these Standing Orders

35.2.2. the Trust's Standing Financial Instructions

35.2.3. any direction by the Trust Board

35.3. Wherever possible and provided it protects the Trust's position adequately, contracts made will reflect the most up to date and relevant model Standard Conditions that are provided by the Department of Health. These models may be amended to develop bespoke contracts.

35.4. The Trust shall comply with all UK ~~P~~procurement ~~L~~legislation and any European Union retained procurement law ~~to the extent that it still applies~~ in all of its procurements. The Trust's procurement service provider is responsible for ensuring compliance ~~to the procurement~~with such legislation. ~~Directives of the Council of the European Union (EU) for awarding all forms of contracts shall take precedence over all other procedural requirements and guidance and shall have effect as if incorporated in these Standing Orders. The EU Procurement Rules apply to public authorities under the, Public Contracts Regulations 2015 for England, Wales and Northern Ireland. The regulations cover fully regulated procurements and 'light touch regime'. The rules set out detailed procedures for contracts where the value equals or exceeds specific thresholds. These thresholds are exclusive of VAT and relate to the full life of the contract.~~

~~35.4.~~35.5. The Chief Executive shall be responsible for ensuring th~~at~~ best value for money can be demonstrated for all services provided under contract or in-house. The Trust Board may also determine from time to time those in-house services should be

Commented [DD1]: Might be a bit strong

Commented [RQ2]: Do we want to reinsert the precedence part, or is the intention that our SOs etc will be compliant with the legislation anyway?

Commented [DD3R2]: Isn't this covered by the any European Union retained procurement law section above?

Commented [XB4R2]: I don't have a view!

Commented [DD5]: This has been superseded.

Commented [DD6]: This additional detail seems unnecessary – it doesn't cover the complexity of the regs

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market tested by competitive tendering.

35.5.35.6. Contract procedures shall take account of the Trust's Declarations of Interest Policy and the necessity to avoid any possibility of collusion or allegations of collusion between contractors and suppliers; or between contractors and suppliers and staff of the Trust.

35.6.35.7. The application of the provisions of this part of the Standing Orders to contracts and purchases may be varied by resolution of the Trust Board from time to time.

36. Delegated authority to enter into contracts

36.1. The Trust Board shall have power to accept tenders and to authorise the conclusion of contracts. It may delegate such authority subject to financial limits set in accordance with Standing Order 36.2 to:

- 36.1.1. a committee appointed under sections 24 and 25 of these Standing Orders
- 36.1.2. the Chief Executive
- 36.1.3. to the Chief Executive jointly with the Chair
- 36.1.4. the directors or nominated officers
- 36.1.5. officers of the Trust's procurement service supplier, in accordance with that organisation's standard operating procedures.

Commented [RQ7]: Is this correct / relevant?

Commented [XB8R7]: Yes

36.2. The financial limits determining whether quotations (competitive or otherwise) or sealed bid tenders must be obtained shall be set in accordance with the procedure in the Standing Financial Instructions; the current thresholds being set out in the Trust Scheme of Delegated Authorities (Appendix 3).

37. Competition in purchasing or disposals – procedures

37.1. The Trust Board shall from time to time adopt procedures which shall be regarded as being incorporated into these Standing Orders and which shall take account of Standing Financial Instructions, the Trust's Procurement rules and regulations including implementing UK Pprocurement Llegislation and any European Union retained procurement law ~~to the extent that it still applies in all of its procurements EC Directives on Public Procurement~~ and which shall deal with:

- 37.1.1. Tender process selection
- 37.1.2. methods for inviting tenders
- 37.1.3. the manner in which tenders are to be submitted
- 37.1.4. the receipt and safe custody of tenders
- 37.1.5. the opening of tenders
- 37.1.6. evaluation
- 37.1.7. re-tendering
- 37.1.8. such other matters in connection with tendering as the Board considers appropriate

38. Disposals of land and buildings

38.1. Land and buildings that are owned by the Trust, or are otherwise recorded as being part of the estate of the Trust, shall be disposed of in accordance with the most recent

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rules and guidance issued by the Department of Health. Disposal will require the approval of the Trust Board.

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Part VII – Miscellaneous

39. Suspension of Standing Orders

39.1. Except where this would contravene any statutory provision or any direction made by the Secretary of State for Health, any one or more of the Standing Orders, except for Standing Order 40 which may not be suspended, may be suspended at any meeting, provided that at least two-thirds of the directors of the Trust are present and the majority of those present vote in favour of suspension.

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

39.3. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

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

39.5. The Audit & Risk Committee shall review every decision to suspend Standing Orders.

40. Variation of Standing Orders

40.1. These Standing Orders shall be varied only if:

- 40.1.1. A notice of motion under Standing Order 17 has been given **and**
- 40.1.2. no fewer than half of the appointed Non-Executive Directors vote in favour of such variation **and**
- 40.1.3. at least two-thirds of the directors who are eligible to vote are present **and**
- 40.1.4. the variation proposed does not contravene a statutory provision or direction made by the Secretary of State for Health.

40.2. Standing Order 40 (this Standing Order) may not be varied.

40.3. Any financial limits in these Standing Orders and the Schedule of Decisions Reserved for the Trust Board and the Scheme of Delegated Authorities may be varied by resolution of the Trust Board at any time.

40.4. Where financial limits are varied the Chief Finance Officer will advise the Audit Committee, and internal and external audit.

41. Availability of Standing Orders

41.1. The Trust Secretary shall make available a copy of the Standing Orders to each director of the Trust and to such other employees as the Chief Executive considers appropriate.

41.2. A copy of these Standing Orders will be held, with unrestricted access to all staff, on the Trust's intranet site.

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42. Signature of documents

42.1. Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall be signed by the Chief Executive, or by any Executive Director of the Trust duly authorised for that purpose by the Board in accordance with the Scheme of Delegated Authorities, unless any enactment otherwise requires or authorises differently.

42.2. The Chief Executive or Nominated Officer(s) ~~directors~~ shall be authorised~~, by resolution of the Board,~~ to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved ~~by the Board or committee or sub-committee to which the Board has delegated appropriate authority~~in accordance with these Standing Orders and Standing Financial Instructions.

~~42.2.~~42.3. ~~[new wording from RQ]~~Unless there is a legal requirement for sealing, the Chief Executive or Nominated Officer(s) shall also be authorised to execute any agreement or other document (the subject matter of which has been approved in accordance with these Standing Orders and Standing Financial Instructions) as a deed on behalf of the Trust by signing in the physical presence of an attesting witness.

~~42.3.~~42.4. Unless there is a legal requirement for a physical seal or a wet ink signature, any signature under SO 42.1, 42.2 or 4~~2~~3~~.~~.3 may be provided in electronic form and shall not be invalid on this basis.

~~42.4.~~42.5. Unless there is a legal requirement for signature by a specific Officer, any person authorised to sign a document on behalf of the Trust under SO 30.2, 42.1, 42.2 or 42.3 shall have the power to delegate such authority to their deputy or another Nominated Officer where such person is unavailable, provided advance written confirmation of such delegation is given to the Director of Corporate Governance/Trust Secretary

43. Standing Financial Instructions

43.1. Standing Financial Instructions adopted by the Trust shall have effect as if incorporated in these Standing Orders.

44. Review of Standing Orders

44.1. Standing Orders shall be reviewed annually, or earlier, if developments within or external to the Trust indicate the need for a significant revision to the Standing Orders. The requirement to review extends to all documents having the effect as if incorporated in Standing Orders.

44.2. Any change will be reviewed by the Audit Committee before a recommendation is made to the Trust Board for adoption.

ENDS

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North Bristol NHS Trust Board

Appendix 1 – Schedule of decisions reserved to the Trust Board

Introduction

Standing Order 1 provides that "the Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session." These powers and decisions are set out in this Schedule.

1. Structure and governance of the Trust, including regulation, control and approval of Standing Orders and documents incorporated into the Standing Orders

1.1. Approve, including variations to:

1.1.1. Standing Orders for the regulation of its proceedings and business (SO40).

1.1.2. this Schedule of matters reserved to the Trust Board (SO 24).

1.1.3. Standing Financial Instructions (SO 43, SO 44, SFI 2)

1.1.4. Scheme of Delegated Authorities, including financial limits in delegations, from the Trust Board to officers of the Trust (SO 24, SO 40).

1.1.5. suspension of Standing Orders (SO 39)

1.2. Determine the frequency and function of Trust Board meetings (SO 8), including:

1.2.1. administration of public and private agendas of Board meetings (SO 8)

1.2.2. calling extra-ordinary meetings of the Board (SO 9)

1.3. Ratify the exercise of emergency powers by the Chair and Chief Executive (SO 24)

1.4. Establish Board committees including those which the Trust is required to establish by the Secretary of State for Health or other regulation (SO 25); and:

1.4.1. delegate functions from the Board to the committees (SO 24)

1.4.2. delegate functions from the Board to a director or officer of the Trust (SO 24)

1.4.3. approve the appointment of members of any committee of the Trust Board or the appointment of representatives on outside bodies (SO 25)

1.4.4. receive reports from Board committees and take appropriate action in response to those reports (SO 25)

1.4.5. confirm the recommendations of the committees which do not have executive ~~decision making~~decision-making powers (SO 25)

1.4.6. approve terms of reference and reporting arrangements of committees (SO 25).

1.4.7. approve delegation of powers from Board committees to sub-committees (SO 25)

1.5. Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust~~;~~ and modifications thereto.

1.5.1. Appoint the Chief Executive (SO 3)

1.5.2. Appoint the Executive Directors (SO 3)

1.6. Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests (SO 21).

1.7. Agree and oversee the approach to disciplining directors who are in breach of statutory requirements or the Trust's Standing Orders.

1.8. Approve the disciplinary procedure for officers of the Trust.

1.9. Approve arrangements for dealing with and responding to complaints.

1.10. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on Trust (SO 25)

1.11. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2. Determination of strategy and policy

2.1. Approve those Trust policies that require consideration by the Trust Board. These will be determined by the individual directors responsible for adopting and maintaining the policies.

2.2. Approve the Trust's strategic direction:

2.2.1. annual budget, strategy and business plans

2.2.2. definition of the strategic aims and objectives of the Trust.

2.2.3. clinical and service development strategy

2.2.4. overall, programmes of investment to guide the letting of contracts for the supply of clinical services.

2.3. Approve and monitor the Trust's policies and procedures for the management of governance and risk.

3. *Direct operational decisions*

3.1. Approve capital investment plans:

3.1.1. the annual capital programme

3.1.2. all variations to approved capital plans over £1 million (SoDA 11~~13f~~)

3.1.3. to acquire, dispose of, or change of use of land and/or buildings (SO 38~~,~~)

3.1.4. capital investment over £2.5 million in value, supported by a business case and in line with the approval guidance issued by NHS England & Improvement. (SoDA ~~13c, 13d~~4)

~~3.1.5. contracts for building works, which exceed the pre-tender estimate by over 10% (minimum £100k). (SoDA 10j)~~

Commented [XB9]: This has been moved elsewhere – linked to contract variations and sign-off limits in SoDA

3.2. Introduce or discontinue any significant activity or operation which is regarded as significant (if it has a gross annual income or expenditure, before any set off, in excess of £1 million.

3.3. Approve individual contracts and commitments to pay, other than Commissioning Contracts, of a revenue nature amounting to, or likely to amount to over £2.5 million:

3.3.1. Tenders and quotations over the lifetime of the contract (SoDA ~~8a~~5)

3.3.2. Revenue funded service developments, in line with the approval guidance issued by the NHS England & Improvement (SoDA 4~~8f~~)

3.3.3. Orders processed through approved supply arrangements (SoDA ~~10c~~5)

3.3.4. Orders processed through non-approved supply arrangements (SoDA ~~10d~~5)

3.3.5. Receipt of loans and trials equipment and materials (SoDA ~~10e~~13)

3.3.6. Prepayment agreements for services received ~~(SoDA 10g)~~

3.4. Decide the need to subject services to market testing (SO 35)

4. *Quality, financial and performance reporting*

4.1. Appraise continuously the affairs of the Trust through receipt of reports, as it sees fit, from directors, committees and officers of the Trust.

4.2. Monitor returns required by external agencies; and significant performance reviews carried out by, including, but not exclusively limited to:

4.2.1. The Care Quality Commission

4.2.2. NHS Improvement

4.3. Consider and approve of the Trust's Annual Report including the annual accounts.

4.4. Approve the Annual report(s) and accounts for funds held on trust.

4.5. Approve the Quality Account

5. *Audit arrangements*

5.1. Approve audit arrangements recommended by the Audit Committee (including arrangements for the separate audit of funds held on trust).

5.2. Receive reports of the Audit Committee meetings and take appropriate action.

5.3. Receive and approve the annual audit reports from the external auditor in respect of the Financial Accounts and the Quality Account.

5.4. Receive the annual management letter from the external auditor and agree action on recommendations of the Audit Committee, where appropriate.

5.5. Endorse the Annual Governance Statement for inclusion in the Annual Report

ENDS

North Bristol NHS Trust Standing Financial Instructions

Appendix 2 – Standing Financial Instructions

1. Interpretation

1.1. The Chair of the Trust is the final authority in the interpretation of Standing Orders on which the Chief Executive and Trust Secretary shall advise them. In the case of the Standing Financial Instructions they will be advised by the Chief Finance 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) 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. **Divisional Operations Directors (Corporate Manager)** are the senior operational managers; and their formally nominated deputies, for the division or specialty, as designated by the Executive Director.

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 is contracted by the Trust for general ledger provision and maintenance, core accounting for accounts payable and receivable and VAT processes.

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

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

North Bristol NHS Trust Standing Financial Instructions

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 (Aappendix 1) and the Scheme of Delegated Authorities (Aappendix 3) which both also form part of the Trust's Standing Orders.

2.4. Detailed procedural advice, which shows how the SFIs should be applied, is maintained in departmental and financial procedure notes.

2.5. These SFIs do not refer to all legislation or regulations and advice issued by the Department of Health applicable to the Trust. Any uncertainty regarding the application of these SFIs should be discussed with the Chief Finance 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.

Compliance with these SFIs

2.7. These SFIs prevail over any division and service guidance or procedural documents. They also prevail over any guidance or instruction issued by other organisations conducting business with the Trust. All staff should notify the Chief Finance 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 Chief Finance 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 Chief Finance Officer to the next formal meeting of the Audit Committee for referring action or ratification.

Responsibilities and delegations

2.9. These SFIs have been compiled under the authority of the Trust Board. They are reviewed by the **Audit and Risk Committee** and approved by the Trust Board.

2.10. **The Trust Board** 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 Delegated Authorities

2.10.4. approving the method of providing financial services.

2.11. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Schedule of Decisions Reserved to the North Bristol NHS Trust Board (Aappendix 1). All other powers have been delegated to the Board's appointed committees;committees, and the directors and officers of the Trust.

2.12. **The Chief Executive** is the Accountable Officer of the Trust and:

2.12.1. is legally accountable to Parliament for all of the actions of the Trust

2.12.2. is accountable to the Trust Board for ensuring that the Board of Directors meets its obligation to perform the Trust's functions within the available financial resources

2.12.3. holds overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that its financial obligations and targets are met

2.12.4. is responsible overall for the maintenance of the Trust's systems of internal control

2.12.5. is responsible for ensuring that all members and staff of the Trust are aware of and understand their responsibilities within these SFIs

2.13. Save for the decisions and actions reserved to the Trust Board, the Chief Executive has full operational authority to approve the financial transactions of the Trust and to delegate such powers to post-holders within the Trust management. The Chief Executive will, as far as possible, delegate detailed responsibilities, as described in these SFIs and, in more detail in the Scheme of Delegated Authorities (Aappendix 3).

2.14. **The Chief Finance 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

3. Financial framework

3.1. The **Chief Finance Officer** shall ensure that members of the Board are aware of the financial aspects of the NHS Improvement's Single Oversight Framework, within which the Trust is required to operate.

4. Business and budget plans

4.1. The **Chief Executive** shall submit to the Board and external regulators as required, strategic and operational plans, as suggested by relevant guidance, to meet the needs of the Board. These plans will include an annual Business Plan, which takes into account financial targets and forecast limits of available resources.

4.2. The plans will include:

4.2.1. description of the significant assumptions on which planning is based

4.2.2. details of major changes in workload, delivery of services or resources required to achieve the plans.

4.3. Prior to the start of each financial year, the **Chief Finance Officer** shall prepare and submit budgets for approval by the Board. Such budgets will:

4.3.1. be in accordance with and reconcilable, at a summary level, to the aims and objectives set out in the annual Business Plan

4.3.2. reconcile to financial plans to be provided to relevant external regulators, such as the NHS Improvement (NHSI)

4.3.3. reflect resource plans, including workload and workforce plans

4.3.4. be prepared within the limits of available funds

4.3.5. show how the plans will deliver against the financial targets and obligations set externally by the Secretary of State and relevant regulatory bodies; and set internally by the Trust

4.3.6. provide a forecast of the Trust's performance over the year against key financial indicators, as determined by the Trust and by relevant regulatory bodies

4.3.7. include summary financial projections for the longer term

4.3.8. identify and assess significant financial risks.

4.4. **All staff** who have been given delegated authority to manage and administer budgets shall be expected to contribute to the preparation of the annual budget.

5. Management of the financial resource

5.1. The **Chief Executive** shall require directors and authorised budget managers to seek to deliver the financial outturn targets set by the Trust Board within the approved annual budget plan and the adjustments to those targets reflected in the re-forecasts performed during the year.

5.2. The **Chief Executive** may change the financial outturn targets of any divisions, or services.

5.3. **Directors** and **authorised budget holders** shall seek to deliver their service responsibilities within the limits of the financial outturn targets set for them. Financial and other resources shall only be used for the purposes for which they are provided, as approved by the Chief Executive and the Board.

Setting the annual financial plan

5.4. The **Chief Executive** shall be responsible for providing the Trust Board with the annual financial plan, taking into account financial targets and forecast income and service developments. The plan will identify the significant assumptions on which it is based; and provide details of significant changes to service and workforce plans and how these will impact on the Trust's financial targets. The plan will identify how the Trust will achieve the annual efficiency savings set by the Department of Health.

5.5. The **Chief Finance Officer** shall be responsible overall for the design and delivery of the annual integrated financial budget plan.

5.6. All **Executive Directors** shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

5.7. **Budget holders** shall provide all financial, statistical and other relevant information, including service, capacity, workforce and efficiency plans, as required by the Chief Finance Officer to enable budgets to be compiled.

5.8. All budget managers should sign up to their allocated budgets at the start of each financial year.

Managing and reporting the financial position during the year

5.9. The **Chief Finance Officer** shall be responsible overall for the design and delivery of adequate systems of financial budgetary control. These systems will include processes for:

5.9.1. identifying the level of earned income directly attributable to each budget area

5.9.2. identifying the target (gross or net) allowable expenditure for each budget area, that will enable each budget holder to deliver their annual financial target contribution to the overall Trust target

5.9.3. updating the forecast income and allowable expenditure, during the year, to reflect changes in contracted income, service capacity and delivery.

5.9.4. monitoring and reporting financial performance against plans and forecasts

5.9.5. delivering monthly integrated financial reports to meet the requirements of the Project Management Office, Finance and Performance Committee and the Trust Board in a form approved by the Board.

5.10. All **Executive Directors** shall be responsible for establishing monitoring and reporting systems for workforce, service delivery and quality, service capacity and activity, and efficiency planning to enable budget holders to deliver an integrated analysis of their service performance.

5.11. **All staff** to whom responsibility is delegated to incur ~~expenditure, or~~expenditure or generate income shall comply with the requirements of those systems.

5.12. Designated **budget holders** shall be responsible for maintaining expenditure within the limits of earned available income.

5.13. Designated budget holders shall monitor and analyse the integrated financial performance of their service during the year. This shall include assessment of:

5.13.1. progress towards delivering the required financial position for the budget area

5.13.2. the impact of resources used, including workforce, progress of service delivery and achievement of efficiency plans

5.13.3. trends and projections

5.13.4. where relevant, plans and proposals to recover adverse performance

5.14. The **Chief Finance Officer** shall ensure that budget holders are provided with advice and support from suitably qualified finance staff, to enable them to perform their budget management role adequately.

5.15. The **Chief Finance Officer** shall be required to compile and submit to the Board of Directors such financial estimates and forecasts, on both revenue and capital account, as may be required from time to time.

5.16. The **Chief Finance Officer** shall keep the Trust Board informed of:

5.16.1. significant in-year variance from the business plan and advise the Board on actions to be taken to address the variance

5.16.2. financial consequences of changes in Trust policy

5.16.3. financial implications of external determinations, such as national pay awards and changes to the pricing of clinical services

5.17. The **Chief Finance Officer** shall:

5.17.1. ensure that budget managers receive adequate training on an on-going basis to help them comply with expectations and to manage successfully

5.17.2. issue timely, accurate and comprehensible advice and financial reports to each budget manager, covering the areas for which they are responsible

6. Annual accounts, reports and returns

6.1. The **Chief Finance Officer** shall:

6.1.1. prepare financial returns in accordance with the accounting policies and guidance provided by the Department of Health (DHSC) and the Treasury, the Trust's accounting policies, and accounting practice as determined by the accounting bodies in the UK.

6.1.2. prepare and submit annual financial reports to the DHSC certified in accordance with current guidelines

6.1.3. submit financial returns to the DHSC for each financial year in accordance with the timetable prescribed by the DHSC

6.1.4. submit periodic monitoring and financial returns to external organisations, such as NHSI, in accordance with the timetables set by those organisations

6.2. The Trust's annual accounts must be audited by an auditor appointed by the Trust. The Trust's audited annual accounts shall be presented to a public meeting and made available to the public, within the timescales set by the DHSC.

6.3. The **Chief Executive** shall publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the current DHSC requirements and guidance.

7. Income, including contracts for the provision of healthcare, fees and charges

7.1. The **Chief Finance 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. 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

7.3. The **Chief Finance Officer** shall:

7.3.1. follow the up to date Department of Health's guidance and regulations for setting prices for providing NHS services

7.3.2. approve and regularly review the level of all fees and charges set, other than those determined by the DHSC or by statutory regulation

7.3.3. take independent professional advice on matters of valuation, as necessary.

7.4. The **Chief Finance Officer** shall approve all property and non-clinical equipment leases, property rentals and tenancy agreements. The **Director of Operational Estates & Facilities** or another individual with appropriate expertise within the Estates & Facilities division shall advise on these arrangements.

7.5. **All employees** shall inform the **Chief Finance 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

7.6. The **Chief Executive** is responsible for ensuring that the Trust enters into suitable Commissioning Contracts with service commissioners for the provision of NHS services to patients, in accordance with the business plans; and for establishing the arrangements for providing extra-contractual services.

7.7. The **Chief Finance Officer** shall provide up to date advice on:

7.7.1. Standard NHS contractual terms and conditions, issued by the DHSC

7.7.2. costing and pricing of services

7.7.3. payment terms and conditions

7.7.4. amendments to contracts, SLAs and extra-contractual arrangements

7.8. The **Chief Finance Officer** shall ensure that SLAs and other contractual and extra- contractual arrangements:

7.8.1. are devised so as to limit the risk to the Trust, whilst enabling opportunities to generate income

7.8.2. are financially sound; and that any contractual arrangement pricing at marginal cost are approved by the Chief Finance Officer and reported to the Trust Board.

7.9. The **Chief Finance 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.

7.10. The **Chief Finance Officer** shall produce regular reports, to the Trust Board or its committees detailing the Trust's forecast financial performance.

7.11. **Budget holders** with responsibilities for managing delivery against service

agreements must ensure they understand and use the contract monitoring information for the financial management of their service areas.

Research and development

7.12. All applications for research funding shall be considered and approved by the Research and Innovation department. This applies to applications to NHS institutions such as grant requests to the National Institute for Health Research, and non-NHS organisations, including commercial sponsorship organisations, charitable bodies and research councils.

Sponsorship and concession agreements

7.13. The **Chief Finance Officer**, or a nominated deputy shall maintain a register of sponsorship received by the Trust.

7.14. Sponsorship arrangements may be entered into subject to the limits set out in the Scheme of Delegated Authorities. Where sponsorship income (including items in kind such as clinical goods or loans of equipment) is considered the most recent NHS guidance on managing conflicts of interest and sponsorship should be followed.

7.15. The **Chief Finance Officer**, advised by the Director of Operational Estates & 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 Chief Finance Officer shall authorise all concession agreements entered into by the Trust.

8. Procurement, tendering and contracting procedure

8.1. The Trust may enter into contracts within the statutory powers delegated to it. The procedure for setting contracts shall comply with those powers and these SFIs. Delegated powers of authorisation are granted to Trust officers according to the Scheme of Delegated Authorities. A contractual arrangement must be in place for all goods and services procured by the Trust. The nature of the contract or agreement will depend on the goods, services or works being provided. The Chief Finance Officer is responsible for signing all contracts and agreements with delegated responsibilities given within the scheme of delegation (see Appendix 3).

8.2. All contracts made shall ensure best value for money using the Trust's ~~P~~procurement ~~S~~service provider procurement service provider (BWPC) and processes established by the Chief Finance Officer. For each contract a Trust Officer shall be nominated and hence responsible for overseeing and managing the contract on behalf of the Trust.

~~European Union and Government directives~~Legislation and guidance ~~-~~regarding public procurement

8.3. The Trust shall comply with all UK ~~P~~procurement ~~L~~legislation, ~~and~~ any European Union retained procurement law and directives ~~to the extent that it still applies~~ in all of its procurements, including any advertising and award requirements. ~~The Trust shall~~

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~~comply with European Union and Government legislation regarding public sector procurement and the procedures to be followed for awarding formal contracts~~

8.4. ~~Contracts above specified thresholds for supply and service contracts (awarded by central government bodies subject to the World Trade Organisation Government Procurement Agreement) shall be advertised and awarded in accordance with UK Procurement legislation, any retained EU European Union retained law, and other directives and relevant equivalent UK government legislation. Works contracts above separate specified thresholds shall also be awarded in accordance with UK Procurement legislation, any retained European Union retained lawEU and other directives and relevant UK government legislation.~~

Commented [DD10]: This feels like a duplication of 8.3

Competitive tendering and quotations

8.6.8.5. The **Chief Finance Officer** shall advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds shall be incorporated in Standing Orders through the Scheme of Delegated Authorities; and shall be reviewed regularly.

8.7.8.6. The **Trust Board** shall ensure that, wherever possible, competitive tenders, or quotations are invited, in line with the thresholds set out in the Scheme of Delegated Authorities, for:

8.7.1.8.6.1. the supply of goods, materials and manufactured articles

8.7.2.8.6.2. services, including management consultancy services from non-NHS organisations

8.7.3.8.6.3. design, construction and maintenance of building and engineering works, including construction and maintenance of grounds and gardens

8.8.8.7. The **Trust Board** shall allow for exceptions to the requirement for formal tendering procedures where:

8.8.1.8.7.1. the estimated contract value is not reasonably expected to exceed £25,000 over the anticipated term of the contract and will be determined through formal quotations

8.8.2.8.7.2. the supply is proposed under special arrangements negotiated by the DH, in which event the special arrangements must be complied with

~~It is a government directive that tenders over the value of £25,000 must be advertised in 'Contracts Finder'~~

Commented [DD11]: This seems to be out of place – shift to Policy?

8.8.3.8.7.3. the supply ~~requirement is a~~ is a compliant call off against a Framework, Contract, or other appropriate legal mechanism which has been established following a formal tendering process carried out by its procurement services provider~~.~~

8.7.4. the supply is ~~from~~ a compliant call off against a Framework, Contract, or other appropriate legal mechanism which has been established by NHS or Government organisation, that has been evaluated and approved for use by its procurement services provider and authorised by the ~~t~~Trust.

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~~8.8.4.~~8.7.5. The requirement is in relation to the purchase of memberships, licenses, permits, and permissions required by the Trust to carry out its normal business.

~~8.9.~~8.8. The **Trust Board** shall allow for the requirement for formal tendering procedures to be waived where:

- the **Chief Executive** decides that formal tendering procedures would not be practicable
- available timescales genuinely mean that competitive tendering is not a realistic option. Failure to plan the work properly should not be regarded as a justification for waiving tendering procedures
- specialist expertise, goods and services are required and are genuinely available from only one source. Evidence of the unique status will be required to support any exemption~~.~~
- the task is essential to complete the project, and arises as a direct and genuine consequence of an existing or recently completed assignment; and engaging different suppliers for the new task would be counter-productive
- there is a clear benefit to be gained from maintaining continuity with an earlier supply. In such cases, the benefits of such continuity must outweigh any potential advantage to be gained from competitive tendering

Note that section 8.~~3~~4 takes precedence over the above list of ~~waived~~ exemptions to competitive tendering. The Trust should take the advice of BWPC when enacting any of the aforementioned exemptions. Approval of any exemptions should be carried out with reference to SoDA~~a~~ 5 (Single Tender Actions)

~~8.10.~~8.9. The **Chief Executive** shall provide formal approval, which may be retrospective where time constraints apply, in each instance where competitive tendering requirements are waived under SO 8.8. These instances will be reported to each meeting of the Audit Committee.

~~8.11.~~ The **Chief Finance Officer** shall ensure that:

~~8.11.1.~~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

~~8.11.2.~~ waivers to competitive tendering procedures are not used to avoid competition, for administrative convenience~~, or to award further work to a supplier originally appointed through a competitive procedure~~

- 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,

Commented [DD12]: I'd link it back to 8.3 – although think it might be better to have a robust "At all times in compliance with …" comment here

Commented [RQ13]: I assume this is the case, rather than the CEO having a separate right to waiver the requirements?

Commented [DD14R13]: I agree around 8.8 - but not 8,7 - in my mind 8.7 was the path of least resistance (8.7. 1)/ compliant path (8.7.2-4) and therefore did not require tracking.

Commented [RQ15R13]: Agreed - amended

Commented [RQ16]: This is a direct conflict with the final bullet of SFI 8.8 above

Commented [DD17R16]: I agree - is there anything to be gained from retaining this last half of the bullet point?

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. [illegible]

8.11.1. Tenders are fair, transparent, competitive and at all times compliant ~~to~~with UK procurement legislation, and in accordance with the Scheme of Delegated Authorities (Appendix 3)~~, SoDa~~

8.11.2. Tenders and quotations expressly state suppliers' obligations to comply with all relevant legislation including but not limited to~~:~~:

- Human Rights Act, 1998
- ~~The~~ Equality Act, 2010~~;~~
- ~~the~~ Health and Safety at Work Act, 1974~~;~~
- ~~the~~ Modern Slavery Act 2015
- ~~[insert relevant Environment legislation – Environment Act 2021?]~~Environment Act, 2021

~~8.15.~~

- ~~Their Carbon reduction plan~~Decarbonisation
- ~~Their~~ Social Value contribution
- ~~Their~~ management of Modern Slavery within their supply chain

~~8.15.9.~~ ~~the t~~Tender process~~es~~ and rules are in accordance with up-to-date and relevant specialist guidance, which is recognised, or recommended by the DH

8.11.5. It maintains a record of competitive tenders and subsequent contract awards.

8.11.6. ~~That a~~Award notices are published for all contracts with a total value above £25,000.

8.11.7. ~~That~~ Procurement Strategy reports are created for all contracts with a total value above £100k unless they are exempted from the formal tendering process ~~(clause~~ (under SO 8.7 or SO 8.8).

~~Tendering procedure~~

Quotations: competitive and non-competitive

~~8.14.~~8.12. The **Trust Board** shall approve the value range whereby formal tendering procedures are not adopted, but quotations will be required. This range is currently for intended expenditure that is reasonably expected to exceed £25,000.

~~8.15.~~8.13. The **Chief Finance 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 £25,000 (SoDA 5)

~~8.15.1.~~8.13.2. types of service or supply to be sought through quotations

~~8.15.2.~~8.13.3. minimum number of competitive quotes to seek, currently set at three

Commented [RQ22]: In Appendix 3 of the SoDA, this is only required for contracts over £5k

Commented [DD23R22]: This is a duplication of 8.7.1

Commented [RQ24R22]: The same point applies to both - I tried to duplicate my comment at SFI 8.7.1, but it appears to have disappeared!

Commented [DD25R22]: I read that the mechanism was that the board approved the upper threshold for tendering to commence from – whereas the CFO sets the lower threshold (£5k) – but I cant see the clause that enables the £5k threshold – although it is in the SoDA

~~8.15.3.~~8.13.4. requirement for written quotations

~~8.15.4.~~8.13.5. retention of records

~~8.15.5.~~8.13.6. ~~treating all records of the process as~~ confidentiality across the process

~~8.15.6.~~8.13.7. recording the decision to go to contract

Temporary suspension of procedures in exceptional circumstances

~~8.16.~~8.14. The **Trust Board** shall allow the SFIs to be suspended temporarily in exceptional circumstances, where the circumstance is:

~~8.16.1.~~8.14.1. a Trust wide problem, rather than a directorate specific issue.

~~8.16.2.~~8.14.2. of sufficient scale that failure to act quickly and decisively would put the Trust at significant financial and reputational risk

~~8.16.3.~~8.14.3. unforeseen and rapidly developing

~~8.16.4.~~8.14.4. such that following normal procedures would hinder the recovery of the situation

~~8.17.~~8.15. The **Chief Finance Officer** shall identify specific procedures to be followed in the instance of a recognised event of exceptional circumstance.

9. Contracts and purchasing

9.1. The **Trust Board** shall only enter into contracts on behalf of the Trust that are within the statutory powers delegated to it by the Secretary of State and shall comply with:

9.1.1. the Trust's Standing Orders and Standing Financial Instructions

9.1.2. ~~EU~~ UK ~~P~~procurement ~~Directives L~~legislation, ~~other~~ European Union retained procurement law and other statutory provisions

9.1.3. any relevant directions issued, or recognised by the DHSC

~~such of the NHS standard contract conditions as are applicable~~

Commented [DD26]: Use of NHS contract conditions is covered above in SO's VI 33.3 (ish) – it also makes no sense.

9.2. In all contracts made by the Trust, the **Trust Board** shall:

9.2.1. seek to obtain best value for money

9.2.2. for contracts subjected to tendering~~,~~ or quotation, ensure that the contracts contain the same terms and conditions of contract as was the basis on which tenders or quotations were invited (unless otherwise permitted by the selected procurement process).

Commented [DD27]: I am not sure how the Trust board can ensure this – it also seems a little narrow. Are we looking for this clause to confirm VFM, compliance to regs and management of Fraud risk?

9.3. The **Chief Executive** and **Executive Directors** shall nominate managers to oversee and manage each contract on behalf of the Trust

Commented [RQ28]: This conflicts with Appendix 3 of the SoDA - "**Contract management, monitoring and reporting** Chief Finance Officer or nominated deputy"

9.4. The ~~P~~procurement ~~S~~service shall maintain a record of the details of all requisitions and orders placed. No requisition or order shall be placed for items for which there is no provision in an authorised budget.

Longer term commitments

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9.5. All contracts, leases, tenancy agreements and other commitments, which might result in a long-term liability, must be notified to and authorised, in accordance with the limits set out in the Scheme of Delegated Authorities, in advance of any commitment being made.

Healthcare Service Agreements

9.6. The **Chief Finance 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 the current guidance set out by the DHSC.

In-house services

9.7. The **Trust Board** shall determine which in-house services should be market tested by competitive tendering; and the frequency with which this should be done. In instances where competitive tendering is required, the Board shall nominate suitably qualified staff to administer the process and ensure that EU procurement and competition laws, legislation and DHSC guidance are applied correctly, including:

9.7.1. setting clearly defined specifications for the service

9.7.2. clear separation between the in-house service provider tender team and the Trust's commissioning team

9.7.3. independent evaluation process

9.8. The **Chief Executive** shall ensure that best value for money can be demonstrated for all services provided on an in-house basis and shall nominate officers to oversee and manage the contract on behalf of the Trust, separate from those that are providing the service.

10. Non-pay expenditure

10.1. Requisitions and orders are subject to the delegations and limits set out in SFI 8 and SFI 9.

10.2. The **Chief Finance 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

Requisitioning and ordering goods and services

10.5.10.4. The **Chief Finance 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 Delegated Authorities

10.4.2. recognition of the Trust's approved supply arrangements, including, but not limited to the following:

- recognised Trust wide procurement systems, (EROS and NHS Supply Chain) which incorporate automatic system controls to ensure adherence to approval and authorisation requirements
- other recognised controlled ordering systems for specific service areas (Pharmacy, Estates, Catering, Disablement Services) providing that they can evidence a secure audit trail
- framework agreements made by the Trust, or by the Procurement Service, including approved suppliers of temporary, locum and interim staff placements; and contractual arrangements for on-going ad-hoc support from chosen service suppliers (eg emergency maintenance and repair services for medical equipment)

~~10.6.~~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 Chief Finance 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 **Chief Finance 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 **Chief Finance Officer** as advised by BWPC.

~~10.7.~~10.6. Employees shall use the Trust's approved supply arrangements.

~~10.8.~~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

~~10.9.~~10.8. The **Chief Finance 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 Better Payments Practice Code).

~~10.10.~~10.9. Such requirements will be specified in any SLA with the Shared Business Service provider.

~~10.11.~~10.10. The **Chief Finance Officer** shall:

10.12.1. ensure the prompt payment of all properly authorised accounts and claims

10.12.2. maintain an adequate system of verification, recording and payment of all amounts payable, including relevant thresholds. The system will include:

- a record of Trust employees, including specimens of their signatures and/or facilities for secure electronic certification, authorised to raise requisitions and certify invoices
- certification that:
  - goods have been duly received, examined and are in accordance with specification and the prices are correct
  - work done or services rendered have been satisfactorily completed in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct
  - contractual measurement units, such as time, materials or expenses are accurate, meet contractual requirements; are supported by appropriate confirmation; and are charged at the agreed rates
  - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained
  - the account is arithmetically correct
  - the account is in order for payment

10.12.3. identify procedures to follow for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.12.4. maintain instructions to employees regarding the handling and payment of accounts within the Finance Department.

Prepayments and payments on account

~~10.12.~~10.11. The **Chief Finance 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 **Chief Finance 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 EU public procurement rules, 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 (~~eg~~e.g., rates, rentals, service and maintenance contracts, insurance, utilities standing charges)

~~10.13.~~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

~~10.14.~~10.13. The **Chief Finance 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 ~~certificates~~ shall only be ~~issued~~ 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.~~

procurements with a projected value of over £100k* must have a signed off Options Appraisal and/or Business Case report for the ~~P~~procurement which is produced in conjunction with the Trust's ~~P~~procurement ~~S~~service provider.

10.16. All Options Appraisals, and ultimately procurement Business Case~~'~~s must include Whole Life Cost~~s~~ estimates as well as identification of projected savings.

~~Unplanned Unforeseen, urgent procurements, shall be manged via the Single Tender Action process [CF reference]. The above process also applies to Extensions and Variations with a projected value which exceeds £100k~~ 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

~~10.20.~~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 ~~subject to specific limits; and~~ shall be approved ~~as part of~~ in accordance with the relevant contract process. ~~Further, or~~All new material variations ~~shall be subject to the authorisation process in place for new contracts. Variations shall be authorised in advance of commencement.~~

10.18. Where a variation to contract (or the aggregate of several variations to contract) leads to an increase in contract cost of either the lower of ~~5~~10% of contract cost or £100k, (a cost overrun) then this shall be ~~reported~~approved in accordance with the Scheme of Delegated Authorities. For the avoidance of doubt the total contract cost, rather than the additional amount, shall be used to determine the correct level of Authority.

~~10.21.~~10.19. Where new material variations are needed in an emergency, approval should be sought from a relevant authorising officer (which in most cases ~~this~~ will be the Chief Finance Officer); and shall be confirmed and authorised, using the relevant contract procedure, on the next working day or otherwise as soon as possible.

~~10.22.~~10.20. Extensions to contracts which exceed the maximum term of the contract ~~expressly permitted when the contract was let~~ shall be confirmed in writing and authorised in accordance with the Scheme of Delegated Authorities. Contract Extensions should not exceed the maximum term permitted under the terms of the contract defined when the contract was let.

Joint finance arrangements with local authorities and voluntary bodies

~~10.23.~~10.21. Payments to local authorities and voluntary organisations shall comply with

Commented [DD29]: I think that JCT only issues a Final Certificate against which a final payment can be made. So final payments certificate is misleading here. Also should probably be agnostic of contract form/ process.

Commented [DD30]: CF reference

Formatted: Indent: Left: 0.55", No bullets or numbering

Commented [DD31]: There currently isn't a defined single tender action process.

Commented [XB32R31]: The SoDA does reference single tender actions and approval limits

Commented [RQ33]: Should this fit with the above exemptions (SFI 8.8)?

Commented [DD34]: We need to be clear here around mechanism – is it the overrun (presume that we mean variation) value that is used, or the total scheme value that is used – suggest total value of scheme. Also think that we should allow a threshold for error – say 5% of original contract value.

Commented [XB35R34]: This is now dealt with below in 10.18

Commented [DD36]: This looks like it is in the wrong place – suggest moving to a separate approvals clause

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Commented [DD37]: Doesn't this suggest chunking up contracts in single year commitments – which cuts across the requirement to not deliberately split spend

Commented [XB38]: David - What does this mean? Is it practicable to do with annual contracts (like linen?).

Commented [DD39]: We need to be clear here around mechanism – is it the overrun (presume that we mean variation) value that is used, or the total scheme value that is used – suggest total value of scheme. Also think that we should allow a threshold for error – say 5% of original contract value.

Commented [DD40]: This looks like it is in the wrong place suggest moving to a separate approvals clause

Commented [RQ41R40]: Where has this come from?

Commented [RQ42R40]: Appendix 3 just requires approvals the same as any new contract - i.e. based on value. Which is preferable?

Commented [DD43R40]: Some of this gets picked up in my comment below – but my concern was that by fragmenting approvals it potentially drives the wrong behaviour

procedures laid down by the Chief Finance Officer which shall be in accordance with current legislation.

11. Terms of service and payment of members of the Trust Board and employees

Board members, directors and specified senior managers

11.1. The **Trust Board** shall be accountable for taking decisions on the remuneration and terms of service of directors and senior managers not on Agenda for Change terms and conditions. The Board shall establish a Remuneration and Nominations Committee responsible for determining the remuneration of~~:~~, and appointment of directors and senior staff in accordance with Standing Orders.

11.2. The **Remuneration and Nominations Committee** shall:

11.2.1. advise the Board about appropriate remuneration and terms of service for the Chief Executive, other directors and any staff remunerated outside of the Agenda For Change arrangements, (as described in the terms of reference of the Committee), employed by the Trust:

- all aspects of salary (including any performance-related elements and bonuses)
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms

11.2.2. advise the Board on the remuneration and terms of service of directors and any staff remunerated outside of the Agenda for Change arrangements to ensure they are fairly rewarded for their contribution to the Trust, whilst having proper regard to the Trust's circumstances and performance~~;~~ and to the provisions of any national arrangements for such members and staff where appropriate

11.2.3. monitor and evaluate the performance of individual directors and senior employees

11.2.4. advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate

11.3. The Trust shall pay allowances to the Chair and Non-Executive Directors of the Board in accordance with instructions issued by the DHSC.

Other employees

11.4. The Trust Board shall consider and approve proposals presented by the ~~**Director of People & Transformation**~~**Chief People Officer** for the setting of remuneration and conditions of service for those employees not covered by the Remuneration and Nominations Committee.

Funded establishment and staff appointments

11.5. The staff establishment plans incorporated within the annual plans approved by the Trust Board shall be regarded as the funded establishment. The funded establishment of any department should reflect the Trust's approved workforce plans, which form part of the Trust's budget plans submitted to the ~~NHS TDA~~NHS England.

11.6. The ~~**Director of People and Transformation**~~**Chief People 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 **Chief Finance 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 **Chief Finance Officer** shall ensure that the arrangements for providing the payroll service are supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures; and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies

11.10. Under the delegated authority of the Chief Finance Officer, the **Head of Payroll** shall:

11.10.1. specify timetables for submission of properly authorised time records and other notifications

11.10.2. agree the final determination of pay and allowances

11.10.3. arrange to make payment on agreed dates

11.10.4. agree allowed methods of payment.

11.11. **Nominated managers** shall ensure that the electronic staff record, including the approved staff establishment, is kept up to date. Nominated managers shall ensure that all staff are keeping their records complete, including requirements to:

11.11.1. submit time records, and other notifications in accordance with agreed timetables

11.11.2. complete time records and other notifications in accordance with the Chief Finance 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. The **People Division** shall establish procedures to ensure that the Trust's interests are protected in the contractual arrangements entered into with self-employed consultants and contractors. These procedures shall ensure that the contractual arrangements do not contravene HM Revenues and Customs' requirements regarding the avoidance of tax and national insurance contributions through the use of intermediaries, such as service companies or partnerships, known as Intermediaries Legislation, or "IR 35".

11.14. All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.

12. Insurance, including risk pooling schemes administered by the NHS Litigation Authority

12.1. The **Trust Board** shall determine the Trust's arrangements for insurance cover, including the option to insure through the risk pooling schemes administered by 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 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 **Chief Finance 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 is informed of the nature and extent of the risks that are self-insured in the event that the Board decides not to use the risk pooling schemes administered by the NHSR for one or other of the risks covered by the schemes

12.4. The Chief Finance Officer shall determine the level of insurance cover to be held by the Trust in the three discrete areas where the Trust can use commercial insurers:

12.4.1. insuring motor vehicles owned by the Trust including insuring third party liability arising from their use

12.4.2. where the Trust is involved with a consortium in a PFI contract and the other consortium members require that commercial insurance arrangements are entered into

12.4.3. where income generation activities take place, which are not covered by the NHSR risk pool

13. Capital investment, private financing, fixed asset registers and security of assets

13.1. The **Chief Finance Officer** is responsible for compiling and submitting for Board approval an annual capital programme, which is affordable within available resources over the lifetime of the investment.

13.2. The **Chief Finance Officer** shall report to the Board, the progress of delivery of the capital programme, against plan, during the year.

13.3. The **Chief Executive** shall ensure that:

13.3.1. there is an adequate appraisal and approval process in place for determining capital expenditure priorities and supporting systems to identify and assess the financial effect of each proposal on business plans

13.3.2. all stages of capital schemes are managed and controlled adequately; and that schemes are delivered on time and to cost

13.3.3. capital investment is risk assessed against the declared commissioning strategic plans of significant commission organisations and is consistent with the Trust's long term strategic plans

13.4. For every capital expenditure proposal, the Chief Executive shall ensure that a business case, or statement of need, is produced in accordance with the Trust's approved procedures and is considered by the **Finance and Performance Committee**, where required. The business case shall set out, as a minimum:

13.4.1. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs

13.4.2. the involvement of appropriate Trust personnel and external agencies

13.4.3. appropriate project management and control arrangements

13.5. The approval of a capital programme shall not constitute approval for expenditure on any scheme.

13.6. The **Chief Finance Officer** shall:

13.6.1. review the costs and revenue analysis, including revenue consequences included in the business case

13.6.2. ensure that, in higher cost, or higher risk investments, advice has been sought from the NHS England & Improvement; and that appropriate Risk Evaluation for Investment Decisions (REID) analysis has been completed

13.7. For approved capital schemes, the Chief Finance Officer shall:

13.7.1. issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes

13.7.2. agree arrangements for managing stage payments

13.7.3. maintain procedures for monitoring and reporting on the progress of delivery of contracts; and capital expenditure and commitments against plans and against the Trust's capital programme

13.8. The Trust's **Procurement Service** shall advise the Chief Finance Officer, on the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.9. Authorisations issued to the manager(s) responsible for any scheme shall be made in accordance with the value limits set out in the Scheme of Delegated Authorities:

13.9.1. specific authority to commit expenditure~~;~~

13.9.2. authority to proceed to tender

13.9.3. approval to accept a successful tender

Private Finance Initiatives (PFI)

13.10. The **Chief Finance Officer** should normally test for PFI when considering capital procurement. If this test supports a proposal to use finance which is to be provided through PFI arrangements, the Chief Finance Officer shall:

13.10.1. demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector

13.10.2. refer any investment proposal over £1 million to NHS England ~~the NTDA~~ for a risk assessment and decision to approve the borrowing

13.11. Any PFI proposal shall be specifically agreed by the **Trust Board**.

13.12. Where a capital scheme is funded using the PFI, any variations to the contract will be dealt with under procedures for variations in capital contracts and shall be authorised by the Trust Board.

Instructions specific to the Southmead Hospital PFI

13.13. The **Trust Board** shall approve and authorise the schedule of payments payable by the Trust to the PFI Project Co (Hospital Company (Southmead) Limited), as documented in the Project Agreement made between the Trust and the PFI Project Co dated 25 February 2014 ("Project Agreement").

13.14. The Schedule of Service Payments (Project Agreement, Schedule 18, Appendix I) shall be fixed for the duration of the Project Term save in respect of

13.14.1. inflationary adjustments

13.14.2. procurement of additional works (i.e. Small Works etc.)

13.14.3. variations in accordance with Schedule 22 of the Project Agreement.

13.15. Inflationary adjustments shall be calculated annually and presented to the Trust Board for approval. Arrangements for the procurement of additional works and variations shall be dealt with in accordance with the procedures for variations in capital contracts and shall be authorised by the Trust Board.

13.16. During the Operational Term, the **Chief Finance Officer** or an individual nominated

by the Chief Finance Officer shall be responsible for monitoring the proper performance and implementation of the Project Agreement by the Project Co and the Trust. In accordance with the monthly reporting arrangements, the **Chief Finance Officer** or an individual nominated by the Chief Finance Officer will be responsible for ensuring the invoices issued by the Project Co are analysed to ensure compliance with the terms of the Project Agreement. This will include verifying records of:

13.16.1. performance failures

13.16.2. unavailability events

13.16.3. service failure points

and associated "deductions" against Trust records.

13.17. The **Chief Finance Officer**, or their nominated deputy shall authorise payment of invoices submitted by the Project Co in accordance with Schedule 18 of the Project Agreement, provided that:

13.17.1. they are satisfied that the appropriate level of Deductions have been applied

13.17.2. the invoice complies with the requirements of Schedule 18

13.17.3. the Trust does not dispute all or any part of the invoice

where all or any part of an invoice is to be withheld, approval of the Chief Finance Officer is required

13.18. The **Chief Finance Officer,** or in their absence, the **Chief Executive** shall approve any decision to withhold, or delay payment of invoices, at the risk of incurring penalties and interest charges for the late payment of amounts due.

13.19. The **Assistant Chief Finance Officer (Financial Services)**, or their nominated deputy, shall process payments of invoices submitted by the Project Co in accordance with Schedule 18, subject to the approval of the Director of Operational Estates & Facilities and, where appropriate, the Chief Finance Officer.

13.20. The **Chief Finance Officer** or an individual nominated by the Chief Finance Officer shall oversee procedures for determining variations to the Project Agreement. Any such variations shall be subject to authorisation in accordance with the limits set out in the Scheme of Delegated Authorities.

Asset registers

13.21. The **Chief Finance 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 once a year.

13.22. The **Chief Finance Officer** shall maintain procedures for verifying additions and amendments to the assets recorded in the asset register. These procedures and records will include:

13.22.1. additions to the fixed asset register clearly identified to an appropriate budget manager

13.22.2. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties

13.22.3. records of costs incurred within the Trust, on stores, requisitions and labour including appropriate overheads

13.22.4. lease agreements in respect of assets held under a finance leases

~~13.25.~~13.24. The **Chief Finance Officer** shall approve procedures for:

13.24.1. applying depreciation charges and indexation valuation adjustment to assets, using methods and rates as specified in the Manual for Accounts issued by the DH

13.24.2. reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers

Security of assets

~~13.26.~~13.25. The **Chief Executive** shall maintain procedures for controlling the security of assets, including fixed assets, cash, cheques and negotiable instruments. The procedures will include:

13.25.1. recording managerial responsibility for each asset

13.25.2. identification of additions and disposals

13.25.3. identification of all repairs and maintenance expenses

13.25.4. physical security of assets

13.25.5. periodic verification of the existence of, condition of, and title to, assets recorded

13.25.6. identification and reporting of all costs associated with the retention of an asset

13.25.7. reporting, recording and safekeeping of cash, cheques, and negotiable instruments

~~13.27.~~13.26. **All employees** are responsible for the security of property of the Trust and for following such routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices, or damage and losses to Trust property shall be reported in accordance with agreed procedures.

~~13.28.~~13.27. Where practical, assets should be marked as Trust property.

Disposals and condemnations

~~13.29.~~13.28. The **Chief Finance Officer** shall prepare procedures for the disposal of assets including condemnations and ensure that these are notified to managers. The procedures will include arrangements to be followed for:

13.28.1. condemning and disposing of unserviceable and redundant assets

13.28.2. maintaining records of assets disposed of, including confirmation of destruction of condemned assets

13.28.3. specific processes to be followed in instances where assets are passed on for future use to another organisation

13.28.4. the sale of assets, including through competitive bids and negotiated bids; and sales linked to larger contracts for work, such as assets arising from works of construction, demolition or site clearance

~~13.30.~~13.29. The **departmental manager** responsible for the decision to dispose of an asset shall advise the Chief Finance 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** shall:

14.1.1. approve the banking arrangements for the Trust.

14.1.2. As the Corporate Trustee, approve separate banking arrangements for the Trust's Charitable Funds

14.2. The **Chief Finance 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 Department of Health.

14.3. The **Chief Finance Officer** shall:

14.3.1. establish and maintain necessary commercial bank accounts and Government Banking Service (GBS) accounts

14.3.2. establish separate bank accounts for non-exchequer funds, including charitable funds

14.3.3. advise the Trust's bankers, formally in writing, of the conditions under which each account will be operated (the bank mandate)

14.3.4. seek to limit the use of commercial bank accounts and the value of cash balances held within them

14.3.5. conduct the Trust's main banking services and financial transactions using accounts provided by the GBS

14.4. Only the **Chief Finance Officer**, or their nominated representative, is authorised to open, operate and control a bank account, where monies owned by the Trust, including charitable funds, are received or expended. All such accounts must be held in the name of the Trust. It is a disciplinary offence for any other officer of the Trust to establish and operate such an account.

14.5. The **Chief Finance Officer** shall:

14.5.1. Ensure that payments made from bank or GBS accounts do not exceed the amount credited to the account

14.5.2. monitor compliance with DHSC guidance on the level of cleared funds.

Where such processes are undertaken by a Shared Business Service (SBS) these will be specified in a Service Level Agreement with the SBS.

Banking procedures

14.6. The **Chief Finance Officer** shall prepare detailed instructions on the operation of bank and GBS accounts which shall include:

14.6.1. the conditions under which each bank and GBS account is to be operated

14.6.2. details of those authorised to sign cheques or other orders drawn on the Trust's accounts

14.6.3. details of limits to delegated authority, including the number of authorised signatories required, and arrangements for authorising alternative mechanisms for 'signing' cheques and orders

Tendering and review

14.7. The **Chief Finance 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.

14.8. Competitive tenders should be sought at least every five years. The **Chief Finance Officer** shall report to the Trust Board the reason(s) for continuing existing banking arrangements for longer than five years, without competitive review.

14.9. The **Chief Finance Officer** shall report the results of any tendering exercise to the Board. This review is not necessary for GBS accounts.

Trust credit cards

14.10. The **Chief Finance 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 **Chief Finance 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.

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 Chief Finance 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 and authorised by the Board. The current rules require that surplus funds are held in the Trust's GBS accounts.

15.2. The **Chief Finance Officer** shall advise the Charity Committee on investments made with endowment funds held; and prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

16. Management of debtors

16.1. The **Chief Finance 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 **Chief Finance 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 **Chief Finance 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 Chief Finance 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. The **Chief Finance Officer** shall advise the Board on the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Chief Finance Officer shall also provide periodic reports to the Board concerning the PDC debt and all loans.

18.2. The **Trust Board** shall agree the list of employees authorised to make short term borrowings on behalf of the Trust. This shall include the Chief Executive and the Chief Finance Officer.

18.3. The Chief Finance 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 DH

18.3.2. the Trust Board is made aware of all short term borrowings at the next meeting

18.4. The **Finance and Performance Committee** shall ensure that all proposed long-term borrowing is consistent with the Trust's financial plans; and is approved by the Trust Board.

19. Losses and special payments

19.1. The **Chief Finance 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. 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 **Chief Finance Officer** shall determine the nature and/or value of losses which must be reported immediately to the **Chief Finance Officer** or **Chief Executive**:

19.2.1. where fraud or bribery is suspected, this shall be reported to the Local Counter Fraud Specialist, in accordance with the Trust Counter Fraud and Bribery Policy

19.2.2. where a criminal offence is suspected, the **Chief Finance 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 Chief Finance Officer must immediately notify the external auditor and the Trust Board

19.3. **Any employee** discovering or suspecting a loss of any kind shall immediately inform their head of department and ensure that the loss is recorded in accordance with instructions.

19.4. The **Trust Board** shall approve the write off of losses, compensations and ex-gratia payments, within the limits delegated to it by the Department of Health.

19.5. The **Audit Committee** shall receive regular reports of losses, compensations and ex-gratia payments made.

19.6. The **Chief Finance Officer** and the Shared Business Service shall be authorised to:

19.6.1. take any necessary steps to safeguard the Trust's interests in the event of bankruptcies and company liquidations

19.6.2. investigate whether any insurance claim can be made

20. Patients' property

20.1. The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival (see "Guidance for NHS organisations on the secure management of patients' property", NHS Protect, July 2012; and Health and Social Care Act 2008, (Regulated Activities) regulations 2010).

20.2. The **Chief Executive** shall ensure that patients or their guardians, as appropriate, are clearly and suitably informed before or on admission into hospital that the Trust will not accept responsibility or liability for patients' property brought into NHS premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

20.3. The **Chief Finance 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. The **Trust Board**, as Corporate Trustee, is responsible for the management of funds it holds on trust and for meeting the requirements of the Charities Commission.

21.2. The **Trust Board's** corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

21.3. Trustee responsibilities for non-exchequer funds for charitable and non-charitable purposes shall be discharged separately and full recognition shall be given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

21.4. The Charity Committee shall ensure that each trust fund for which the corporate trustee is responsible is managed appropriately in terms of its purpose and requirements.

22. Retention of records

22.1. The **Chief Executive** is responsible for managing all NHS records, regardless of how they are held; and shall require policy and procedures to be followed that ensure compliance with the current DHSC best practice guidelines on records management. These procedures will include arrangements for:

22.1.1. managing archives of all records required to be retained in accordance with DHSC guidelines

22.1.2. records held in archives to be accessible for retrieval by authorised persons

22.1.3. destruction of records in accordance with the DHSC "Records Management: NHS Code of Practice" Part 1 (30 March 2006) and Part 2 (8 January 2009)

22.2. Where documents are held by a Shared Business Service detailed records storage requirements will be set out in a SLA with the Shared Business Service.

23. Information Technology and data security

23.1. The **Chief Finance Officer** shall be responsible for the accuracy and security of

the performance and financial data of the Trust and shall devise and implement any necessary procedures to ensure:

23.1.1. computer assets and data programmes are protected from theft or damage

23.1.2. adequate and reasonable protection of the Trust's data from deletion or modification; accidental or intentional disclosure to unauthorised persons, having due regard for the Data Protection Act 1998

23.1.3. adequate controls operate over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data

23.1.4. controls exist such that the computer operation is separated from development, maintenance and amendment

23.1.5. adequate audit trails exist through the computerised system; and that these are subjected to periodic reviews as the Director may consider necessary

23.2. Where computer systems have an impact on corporate financial systems, the Chief Finance 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 Chief Finance 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 **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 **Chief Finance 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 Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

Risk assessment

23.6. The **Chief Information Officer** shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered; and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

24. Risk management

24.1. The **Chief Executive** shall ensure that the Trust has adequate procedures for managing risk and meeting current DHSC requirements for assurance frameworks, which shall be approved and monitored by the Trust Board.

24.2. The programme of risk management shall include:

- 24.2.1. arrangements for identifying and quantifying risks and potential liabilities
- 24.2.2. promotion, to all levels of staff, of a positive attitude towards the identification and management of risk
- 24.2.3. procedures to ensure all significant risks and potential liabilities are assessed and addressed, including through maintenance of effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk
- 24.2.4. contingency plans to offset the impact of adverse events
- 24.2.5. arrangements for reviewing the effectiveness of the risk management processes in place, including: internal audit; clinical audit; and health and safety review
- 24.2.6. arrangements for reviewing the risk management programme

24.3. The Chief Executive shall ensure that the existence, integration and evaluation of the risk management system is used to inform the Annual Governance Statement within the Annual Report and Accounts as required by current DHSC guidance.

25. Audit

25.1. In accordance with Standing Orders, the Board shall formally establish an **Audit Committee**, with clearly defined terms of reference. The Committee will seek assurance for the Board on the range of issues in accordance with guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

- 25.1.1. overseeing internal and external audit services
- 25.1.2. reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments
- 25.1.3. reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

25.1.4. monitoring compliance with Standing Orders, Standing Financial Instructions, delegations and reservations

25.1.5. reviewing schedules of losses and compensations and advising the Board where necessary

25.1.6. reviewing the arrangements in place to support the application of the Assurance Framework on behalf of the Board and advising the Board accordingly.

25.2. Where the Audit Committee considers there is evidence of *ultra vires* transactions, or improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health (to the Chief Finance Officer in the first instance).

25.3. It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit service is provided. The Audit Committee shall be involved in the selection process when the internal audit service provision is subjected to market testing.

25.4. In the case of the Shared Business Service, the Chief Finance 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 **Chief Finance 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 (DH, April 2011)

25.5.4. the internal audit service provides the Audit Committee with an annual report of the coverage and results of the work of the service. The report must address, as a minimum:

- a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health
- major internal financial control weaknesses identified
- progress on the implementation of internal audit recommendations
- progress against plan over the previous year
- strategic audit plan covering the forthcoming three years
- a detailed audit plan for the next financial year

25.5.5. the police are informed at the right time, in cases of misappropriation and other irregularities not involving fraud or bribery

25.5.6. there is effective liaison with the Trust's appointed Local Counter Fraud

Specialist (LCFS), or NHS Counter Fraud Authority on all suspected cases of fraud and bribery and all anomalies which may indicate fraud or bribery

25.6. The **Chief Finance 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 or employees of the Trust

25.6.3. sight of any cash, stores or other property of the Trust under the control of any member of the Board or Trust employee

25.6.4. explanations concerning any matter under investigation

Internal Audit

25.7. The internal audit service shall:

25.7.1. provide an independent and objective assessment for the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance arrangements support the achievement of the Trust's objectives.

25.7.2. operate independently of the decisions made by the Trust and its employees; and of the activities which it audits. No member of the team providing the internal audit service will have executive responsibilities.

25.8. The **Head of Internal Audit** shall develop and maintain an Internal Audit Strategy for providing the Chief Executive with an objective evaluation of; and opinions on the effectiveness of the Trust's risk management, control and governance arrangements. The planned programme of work will inform the Head of Internal Audit's opinion. This will contribute to the framework of assurance that supports completion of the Annual Governance Statement, which forms part of the annual financial accounts.

25.9. The **Head of Internal Audit** shall ensure that the audit team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience needed to deliver the internal audit plan in line with the NHS Internal Audit Standards (DH, April 2011).

25.10. The **Head of Internal Audit** will normally attend Audit Committee meetings and has an independent right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

25.11. The **Head of Internal Audit** shall be accountable to the Chief Finance Officer. The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards.

25.12. The internal audit service will review, appraise and report upon:

25.12.1. the extent of compliance with and the financial effect of, relevant policies, plans and procedures

25.12.2. the adequacy and application of financial and other related management controls

25.12.3. the suitability of financial and other related management data

25.12.4. the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from

25.12.5. fraud and other offences

25.12.6. waste, extravagance and inefficient administration

25.12.7. poor value for money or other causes

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 Chief Finance Officer must be notified immediately.

25.14. In obtaining third party assurance from other auditors, for example SBS's auditors, the Head of Internal Audit should follow the Internal Auditors Practitioners Group (IAPG) assurance guidance.

External Audit

25.15. The **External Auditor** is appointed by the Trust's Auditor Panel and paid for by the Trust. The Audit Committee shall ensure that a cost-effective service is provided. If the Trust Board has concerns about the service provided by the External Auditor, which cannot be resolved by the Board, this should be raised with the External Auditor.

Counter Fraud and Bribery

25.16. In line with their responsibilities the Trust **Chief Executive** and **Chief Finance Officer** shall ensure compliance with section 24 of the NHS Standard Contract;

25.17. The **Chief Finance Officer** shall ensure that:

25.17.1 the Trust's Counter Fraud and Bribery Policy is maintained and remains up to date;

25.17.2 an NHS accredited Local Counter Fraud Specialist is appointed to the Trust to deliver the requirements of the Policy in accordance with the NHS Counter Fraud Authority Standards;

25.18. The appointed **Local Counter Fraud Specialist** shall report to the Chief Finance Officer and shall work with staff in NHS Counter Fraud Authority, when required;

25.19. The Local Counter Fraud Specialist will provide a written report to the Audit Committee, on an annual basis at least, on the counter fraud work completed within the Trust;

25.20. In accordance with the Trust's Counter Fraud Policy, any suspicions involving financial crime must be reported to the Local Counter Fraud Specialist, and/or the Chief Finance Officer or via the NHS Fraud and Bribery Reporting Line.

All reported concerns will be treated in the strictest confidence and professionally

investigated in accordance with the Fraud Act 2006 and Bribery Act 2010.

Where evidence of Fraud and/or is identified all available sanctions will be pursued against offenders. This may include internal and professional body disciplinary sanctions, criminal prosecution and civil action to recover identified losses.

Security Management

25.21. The **Chief Finance 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 NHS Standard Contract (currently 2013/14).

25.22. The **Local Security Management Specialist** will provide a written report to the Audit Committee, on an annual basis at least, on the security management work completed within the Trust.

ENDS

Appendix 3 – Scheme of Delegated Authorities

1. Trust Policies and procedural guidance

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Adoption (and responsibility for currency of): - Trust Policies	Relevant Director to be appointed as Policy owner	SFI 2 *Policy on Policies*
	- Procedural guidance (Procedure notes, Standard Operating Procedures, Protocols, Guidance)	Officer nominated by the Relevant Director	SFI 2 *Policy on Policies*
	Maintain and update Trust's financial procedures (eg administrative procedure notes, desktop guides, guidance to Budget Managers)	Chief Finance Officer	SFI 2.14

2. Planning and budget management

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Financial Framework Advising the Board on the financial framework within which the Trust operates	Chief Finance Officer	SFI 3.1
	Compliance with and update of Trust financial framework	Chief Finance Officer	SFI 3.1
	Business and budget plans		SFI 4
	Preparation of strategic and annual plans for the Trust	Chief Executive	SFI 4.1
	Preparation of annual (and longer term) financial budget for the Trust	Chief Finance Officer	SFI 4.3
	Contribute to the preparation of annual budgets	All nominated Budget Managers	SFI 4.4

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Budget management (and responsibility levels)		SFI 5
	i. at individual cost centre level	Budget Manager or nominated deputy	SFI 5
	ii. at department level	Departmental Manager or nominated deputy	SFI 5
	iii. division level	Clinical Director / Corporate Manager (some or all of the Division Management Team as authorised by the Clinical Director / Corporate Manager)	SFI 5
	iv. at Executive Director level	Executive Director, or nominated deputy	SFI 5
	Recognition and adoption of the annual budget at cost-centre level	Budget Managers	SFI 5.9
	Variations from reserves (additional funds provided to address inflationary pressures and/or investments and/or risks) *Report periodically to the Finance & Performance Committee*	Chief Finance Officer or nominated deputy	SFI 5

Approval of variation of budgets, including authority to vire

SoDA	Delegated Authority	Between budget lines	Capital to revenue & *vice versa*	SFI reference
	Within a cost centre	Budget manager **plus** one of: Head of Nursing, Matron, Divisional Operations Director, Assistant Department Manager	Agreement between Business Partner and	SFI 5.9
	Within a department, or specialty; between cost centres	Department Manager **plus** one of: Director, Deputy Director, Head of Nursing, Matron, Divisional Operations Director		SFI 5.9

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	Within a division; between departments and specialties	Director, **or** Deputy Director **or** Divisional Operations Director	Director of Operational Finance , with the express agreement of the Chief Finance Officer	SFI 5.9
	Between divisions, up to **£5,000**	Deputy Director of both divisions		SFI 5.9
	Between divisions, over **£5,000**	Executive Director of both divisions		SFI 5.9

Preparation of financial reports and returns

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Preparation of annual financial accounts and associated financial returns For Board approval	Chief Finance Officer	SFI 6.1
	Preparation of Annual Report (or equivalent) For Board approval	Chief Executive	SFI 6.3
	Preparation of monthly and quarterly financial returns to NHSI	Chief Finance Officer or nominated deputy	SFI 6.1

3. Contracted Income and Expenditure[1]

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Setting of fees and charges for NHS services		SFI 7
	Agree and execute service level agreements, in accordance with NHS standard commissioning contract terms		SFI 7.6 SFI 7.7
	i. under or equal to £~~1~~2 million	i. Chief Finance Officer~~, or nominated deputy~~	
	ii. over £~~1million~~2 million	ii. Chief Executive and Chief Finance Officer	
	Subject to all approvals required in accordance with this SoDA and the relevant procurement process~~es~~ being completed, ~~Subject to any required approvals being obtained~~, execute Agreements/Contracts (including Service Level Agreements and ~~Deeds of~~ v~~V~~ariations[2]) with NHS and non-NHS bodies for the purchase or provision of works, goods and/or services i. Up to £250,000 ~~i.~~ii. ~~under~~ >£250,00 ~~or equal~~ to £~~2~~1 million ~~ii.~~iii. over £~~2~~1million	i. Divisional Operations Director or relevant Corporate Director ~~i.~~ii. Chief Finance Officer ~~ii.~~iii. Chief Executive and Chief Finance Officer	~~SFI 7.6~~ ~~SFI 7.7~~ SFI 7.8 SFI 9.5 SFI 9.6
	Contract management, monitoring and reporting	Chief Finance Officer or nominated deputy	SFI 7.9 SFI 7.10
	Subject to all approvals required in accordance with this SoDA, execute Business Transfer Agreements ~~(subject to approval of associated business case in accordance with this SoDA)~~ i. ~~nil,~~ under or equal to £2 million (including nil value)	i. Chief Finance Officer ii. Chief Executive and Chief Finance Officer	SFI 7.6 SFI 7.7

Commented [RQ44]: Do the commissioning contracts go through Board approval as well?

Commented [XB45R44]: No

Commented [RQ46]: I am not sure how to do it on this version, but the formatting here is a sub-table, which is not used anywhere else

Commented [XB47]: Do we need this wording? Need to discuss the intended scope of this particular section of the SoDA. Compared to section 6 below (which has been amended. We've lost any reference to Div Ops Director and Corporate Director referenced in old section 6

Commented [XB48]: Need to include Div Ops Director and Corporate Directors for up to £250k (if all is fully compliant)

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	ii. over £2million		
	Private Patients i. set pricing policy and price structure	i. Chief Finance Officer ii. Chief Finance Officer iii. Chief Finance Officer, Medical	SFI 7.3

[1] All legally binding documentation must be entered into in the name of "North Bristol NHS Trust" as the relevant legal entity
[2] If any variation is not included within the original Agreement/Contract, such variation shall require approval as if a new Agreement/Contract (SFI 10.18)

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	ii. set payment policy, including use of deposits, income guarantees, arrangements with insurance companies iii. approve service coverage policy (i.e. clinical services offered)	Director, and Chief Executive	
	Overseas visitors i. set pricing policy and price structure ii. set payment policy, including use of deposits, income guarantees	i. Chief Finance Officer ii. Chief Finance Officer	SFI 7.3
	~~**Authorise**~~ **Approve sponsorship deals** i. Approve and execute Agreements to receive sponsorship from third parties (including funding of staff and loan of equipment): up to £15,000 ii. £15,000 to £50,000 iii. over £50,000	i. Divisional Operations Director ii. Chief Finance Officer iii. Chief Executive	SFI 7.13
	~~**Authorise**~~ **Approve and execute concession arrangements**	Chief Finance Officer	SFI 7.15
	~~**Authorise**~~ **Approve research projects and clinical trials**, including approvals to apply for research funding and approvals to undertake research, once considered by the Research and Development Committee i. execute required Agreements/Contracts and authorise grant submission ~~ii. execute documentation where the Trust Seal is required~~	i. Deputy Director of Research or nominated Deputy ~~ii. As per SFI 8e~~	SFI 7.12

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Commented [RQ50]: As above, we do need to consider the rights of DoDs - e.g. Contracts under a certain value or for no value, such as Stewarts Law

Commented [RQ49]: Again, I can't amend the document, but this needs formatting as per my last version, as "i" is in the wrong place

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SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	~~Authorise~~ Approve **funded training posts**	Head of Learning and Development	Not within SFIs
	Tenancy agreements and licences ~~Prepare and~~ Approve and execute all tenancy agreements and licences for staff (subject to Trust policy on accommodation) form of tenancy agreements i. signature of individual tenancy agreements ii. extensions to existing agreements	i. Chief Finance Officer or an individual nominated by the Chief Finance Officer ii. Residences Manager ~~iii. Residences Manager~~	SFI 7.4 SFI 9.5
	Approve letting of premises to/from third parties ~~or letting premises from third parties~~ (including leases and licences) i. execute documentation where not a Deed ~~i.~~ii. executive documentations ~~s~~ where a Deed but the Trust Seal is not required ~~ii.~~iii. execute documentation where the Trust Seal is required	i. Chief Finance Officer ii. ~~As per SFI 8e~~As per SO 42.3 ~~ii.~~iii. As per SO 30.2	SFI 7.4
	Approve rent based on professional assessment	Chief Finance Officer or individual nominated ~~deputy~~by the Chief Finance Officer	SFI 7.4
	Legal Services i. authority to engage with legal advisors ii. maintenance of framework arrangements with approved legal advisors iii. approval of call ~~-~~off of services	i. Chief Executive ii. Trust Secretary iii. Trust Secretary (delegated to Commercial and Legal Services Manager)	SFI 8

Commented [RQ51]: Should this be "approve" as well? WHat is the approval process otherwise?

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4. Approval of Business cases

Before any case can progress through the approval processes detailed below, divisional and corporate support is needed for both capital and revenue cases as follows:

. **Divisional**	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): o To ensure trust-wide impacts have been understood within the case o To maintain consistent quality standard for cases going through for approval o ~~Appendix A outlines the process for cases of value below £100k~~ • Provide an approval recommendation to ~~TMT~~ 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

Commented [XB52]: What is "Appendix A"

Approval Process - Business Cases

Full life cost of ~~-~~new expenditure - Revenue, Capital or Combined (for recurring revenue commitments - annual costs)	<£1m	≥£1m, <£2.5m	≥£2.5m, <£15m	≥£15m
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)			
Chief Finance Officer ~~(or nominated deputy)~~	Approval	Approval	Approval	Approval
Chief Executive		Approval	Approval	Approval
Finance & Performance Committee			Approval	Approval
Trust Board			Approval	Approval
NHS England~~l~~				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, <£~~500k~~ 2.5m**	**≥£~~500k~~2.5m, <£15m**	**≥ £15m**
Business Case type required	**CFO business case**	**Single-stage Business Case**	**OBC and FBC**	**SOC, OBC and FBC**

Key
CFO – Chief Finance Officer

SOC – Strategic Outline Case
OBC – Outline Business Case
FBC – Full Business Case

Order of Approvals

Approvals are sequential and all steps in the process need to be followed in order i.e., for a revenue scheme of £1m+ the order of approvals are:

5. Approvals to Award from Tenders and Qquotations (revenue and capital)

Definitions	
Non-Contracted spend	Spend that cannot be demonstrated as assigned to a valid contract Spend that should the proposed action not be completed will become unsupported by a contract (ie. spend approaching contract expiry date or contract extension date)
Compliant Procurement Process:	A procurement activity that complies with PCR (Public Contracts Regulations)
Recommendation Report:	Report created by BWPC seeking approval of the outcome of a compliant procurement process, prior to contract award or extension Value contained within recommendation report identifies the initial contract term, plus extensions. However, initial approve is ONLY for contract term, secondary recommendation report required to extend contract
Exception Report:	Report created by BWPC, seeking directional guidance on a procurement process where a non-compliant outcome is preferred by the Trust, prior to contract award or extension
STA:	A document used to seek approval, with justification, for award of contract or out-of-scope extension without documented proof of value of money via direct comparison

BWPC remit	As custodians of the Procurement Process, BWPC are tasked with two aspects of validation: 1. Adherence to Trust SFI's; in simplified terms a requirement to ensure due process has been performed that will prove value for money 2. Adherence to The Public Contracts Regulations 2015 and other relevant legislation The intention of BWPC is to offer insight into the compliance of both aspects of validation for all relevant procurement activities As the element of risk concerning exceptions to Trust SFI's &/or PCR/OJEU non-compliance resides with the individual Trust/s, BWPC remit remains one of guidance and not decision maker.

Commented [XB53]: David Druett needs to review and update as appropriate.
Query under recommendation report whether we do actually require a separate recommendation report for any extension?

Commented [DD54R53]: the extension is a useful reminder / check in to confirm we remain happy with the agreement. so a simple/ short form rec report does provide the governance to support that.

Management of non-Contracted Spend			
	Description	Consortium	
1. Up to £5,000	*No requirement to evidence value for money*	5,000	Budget manager
2. £5,000 to £25,000	*Trusts responsible for quotation provision, BWPC operate a validation activity*	25,000	Divisional Operations Director or Executive Director or nominated Deputy
Written Quote Requirement	*The number of quotes required prior to a Purchase Order being progressed*	3	

For values between ~~SFI threshold~~£5k and £25k (the "Medium value process")

Procedure ~~(between SFI threshold & £25K)~~	**~~Procedure~~ Outcome Detail**	**~~BWPC~~ ConsortiumGovernance mechanism**
Quotation Process	*3 or more valid quotes provided*	PO ~~P~~progressed
Quotation Process	*Fewer than ~~2 or less~~3 valid quotes*	STA and PO progressed
~~Call off against existing agreement~~Framework Agreement (Internal, External)	*Compliant direct award*	PO progressed
~~**3. Above £25,000**~~	~~Outcome Detail~~	~~BWPC Consortium~~
-	-	-
~~Tender Process (Local, OJEU, Quote)~~	~~*3 or more competitively priced bids received*~~	~~Recommendation Report~~

Commented [DD55]: Formatting is odd – and is embedded as a picture. Need to review text to ensure that spend that is capable of being placed within an existing agreement is directed that way first. Also – UHBW lower threshold is £10k (which I understand NBTs was until it was changed to bring it into line with UHBW)

Commented [XB56R55]: David – what do we need to do to finalise this table? Are you recommending it be increase to 10k?

Commented [RQ57]: What s this threshold? Is it £5k?

Commented [DD58R57]: Yes – but (as above) I am not sure where/ how this is set.

Commented [DD59]: This links back to procurement policy

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Commented [DD60]: Project overruns

Commented [RQ62]: Waht if it is not compliant or there is no tender proces?

Commented [DD63R62]: That flips into the quotation process above

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Commented [DD61]: This might not be a Framework call off – it could be placed against a catalogue or a call off against a contract.

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~~Tender Process (Local, OJEU, Quote)~~	~~*Less than 3 competitively priced bids received*~~	~~Recommendation report~~
~~Tender Process (Local, OJEU, Quote)~~	~~*Contract not awarded to process winner*~~	~~Exception Report, followed by STA if exception awarded~~
~~Framework Agreement (External, Internal)~~	~~*Mini-Competition - 3 or more competitively priced bids received*~~	~~Recommendation Report~~
~~Framework Agreement (External, Internal)~~	~~*Mini-Competition – Less than 3 competitively priced bids received*~~	~~Recommendation report,~~
~~Framework Agreement (External, Internal)~~	~~*Compliant direct award (without proof/evaluation of competition)*~~	~~Recommendation report,~~
~~Framework Agreement (External, Internal)~~	~~*Non-compliant direct award*~~	~~Exception Report, followed by STA if exception awarded~~
~~VEAT Notice~~	~~*VEAT Notice*~~	~~Recommendation report, followed by STA if approved~~
~~Contract Modification~~	~~*Contract Extension (In scope)*~~	~~Recommendation Report~~
~~Contract Modification~~	~~*Contract Extension (Out of scope)*~~	~~Exception Report,~~
~~Contract Modification~~	~~*Contract Variation (In scope)*~~	~~Recommendation Report~~
~~Contract Modification~~	~~*Contract Variation (Out of scope)*~~	~~Exception Report,~~

Commented [DD64]: I have deleted these from the table below – as it is covered under "Tender process"

~~Non-contracted to contracted spend~~	~~*Non-PO to PO (first 12 months/specified period)*~~	~~Single Tender Action, with commitment to run procurement within 12 months~~
~~Non-compliant direct award~~	~~-~~	~~Single Tender Action~~

For values between £25k and £100k (the "High value process")

Procedure	**Outcome Detail**	**Governance mechanism**
Tender Process (Local Quote, Framework ~~mini-competition~~, Tender, Find a Tender Service (FTS))	*2 or more competitively priced bids received, provided that a minimum of ~~three~~ 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 ~~three~~ 3 quotes or tenders were requested~~.~~*	Recommendation ~~r~~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 ~~r~~Recommendation ~~r~~Report~~.~~
Framework Agreement (External, Internal)	*Non-compliant direct award*	Exception ~~r~~Report, followed by STA if exception awarded

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Commented [RQ65]: Can we use consistent terminology where things are the same

Commented [DD66R65]: Sorry - my bad!

Commented [RQ67]: What does FTS stand for?

Commented [DD68R67]: Find a Tender Service (it is the new OJEU)

Commented [DD69]: Technically a competitive process has been followed – irrespective of the number of bids returned.

Commented [DD70]: I think we should seek to include STA's into recommendation reports in this instance.

Compliant call off from approved Framework/ Call off agreement	*None required*	PO Progressed
~~VEAT Notice~~	~~*VEAT Notice*~~	~~Recommendation report, followed by STA if approved~~
Contract Modification	*Contract Variation / Extension (In scope)*	Short form ~~r~~Recommendation Report
Contract Modification	*Contract Variation / Extension (Out of scope)*	Exception Report~~.~~
~~Contract Modification~~	~~*Contract Variation (In scope)*~~	~~Short form recommendation Report~~
~~Contract Modification~~	~~*Contract Variation (Out of scope)*~~	~~Exception Report.~~
~~Non-cContracted to cContracted sSpend~~	~~*Non-PO to PO (first 12 months/specified period)*~~	~~Single Tender Action, with commitment to run procurement within 12 months~~
No Tender Process~~n-compliant direct award~~	*Non-compliant direct award*	~~Recommendation~~ Exception ~~r~~Report incorporating an STA

For values above £100k (the "Very high value process")

Procedure	**Outcome Detail**	**Governance mechanism**
Procurement strategy creation	*Requirement for spend above £100k*	Procurement ~~s~~Strategy Report
Tender Process (Local Quote, Framework ~~mini competition~~Tender, FTS)	*2 or more competitively priced bids received, provided that a minimum of ~~three~~ 3 quotes or tenders were requested.*	~~Full r~~Recommendation ~~r~~Report

Commented [RQ73]: Does this not require a Recommendation Report as well?

Commented [DD74R73]: No because the governance around calling off against the Framework will have been completed in advance – the only approval required is a budgetary one. This links back to 8.7.3&4

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Commented [RQ71]: Is this not the same as a compliant direct award?

Commented [DD72R71]: I think that we the word Internal needs to be removed - In my mind one is about using an external framework that is not pre approved by the trust for use, the other (this one) is the path of least resistance route again – so calling off against an existing agreement.

Commented [RQ75]: But, this has been used as effectively a "route to market" - e.g. LIMS extension

Commented [DD76R75]: I don't think so, it is not the VEAT that drives the governance process, it is the direct award. VEAT it is just a mechanism for testing compliance to a process with the market. In the eyes of the SFIs LIMS was ...

Commented [RQ77R75]: Agreed on reflection, but I coul ...

Commented [DD78]: This seems to be superfluous – the ...

Commented [RQ79R78]: As below

Commented [DD80]: This is covered below.

Commented [DD81]: I think we should seek to include ...

Commented [RQ82]: These tables are so similar that I ...

Commented [DD83R82]: They were originally merged – ...

Commented [RQ84]: Is this the same as the Options ...

Commented [DD85R84]: This is the full on market analy ...

Commented [DD86]: Technically a competitive process l ...

Commented [XB87R86]: Comments as above – why are ...

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Tender Process (Local Quote, Framework Tender, FTS)	*2 or fewer competitively priced bids received, where fewer than ~~three~~ 3quotes or tenders were requested~~.~~*	~~Full~~ rRecommendation ~~r~~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 ~~r~~Report,
Framework Agreement (External, Internal)	*Non-compliant direct award*	Exception report, followed by STA if exception awarded
~~Framework Agreement (External, Internal)~~	~~*Compliant call off from approved Framework/ Call off agreement*~~	~~None required~~
Contract Modification	*Contract Variation / Extension (In scope)*	~~Full~~ Recommendation Report
Contract Modification	*Contract Variation / Extension (Out of scope)*	Exception Report~~.~~
~~Contract Modification~~	~~*Contract Variation (In scope)*~~	~~Full Recommendation Report~~
~~Contract Modification~~	~~*Contract Variation (Out of scope)*~~	~~Exception Report,~~
~~Non-cContracted to cContracted sSpend~~	~~*Non-PO to PO (first 12 months/specified period)*~~	~~Single Tender Action, with commitment to run procurement within 12 months~~
No Tender Process~~n-compliant direct award~~	*Non-compliant direct award*	~~Recommendation~~ Exception ~~r~~Report incorporating an STA

Commented [DD88]: I think we should seek to include STA's into recommendation reports in this instance.

Commented [XB89R88]: As above

Commented [DD90]: This is covered below.

Commented [DD91]: I think we should seek to include STA's into recommendation reports in this instance.

STA & Exception ~~r~~Report ~~-~~ Authorisation ~~Financial~~ Values

Up to £25k
Director of Procurement

£25k to £500k
Chief Finance Officer

£500k-£1m
Chief Executive

£1m+
Trust Board

Recommendation Report – Authorisation Levels

Up to £100k
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant ~~Corporate~~ Executive Director

£100k to £1m
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant ~~Corporate~~ Executive Director **and**
Chief Finance Officer

>£1m ~~+~~ – £2.5m

Commented [XB92]: To discuss with David & Glyn:

Suggesting that for non-compliant procurement, we are seeking Trust Board oversight for anything over £1m

Whereas for compliant procurement, we have aligned recommendation report sign-off with business case sign-off levels.

Commented [RQ93]: Should this be CFO as well?

Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant ~~Corporate~~ Executive Director **and**
Chief Finance Officer **and**
~~Trust Board~~Chief Executive

>£2.5m
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant ~~Corporate~~ Executive Director **and**
Chief Finance Officer **and**
Chief Executive **and**
Trust Board

6. Contract Signature

~~The following applies for contract signatures (a~~After all relevant approvals have been ~~given~~obtained, contract signatures shall be as per Table 3 above ("Contract Income and Expenditure").~~:~~

- ~~**Up To EU threshold – Divisional Operations Director or relevant Corporate Director**~~
- ~~**EU threshold to £2m – Chief Finance Officer**~~
- ~~**Over £2m - Chief Executive**~~

Commented [DD94]: Should we seek to add in a section on Insurances and indemnities (minimum values) here?

Commented [RQ95R94]: As discussed, this would not be appropriate for the SFIs, at least not at this stage

Commented [DD96]: Once all of the approvals have been given it is unusual for all but very large contracts and deeds to be signed by the exec – normally this is picked up by DoP.

Commented [XB97R96]: We have lost that nuance by deleting the table in this section (which allowed Corporate Directors, which would including DoP, to sign up to the EU threshold). Do we need to incorporate this into Table 3 above?

7. Contract Management

Other tendering and contractual arrangements

	Delegated matter	Authority delegated to	Delegation ref.
	Approve insurance policies i. Schemes administered by the NHSR ii. Other insurance arrangements	i. Chief Finance Officer or nominated deputy~~.~~ ii. Chief Finance Officer or nominated deputy~~.~~	SFI 12.1 SFI 12.4
	Affix Trust Seal to ~~contract~~ 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~~: Including property documentation and contractual arrangements where there is no consideration~~	Chair of the Trust and Chief Executive~~, or in their absence, the designated acting Chair or Chief Executive~~	SO 30
	Executive documentation as a Deed Including Agreements, Leases~~,~~ and Licences, provided there is no legal requirement for a physical seal (as above)	As per Table 3 above ("Contracted Income and Expenditure"), in the physical presence of an attesting witness for each signature	SO 42.3

Non-pay requisitions, orders, and payment authorisation

Financial thresholds in this section mirror the procurement limits and as such exclude VAT and/or delivery charges. Where there is an order/contract for more than one financial year, the total cost must be included not just the 12 months element.

	Delegated Matter	Authority Delegated to	Delegation Ref.
	Maintain records of officers who are authorised to place requisitions and orders; and the maximum value of orders that they have the authority to place.	Chief Finance Officer	SFI 10.2
	Identify the Trust's approved supply arrangements (controlled procurement systems, framework agreements)	Chief Finance Officer	SFI 10.4

Commented [RQ98]: This is covered by the general right of delegation

Trust-wide ***(excepting elements of delegated authority for specific disciplines specified in the subsequent tables)***

8. Ordering limits (EROS)

Up to £2,500	Authorising manager approved by Divisional Operations Director/Corporate manager
Over £2,500	Vetting manager approved by Divisional Operations Director/Corporate manager

9. Oracle Limits - Invoice processing

a. General Oracle Limits

Up to £25,000	Budget holder/manager designated by Divisional Operations Director or equivalent
£25,000 to £100,000	Divisional operations Director//Corporate Manager
£100,000 to £1m Grouped NHS Supply Chain invoice up to £500K	Executive Director Director of Procurement
Over £1m	Chief Finance Officer/Chief Executive

b. Subsidiary Systems

Subsidiary Systems where grouped requisitions are used:

	Pharmacy	**Capital Estates**
Grouped requisitions up to £500k per week	Director of Pharmacy or nominated deputy	Capital estates Mailbox
Grouped requisitions over £500k per week	Director of Pharmacy	Chief Finance Officer or nominated Deputy

c. In addition to the general oracle limits, additional limits are in place within the finance department which are used to process high value pre-approved invoices e.g Unitary Payment, loan repayments etc.

Up to £1m	Head of Financial Control
£1m-£10m	Assistant Chief Finance Officer (Financial Services) or Assistant Chief Finance Officer (Planning & Income) (or nominated deputies in their absence)
Over £10m	Director of Operational Services or Chief Finance Officer

10. Workforce and payroll

Appointment of Senior Medical Staff and team (investment may include capital elements)

		Replacement posts	New posts / clinical teams[1]	
		Within existing budget	Up to £500k	Over £500k
	Approval / Sign-Off[2] by:			
	~~Trust Management~~Executive Team		Agree project mandate and priority	
	Finance Business Partner	Sign	Sign	Sign
	HR advisor	Sign	Sign	Sign
	Divisional Operations Director or equivalent corporate manager	Sign	Sign	Sign
	Clinical Director	Sign	Sign	Sign
	Chief Operating Officer	-	Sign	Sign
	Chief Finance Officer	-	Sign	Sign
	Consultant Post Panel	**Approve**	**Approve**	Recommend
	~~Finance & Performance Committee~~			~~OBC & FBC in accordance with Business Case approval limits~~
	~~Trust Board~~			~~Approve FBC~~

Approval of new posts/clinical teams must follow the business case approval processes outlined in this SoDA

[1] New clinical teams to deliver new services. Approach follows the same sign-off steps as for new service developments

[2] Signature indicates sufficient understanding and confidence in the details of the business case to confirm responsibility for support for the proposal

Commented [XB99]: Should this be aligned to business case approval limits? Check with Glyn / Elizabeth

Commented [XB100]: Does this still exist? Tim Whittlestone to advise

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		Existing establishment	New posts / Outside of establishment	
	Approval / Sign-Off by:	**Within existing budget**	**With specifically allocated funding**	**Without specifically allocated funding**
	Fill funded post on establishment with permanent staff (subject to any vacancy review policy in place)	General / Corporate Manager **or** nominated deputy **and** finance Business Partner **and** HR advisor[1]	-	-
	Appoint staff to post not on formal establishment	-	General / Corporate Manager **or** nominated deputy **and** finance Business Partner **and** HR advisor[1]	General / Corporate Manager **or** nominated deputy **and** finance Business Partner **and** HR advisor[1]
	(Re)new fixed term contracts	General / Corporate Manager	General / Corporate Manager	General / Corporate Manager
	Engage non-medical, non-payroll consultancy staff (subject to contracting rules):			
	- Below **£100k** gross commitment	-	General / Corporate Manager or Executive Director	
	- **£100k** to **£500k** gross commitment	-	Chief Finance Officer	
	- over **£500k** gross commitment	-	Chief Executive	

This version of the Standing Orders can only be guaranteed to be the current adopted version, if it is opened directly from the Trust's intranet library of policies and procedures.

	- over 6 months length of contract	-	Chief Executive

[1]Need to ensure fit with workforce plans

Bank, agency and locum staff	Within establishment		Extra to establishment	
	Within budget	Without budget	Within budget	Without budget
~~SoDA reference~~	~~11g~~		~~11h~~	
Nursing	(Deputy) Budget Manager	Chief Nursing Officer or Chief Medical Officer ~~Director of Nursing or Medical Director~~ and Chief Finance Officer **or** Chief Executive	Budget Manager	Chief Nursing Officer or Chief Medical Officer ~~Director of Nursing or Medical Director~~ and Chief Finance Officer **or** Chief Executive
Clerical support services	(Deputy) Budget Manager		Budget Manager	
Medical	(Assistant) General / Corporate Manager		Divisional Operations Director/ / Corporate Manager	
Through non-framework agency	As above, plus Executive Director approval		As above, plus Executive Director approval	

Approvals relating to staff on the payroll

General approvals	Approval / sign off

This version of the Standing Orders can only be guaranteed to be the current adopted version, if it is opened directly from the Trust's intranet library of policies and procedures.

	Grant additional increments to staff (outside of Department of Health national T&C)	Director of People & Transformation **and** Chief Finance Officer
	Authorise (electronic and paper) timesheets and other positive reporting forms which will affect the amount of salary to be paid to confirm: attendance at work; sickness and absence records; overtime and unsocial hours	Line Manager **or** Authorised Signatories
	Authorise travel and subsistence claims (only available through e-expenses)	Line Manager
	Approve departure under compromise agreement (excluding mutually agreed resignation scheme (MARS) arrangements) i. directors and very senior managers ii. other staff	i. Remuneration and Nominations Committee and Chief Finance Officer ii. ~~Director of People & Transformation~~Chief People Officer and Chief Finance Officer
	Approve redundancy (and mutually agreed resignation schemes, or similar arrangements) **i.** payment up to **£100k** **ii.** payment over **£100k**	i. ~~Director of People and Transformation~~Chief People Officer and Chief Finance Officer ii. Remuneration and Nominations Committee and Chief Finance Officer

11. Approval for variations to capital plan

Change to Total Annual Capital Expenditure Plan	Delegated Authority
Up to **£500k**	Capital Planning Group
£500k to **£1m**	Finance & Performance Committee
Over £1m	Trust Board

Funding capital investments through Private Finance Initiative

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Assess comparative merit of progressing scheme through PFI	Finance and Performance Committee, advised by Chief Finance Officer	SFI 13.10
	Authorise payment of the sums identified in the schedule of the unitary payment (being the annual service payment defined in Schedule 18 of the Project Agreement) to be made to the PFI partner over the lifetime of the scheme (project term). Authorise annual Retail Price Index (all items) adjustment, in accordance with the PFI Project Agreement.	Trust Board	SFI 13.13
	Oversee delivery of the PFI contract terms, ensuring appropriate delivery and monitoring of the PFI contract; and including agreement of fee adjustments resulting from facilities management service and performance issues, to verify the invoice total.	Chief Finance Officer or an individual nominated by the Chief Finance Officer	SFI 13.14 SFI 13.15
	Approve decision to withhold, or delay payment of all or part of an invoice submitted by the PFI partner, at risk of incurring penalties and late payment charges	Chief Finance Officer	SFI 13.16
	Process payment of monthly account to the PFI partner, in accordance with the Trust Board authorisation.	Assistant Chief Finance Officer (Financial Services), or nominated deputy	SFI 13.17

Fixed assets records and accounting for fixed assets

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Maintain register of (fixed) assets Including verification of additions and disposals, revaluations, calculation of annual capital charges	Chief Finance Officer	13.~~19~~ 21 to 13.2~~7~~2

12. Bank and cash and investments

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Day to day operation of bank accounts i. maintain list of approved signatories ii. approval to pay	i. Shared Business Services (SBS), under terms of contract with the Trust ii. SBS following confirmation of availability of cash required by Head of Financial Control	SFI 14.5
	Determine when to subject commercial bank service supplier to competitive tendering	Chief Finance Officer	SFI 14.8
	Establish, or close a petty cash facility	Chief Finance Officer (or nominated deputy)	Not within SFIs
	Approve the use of Trust credit cards (in the name of North Bristol NHS Trust only)	Chief Finance Officer (or nominated deputy)	SFI 14.10
	Investment of funds i. surplus exchequer funds ii. charitable fund cash balances	i. Chief Finance Officer ii. Investment advisors appointed by the Charity Committee	SFI 15

13. External borrowing and Public Dividend Capital

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Short-term borrowing (temporary borrowing limit)	Trust Board	SFI 18.2 SFI 18.3
	Borrowing, including commercial loans	Trust Board	SFI 18.4
	Borrowing of Public Dividend Capital	Trust Board	SFI 18.1 SFI 18.4

14. Disposals, write-offs losses and special payments

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Terminate lease and rental arrangements early at cost to the Trust	Chief Finance Officer	SFI 7.4, 13.2~~81~~
	Condemn and arrange for disposal of equipment assets Items that are obsolete, redundant, irreparable or cannot be repaired cost effectively i. with a current or estimated purchase price up to £1,000 ii. with a current purchase price of £1,000 - £5,000 iii. with a current purchase price over £5,000.	i. Budget manager ii. General / Corporate Manager iii. Executive Director	SFI 13.~~26~~28
	Dispose of x-ray films	Radiology Departmental Manager\Clinical Director	SFI 13.2~~96~~

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Disposal of mechanical engineering plant. With replacement value estimated at: i. up to £10,000 ii. £10,000 to £100,000 iii. over £100,000	i. Head of Estate Maintenance ii. Director of Operational Estates & Facilities iii. Chief Finance Officer	SFI 13.2~~86~~
	Approve sale, or transfer (eg donation) of equipment assets to another organisation for continued use i. clinical equipment ii. IT equipment iii. other equipment	i. ~~Medical Director~~Chief Medical Officer ii. Chief Finance Officer iii. Chief Finance Officer **and** relevant Executive Director	SFI 13.2~~86~~
	Approve losses, write-offs and compensation payments due to / made under: • theft, fraud, overpayment of salaries and overpayment of third parties; • fruitless payments, including abandoned capital schemes; • bad debts and claims abandoned, including in respect of Private Patients, Overseas Visitors and other third parties; • damage to buildings, fittings, furniture, equipment and property in stores and in use due to culpable cause (e.g. fraud, theft, arson); • additional payments made to third parties in connection with or arising out of contractual liabilities, including sums payable under agreed settlements and court judgments; • personal injury claims involving negligence (legal advice must be obtained and guidance applied); • ex-gratia payments patients and staff for loss of personal	i. Assistant Chief Finance Officer (Financial Services) or nominated deputy in their absence ii. Chief Finance Officer or deputy iii. Audit & Risk Committee	SFI 19 Schedule of reservations 3

	effects; i. up to £1,000 ii. £1,000 up to £50,000 iii. Over £50,000 *All to be reported to the Audit & Risk Committee.*		
SoDA	**Delegated matter**	**Authority delegated to**	**Delegation ref.**
	Report incidents to the Police i. general ii. where a fraud is involved	i. departmental manager (inform General / Corporate Manager or Director as soon as possible. Also inform Local Security Management Specialist) ii. Chief Finance Officer or Local Counter Fraud Specialist	SFI 19 *Counter Fraud and Bribery Policy*

15. Patients' property

Delegated authority	Holding	Receive and safeguard valuables	Discharge patients' valuables
Valuable items	Ward safe	Any member of nursing staff	Any member of nursing staff
Cash under **£5k**	Ward safe	Ward Manager	Ward Manager

16. Access to charitable funds

Delegated authority	Approve expenditure from charitable funds
Up to £1,000	One fund signatory
£1,000 to £10,000	Two fund signatories
Delegated authority	**Approve expenditure from charitable funds**
£10,000 to £50,000	Two fund signatories plus the Chief Finance Officer (or nominated deputy)
Over £50,000	Two Fund signatories and the Charity Committee.

Spending plans will be submitted to the Charity Committee for approval in March each year. Approval is delegated to approve additional spending plans that arise during the year as follows:

Delegated authority	Approve expenditure from charitable funds
Up to £10,000	Assistant Chief Finance Officer (Financial Services) or nominated deputy in their absence
£10,000 to £50,000	Chief Finance Officer (or nominated deputy)
Over £50,000	Charity Committee.

17. Glossary of terms and acronyms

BC	**Business case**
CEO	**Chief Executive Officer**
Director	Non-Executive or Executive Director, with or without voting rights at Trust Board. The term excludes Clinical Directors, who are identified separately
CFO	**Chief Finance Officer**
FBC	**Full Business Case**
Divisional Operations Director /Corporate Manager	The senior operational manager(s); and their formally nominated deputy, for the division or specialty, as designated by the Executive Director.
OBC	**Outline Business Case**
PMO	**Programme Management Office**
SBS	**Shared Business Services.** The Trust's provider of accounts transactions and ledger process
SFI	**Standing Financial Instruction.** Reference to the detail in the full SFIs
SOC	**Strategic Outline Case**
SoDA	**Scheme of Delegated Authorities**. Reference to the detail in the full SoDA

Board Assurance Framework (BAF)

NHS North Bristol NHS Trust

Introduction

The following document is the Trust's Board Assurance Framework (BAF) for 2021/22. The Board Assurance Framework defines and assesses the principle strategic risks to the Trust's objectives. It provides the Trust Board with assurance that those risks are being proactively managed and mitigated.

The BAF is designed to provide the Trust Board with a simple but comprehensive method for the effective and focussed management of principal risks to its strategic and business objectives. The Board defines the principal risks and ensures that each is assigned to a lead director as well as to a lead committee:

- The lead director is responsible for assessing any principal risks assigned to them by the Board and for providing assurance as to the effectiveness of primary risk controls to the lead committee;
- The role of the lead committee is to review the lead director's assessment of their principal risks, consider the range of assurances received as to the effectiveness of primary risk controls, and to recommend to the lead director any changes to the BAF to ensure that it continues to reflect the extent of risk exposure at that time;
- The Audit & Risk Committee is responsible for providing assurance to the Trust Board that the BAF continues to be an effective component of the Trust's control and assurance environment;
- The Trust Board reviews the whole BAF on a quarterly basis to ensure that the principal risks are appropriately rated and are being effectively managed; and to consider the inclusion within the BAF of additional risks that are of strategic significance.

BAF Risks should be kept under review regularly, with a formal review and update mandated ahead of each meeting of the Audit & Risk Committee (reviews in April, July, October and January)

A guide to the criteria used to grade all risks within the Trust is provided in Appendix A.

Trust Strategic & Business Plan Objectives:

Strategic Theme: (2022/23)	Aligned BAF Risk:
1. Provider of high quality patient care	SIR1 SIR1.1 COV2 SIR8 SIR15 SIR17
2. Developing Healthcare for the future	COV2 SIR17

RESPONSIBLE COMMITTEES/BOARDS:

Finance & Performance Committee
- SIR1 (with QC)
- SIR1.1 (with QC)
- SIR8
- COV2 (with QC)
- SIR16
- SIR15
- SIR 17

People Committee
- SIR2

Quality Committee
- SIR1 (with F&PC)
- SIR1.1 (with QC)
- COV2 (with F&PC)

Board Assurance Framework (BAF)

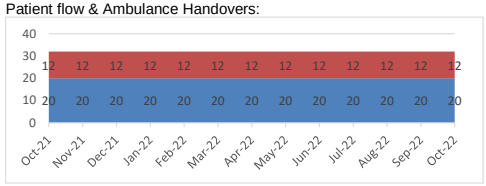
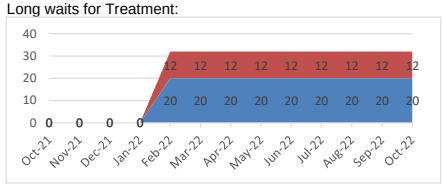
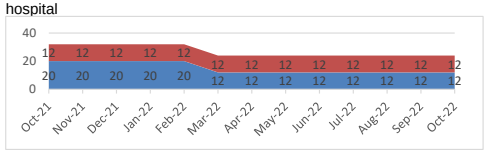
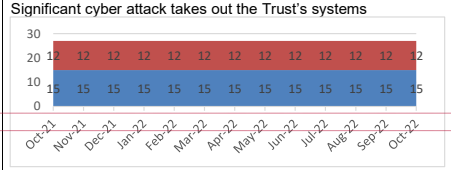
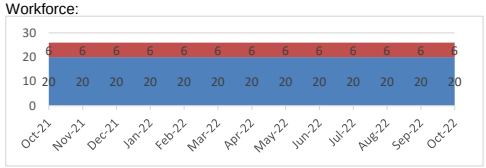
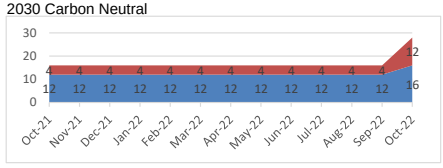
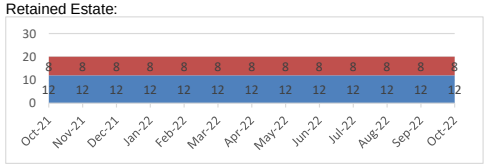
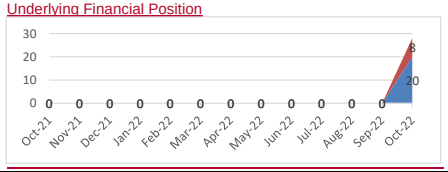
4. An anchor in our community	COV2 SIR8 SIR16 SIR17

Version Control (2022/23):

Version:	Summary of changes:	Reported to:
V1	Full BAF update for 2022/23 – taking into account Audit findings from 2021/22	FPC July 2022 Audit Committee August 2022 Trust Board August 2022
V2	Updates for Quality Committee meeting September 2022	Quality Committee September 2022 Finance & Performance Committee Sept 2022
V3	Updates for People Committee meeting October 2022 Updates for Audit & Risk Committee November 2022 (including proposal of new finance risk)	People Committee October 2022

Board Assurance Framework (BAF)

Summary of Risks

Risk	Current Residual Risk	Risk Summary and Trend	Forecast Trajectory (next 12 months)	Risk	Current Residual Risk	Risk Summary and Trend	Forecast Trajectory (next 12 months)
SIR1	20	Patient flow & Ambulance Handovers: 	⇔	SIR 1.1	20	Long waits for Treatment: 	⇔
COV2	12	Covid-19 pandemic /infectious disease has potential to overwhelm hospital 	↑ Likely to increase over winter period	SIR15	15	Significant cyber attack takes out the Trust's systems 	⇔
SIR2	20	Workforce: 	↑	SIR16	12	2030 Carbon Neutral 	⇔
SIR8	12	Retained Estate: 	⇔	SIR17	20	Underlying Financial Position 	↑

Assurances set out for each risk in the Board Assurance Framework are categorised in line with the 'three lines of defence' model of risk management:

Key:

(1) **First line - Functions that own and manage risks**
(2) **Second line - Functions that oversee risks**
(3) **Third line - Functions that provide independent assurance**

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Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high-quality patient care		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 1	**Steve Curry, Chief Operating Officer** Last reviewed: 11/10/2022 Lead Committee: **Finance & Performance Committee** Also monitored by: **Quality Committee** Last reviewed: QC 13/09/2022 FPC 22/09/2022 Risk added to BAF: **Pre-2019**	**Patient flow & Ambulance Handovers:** Due to a combination of factors, primarily high number of patients with no criteria to reside, but also including constrained community and primary care capacity and workforce pressures, the flow of patients across the hospital is constrained. This results in delays to key targets within the Emergency Zone, including the timely treatment of patients and delayed ambulance handovers. In turn this has the potential to result in patient harm, poor patient experience, and reputational damage to the Trust. Note: Elements of this risk are outside of the Trust's direct control – actions are focused on those areas that are within the organisation's influence. EXTERNALLY AND INTERNALLY DRIVEN RISK	Inherent likelihood: **5** **(Almost certain)** Inherent impact: **5** **(Catastrophic)** Inherent risk rating: **25** **(Extreme)**	**Internal:** FLOW boards (real-time bed state) Criteria to Reside data Integrated Discharge Service Repatriation Policy UEC Board and Improvement Plan OPEL/ICI Escalation & COVID-19 surge policies/procedures Accountability Framework Divisional Review assessment of and support to Divisions. Internal Professional Standards **External:** COVID-19 Command & Control (External) Whole System Operational Group (WSOG – external) OPEL escalation process in system forums (Whole System Operational Group, OOH Delivery Group) Initiation of NHSEI UEC Recovery Model Engagement with National UEC Improvement Team Discharge to Assess Winter pressure funding mechanisms UEC improvement plan New Same Day Emergency Care (SDEC) Model Clinically led dynamic risk assessed approach to pre-emptive transfers out of the emergency department	**Internal Assurance** Board rounds and site management processes (1) Integrated Performance Report (2) Patient flow metrics – daily control centre information (1) Executive Team review of dashboards (2) Performance report to Finance & Performance Committee (2) Finance & Performance Committee deep-dives into operational performance (2) QRMC Deep dives into patient harm (2) Divisional Performance Reviews (2) UEC Board(2) **External Assurance** Urgent & Emergency Care Steering Group (external) (2) System Delivery & Operational Group (external) (2) CQC 2019 inspection – Urgent and Emergency Services rated Good (3)	Residual likelihood: **5** **(Almost Certain)** Residual impact: **4** **(Severe)** Residual risk rating: **20** **(Severe)** Previous residual risk rating: **3x5=15** **4x5=20** **5x4=20** Residual risk rating last changed: **22/10/2020** **09/03/2021** **08/07/2021** Forecast trajectory (next 12 months): ⇔	Not yet seeing evidence that investment in "Discharge 2 Assess" initiative is delivering planned improvements to discharge numbers or reducing proportion of patients with no criteria to reside (led by BNSSG/Sirona). Other actions:	NBT has seconded experienced manager to act as Programme Director for D2A and is working in partnership to support improvements. **Owner: COO** **Due date: review benefits in Q3 2022/23** Trust reviewing opportunities for additional capacity in Brunel Building to provide winter contingency beds (to protect patient flow) **Owner: CFO** **Due date: ~~October~~ December 2022/~~23~~** Working with ICS via the system Chief Executive group and the D2A Board to identify bridging strategies and sort term mitigations to compensate for delayed D2A impact. **Owner: Various (COO & CEO)** **Delivery date: November – March 2022/23** Urgent and Emergency Care Improvement Plan actively overseen and sponsored by Executive Leads. **Owner: COO** **Due date: various actions – review of SDEC delivery in Q4 2022/23**	Target likelihood: **3** **(Possible)** Target impact: **4** **(Severe)** Target risk rating: **12** **(High)**

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Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Developing healthcare for the future		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 1.1	**Steve Curry, Chief Operating Officer** Last reviewed: 11/10/2022 Lead Committee: **Finance & Performance Committee** Also monitored by: **Quality Committee** Last reviewed: QC 13/09/2022 FPC 22/09/2022 Risk added to BAF: **January 2022**	**Long waits for Treatment** **The impact of the Covid-19 pandemic, together with high numbers of patients with no criteria to reside, workforce/skills shortages, and complex clinical pathways, has resulted in a demand/capacity gap in cancer services, diagnostics, and planned care. This has the potential to result in long-waiting patients deteriorating and coming to harm, poor patient experience, and reputational damage to the Trust.** Note: drivers of this risk are outside of the organisation's direct control actions are focused on those areas that are within the organisation's influence. EXTERNALLY DRIVEN RISK	Inherent likelihood: **5 (Almost certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	**Internal:** FLOW boards Integrated Discharge Service Repatriation Policy OPEL/ICI Escalation & COVID-19 surge policies/procedures Accountability Framework Internal Professional Standards Protected Green Capacity Use of WLI Use of independent sector Clinical Long-wait Harm Review Process (no wait related harm identified) Fortnightly Cancer Steering Group Cancer Improvement Plan Diagnostics Plan RTT Recovery Plan Agile and responsive IPC controls **External:** Whole System Operational Group (WSOG – external) OPEL escalation process in system forums (Whole System Operational Group, OOH Delivery Group) Elective Recovery Fund Access (system-wide)	**Internal Assurance** Board rounds and site management processes (1) Integrated Performance Report (2) Patient flow metrics – daily control centre information (1) Executive Team weekly review of dashboards (2) Performance report to Finance & Performance Committee (2) Finance & Performance Committee deep-dives into operational performance (2) QRMC Deep dives into patient harm (2) Divisional Performance Reviews (2) Trust Board presentations on Planned Care Trajectories, Cancer Performance 2022 (2) **External Assurance** System Delivery & Operational Group (external) (2)	Residual likelihood: **5 (Almost Certain)** Residual impact: **4 (Severe)** Residual risk rating: **20** **(High)** Previous residual risk rating: Residual risk rating last changed: Forecast trajectory (next 12 months): ⇔	Not yet seeing evidence that investment in "Discharge 2 Assess" initiative is delivering planned improvements to discharge numbers (led by BNSSG/Sirona), to allow increased surgical activity. Emerging issues that may impact this risk,and which remain under review: - Winter pressures - Covid-19 - Potential nursing and other strikes	Trust reviewing opportunities for additional capacity in Brunel Building to provide winter contingency beds (to protect patient flow) **Owner: CFO** **Due date: October 2022/23** Exploring opportunities for additional Elective Care Capacity in BNSSG via national Targeted Investment Fund (possible Elective Care Centre) **Owner: CFO** **Due Date: Full Business Case November 2022, online 2024** Other actions: RTT Recover Plan Actions overseen at Executive level. Good progress and line-of sight to national improvement targets. (Ongoing – review March 2023) Cancer Improvement Plan reliant on recruitment (to be complete by Q3 2022/23) Diagnostics Plan to be compliant with national improvement trajectories by 31 March 2023 **Owner: COO**	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**

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NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high-quality patient care Developing healthcare for the future Anchor in the community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
COV 2	**Steve Hams,** **Chief Nursing Officer (Director of Infection Prevention Control)** Last reviewed: 13/10/2022 Lead Committee: **Quality Committee** **Also monitored by:** Finance & Performance Committee Last reviewed: QC 13/09/2022 FPC 22/09/2022 Risk added to BAF: **Q1 2020**	**Covid-19 Pandemic** **A further significant surge in Covid-19 or other respiratory infection would have the potential to impact the Trust in key areas including capacity to provide timely, safe and effective care, reduction in staff numbers due to infection, closure of beds as part of Infection Prevention Control, reduced patient flow and inability to achieve key quality and performance standards.** Note: drivers of this risk are outside of the organisation's direct control actions are focused on those areas that are within the organisation's influence. EXTERNALLY DRIVEN RISK	Inherent likelihood: **5** **(Almost certain)** Inherent impact: **5** **(Catastrophic)** Inherent risk rating: **25** **(Extreme)**	**Internal** COVID-19 Command and Control structures (not currently active) Covid-19 Surge and super-surge plans / policies for ICU and general acute capacity, testing and mortuary Increased capacity for remote working Daily Operational Bed Meetings Infection Prevention Control structure and rules Workforce wellbeing support offering 2022/23 Winter Plan and Covid/Flu modelling Covid-19 and Flu Vaccination Programmes **External** Significant engagement in system and regional forums Engagement and leadership role in Severn Critical Care Network System COVID-19 Command and Control structures National Vaccination Programme, including Covid-19 booster programme and Flu vaccination programme Protected Green Capacity	**Internal Assurance** COVID-19 sit-rep [1] NBT specific pandemic modelling [1] COVID-19 exception reports to Trust Board and TMT [2] Integrated Performance Report [2] **External Assurance** Regional and local specific pandemic modelling [3] Reports and updates via local and regional forums [3]	Residual likelihood: **3** **(Possible)** Residual impact: **4** **(Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **4x5=20** Residual risk rating last changed: **14/03/2022** Forecast trajectory (next 12 months): ↑ Risk likely to increase over winter period	This risk is monitored regularly via Executive Assurance Forum and Board Committees but is considered "controlled" at this point in time, with no significant gaps identified. This will remain under review as the Trust approaches the 2022/23 winter period.		Target likelihood: **3** **(Possible)** Target impact: **4** **(Severe)** Target risk rating: **12** **(High)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of High-Quality Care Healthcare for the Future		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 2	**Jacqui Marshall, Director of People & Transformation** Last reviewed: 17/10/2022 **People Committee** Last reviewed: 11/10/2022 Risk added to BAF: **Pre-2019**	**Workforce** **National/system competition for workforce in key specialties/ professions (e.g., sonographers & histopathologists), together with increasing demands on staff plus Covid-19 sickness and fatigue could result in skills/capacity shortages within the Trust and increased instability in the workforce.** **Consequences would include** - **Increased reliance on expensive agency staff** - **Higher turnover, which could result in dramatic increase in recruitment activity and associated costs** - **Poor patient safety & experience due to staff shortages.** Elements of this risk are outside of the Trust's direct control (training of professionally registered medics and other specialists) – actions are focused on those areas that are within the organisation's influence. INTERNALLY & EXTERNALLY DRIVEN RISK	Inherent likelihood: **4** **(Likely)** Inherent impact: **5** **(Catastrophic)** Inherent risk rating: **20** **(Extreme)**	BNSSG Workforce Strategy Nursing Workforce Group overseeing mitigating work Medical Workforce Group overseeing mitigation work Retention steering group & Pathfinder Programme Retention interventions (overseen by Retention steering group) Covid-19 Recovery & Restoration Programme Award-winning, nationally recognised Staff Health & Wellbeing offering Buying & selling annual leave policy Itchy feet campaign Flexible working offer expanded Strong development and leadership offer Increased opportunities through SLM Programme BNSSG workforce recovers cell in place from Feb 2021 BNSSG development of EVP offer BNSSG integrated staff bank Increased use of traineeship and apprenticeships. Shared recruitment material and Employee Value Proposition for system recruitment. System Pay Harmonisation Group 1,2,3 Year System Workforce Planning Programme System-wide recruitment campaigns (e.g., HCA in May 2022) System Workforce Incentives Group	**Internal Assurance** Integrated Performance Report – HR/Well-Led section [2] People Committee deep-dives and performance review [2] People Balanced Scorecard [1] Staff survey results & action plans [2] Voice Programme [1] Exit interview data [1] Pulse Surveys [1] Freedom to Speak Up Report [2] Recruitment & retention deep-dive – March 2021 People Committee meeting [2] System-level workforce cell monitors and shares terms and conditions data and any operational WLI proposals to ensure transparency and parity. [2] **External Assurance** Gender pay-gap report (2018) [3] National Retention Data [3] Staff Survey Results [3]	Residual likelihood: **5** **(Almost certain)** Residual impact: **4** **(Severe)** Residual risk rating: **20** **(Extreme)** Previous residual risk rating: **4x4=16** **3x4=12** **5x4=20** Residual risk rating last changed: **12/08/2020** **05/10/2021** Forecast trajectory (next 12 months): ↑	There is potential competition between providers within the BNSSG ICS for the same staff, and there are identified differentials in grading between similar roles. There are insufficient trained staff in certain professions (including nursing, sonographers, histopathologists etc.) to meet ongoing and increasing needs.	System-level Workforce Plan (1, 3,5 year) is under development via the system workforce cell. Next step: Join system Bank to be complete by March 2022 **Due date:** ~~draft 1 April 2022, then due dates as per long-term plan~~March 2022 **Owner:** Chief People Officer (CPO) Aspiring joint future skill plan with Universities in Bristol to support specific skills pipeline and avoid competition. **Due date:** from 2023/24 **Owner:** CPO International recruitment pipeline – ongoing for 2022/23. **Due date: review Q4 2022/23** **Owner: CPO** Financial wellbeing offering being developed and rolled out, including pension recycling, free advice, salary sacrifice, loans etc. **Delivery date:** key benefits from November 2022 onwards Revised Management Development Offering from January 2023. **Owner:** CPO	Target likelihood: **3** **(Possible)** Target impact: **4** **(Severe)** Target risk rating: **12** **(High)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care An anchor in our local community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 8	**Glyn Howells, Chief Finance Officer** Last reviewed: 18/10/2022 **Finance & Performance Committee** Last reviewed: 22/09/2022 Risk added to BAF: **Pre-2019**	**Retained Estate** **Parts of the retained estates are aging and approaching the point where significant refurbishment is required. Without decant facilities or alternative provision this work cannot be undertaken in a proactive manner, exposing the Trust to the risk of unplanned service failure, and associated degradation of patient safety, operational performance, and patient/staff experience.** Note: The Trust has control over its internal capital spend. This risk is considered a controllable risk. INTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	Capital Planning Group & sub-structure 10-year Estates Capital Plan (CRISP) Estates Strategy/Masterplan approved 2020 Health & Safety Committee & policies Preventative Maintenance Programme Facilities help-desk (to advise on any deterioration of estate) Executive walk-arounds Expected capital programme slippage used as a contingency for unexpected works in the retained estate	**Internal Assurance** Capital Planning reports to Finance & Performance Committee (twice-yearly) (2) Health & Safety reports to People Committee (quarterly + annual report) (2) Compliance Governance committees; COIC, Water Safety Group, Ventilation Safety Group, Electrical Safety Group, Fire Safety Group(2) ERIC Benchmarking confirms relative position to other Trusts backlog status (annual process) (2) Fire risk audits undertaken regularly across the site (1) Estates Master Plan (August 2020) (1) **External Assurance** Six Facet Survey completed 2020 (3)	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): ⇔	Weaknesses in the Trust's Fire Safety governance has been identified, including training, policies and audits. This is reflected on the Trust's operational risk register.	A report identifying required improvements was commissioned in 2022, with an improvement plan in place. Additional capacity expected to arrive in ~~August~~ November 2022, with an update to People Committee in ~~November~~ January 2023~~2~~. **Owner: Chief Finance Officer** **Due Date: January ~~November~~ 2022~~3~~**	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**
							The Trust continues to ensure that there is regular capital investment in Critical Infrastructure towards compliant and appropriate clinical accommodation. However, this is limited by all other Trust-wide requirements therefore some programmes will be delivered over extended periods. It is assumed that major estates improvements will be specifically externally funded. There is a growing concern that due to the nature of the improvement works that are needed in the retained estate that there will be a need to decant buildings to facilitate this work namely, Elgar House, NICU, Cossham, CDS and Gynae Theatres. These works are mainly related to fire improvement works and ventilation improvement works.	The Trust Estates/Capital Team are progressing various significant schemes to "shovel ready" state, in anticipation of national funding calls becoming available. Elective Care Centre, W&C Estates and Accommodation Projects are specifically being progressed in this manner. **Owner: Chief Finance Officer** **Due Date:** TIF funded OBC for Elective Centre to Trust Board in July/August 2022 **October update:** OBC approved, FBC due to Trust Board January 2023.	

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Board Assurance Framework (BAF)

NHS North Bristol NHS Trust

Trust Strategic Theme:	Provider of high quality patient care Healthcare for the Future		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 15	**Neil Darvill, Director of IM&T** Last reviewed: 06/10/2022 **Finance & Performance Committee** Last reviewed: FPC 22/09/2022 Risk added to BAF: **Pre-2019**	**Cyber Security** **A significant cyber-attack takes out the Trust's IT systems leading to a failure of business continuity and the inability to treat patients.** Note: while this risk is externally driven, there are element of the risk that the trust can control through mitigations and additional back-up/protection. EXTERNALLT DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	IT security measures Daily immutable system back-ups Business continuity and recovery plans Timely server and software updates NHS Digital cyber security programme Care Cert Server and Network vulnerability scanners STP Cyber Security Group aligning organisational standards and ensuring best practice. Extensive migration to Windows 10 and Office 365 during 2020/21 Updated Enterprise Network completed in Q4 2019/20 NHS Digital South West Regional Cyber Security Group for direction and access to national solutions. Ongoing monitoring and software upgrades (see further information under "gaps" and "planned actions")** Office 365 cloud-to-cloud backups for email and teams data Microsoft Defender Endpoint (antivirus) live across Microsoft Windows estate	**Internal Assurance** Data security protection toolkit return (Highest compliance in 2022) (1) Cyber security report (monthly to IM&T Divisional Board and Audit & Risk Committee) (2) Audit Committee Assurance Report (February 2022) (1) **External Assurance** Information Commissioner Audit December 2019 (3) Penetration Tests and assessments, October 2020 (2) KPMG Data Security Protection Toolkit Audit 2022 "significant Assurance" (3)	Residual likelihood: **3 (Possible)** Residual impact: **5 (Catastrophic)** Residual risk rating: **15** **(Extreme)** Previous residual risk rating: **4x5=20** Residual risk rating last changed: **22/05/2020** Forecast trajectory (next 12 months): ⇔	**Significant work has been completed to reduce the likelihood of a cyber-security incident, through updating networks and migration to up-to-date operating systems. .	Additional work is underway to implement software tools to proactively monitor network activity and quickly identify and respond to any changes to normal activity. **Owner: Phil Wade** **Due Date: see below** ~~Update Jan 2022: antivirus and end-point data being assessed for upload to SW Regional Security Information and Event Management (SIEM) solution **(target delivery June 2022)**~~ SW SIEM is live and operational for log retention; however, it requires additional investment or a switch to an alternative product to increase functionality. **Target for change: June 2023.** ~~Vulnerability scanning software has been purchased **target implementation June 2022**~~ Vulnerability scanning software is now active on the network and highlighting areas for remediation work. Target Deliveries: New BNSSG Cyber Security Governance Group to be established to assess compliance across the ICS and look to converging Cyber Security toolsets. Target April 2023. Improvements to backup infrastructure to improve capability in line with NHS Digital backup audit. Target June 2023.	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**

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Board Assurance Framework (BAF)

							~~The Trust does not yet have cyber security insurance in place. This is consistent with other NHS organisations due to the immaturity of this particular insurance market~~	~~Update January 2022: Whilst we have met and exceeded some of the Data Security Protection Toolkit requirements, the nature of NHS Acute trust organisations creates unique challenges when being assessed against Cyber Essentials Plus. NHS Digital do not have this as a mandatory requirement for NHS organisations. We continue discuss cyber insurance with our colleagues in the South West Regional Cyber Security collaborative and are yet to find another NHS organisation that has purchased a policy.~~	

Board Assurance Framework (BAF)

Trust Strategic Theme:	An anchor in our Community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Areas of influence/controls	Monitoring/assurance	Residual risk score	Gaps in influence or monitoring/assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 16	**Glyn Howells, Chief Finance Officer** Last reviewed: 21/10/2022 **Finance & Performance Committee** Last reviewed: FPC 21/06/2022 Risk added to BAF: **Q1 2020**	**There is a risk that due to lack of resource and the complexity of the required planning, the Trust fails to meet its 2030 Net Zero goal and adapt to climate change (i.e. key objective in Business Plan not met)** **This would constitute a failure to support Bristol's One City Plan and Climate Strategy and would represent a reputational risk** Note: The Trust has control over setting its internal priorities. This risk is considered a controllable risk. INTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **4 (Severe)** Inherent risk rating: **16** **(Extreme)**	Sustainable Development (SD) structure formally approved to lead and steer on behalf of NBT and the ICS. Annual, Board approved, Green Plan to be aligned with the 3-yearly ICS Green Plan. ~~SD Steering Group~~Green Plan Board with multi-disciplinary and NED membership. Understanding of NBT's current basic carbon footprint, together with actions needed to get to net zero carbon. Monitoring of annual carbon emissions Business Planning process includes a Sustainability Impact Assessment requirement. Carbon Assessment Tool is available to support Divs/Dirs in identifying carbon reduction opportunities. BNSSG Climate Change Adaptation Plan and Risk Assessment and NBT Heatwave Policy and Adverse Weather Place Sustainable Procurement Strategy. Representation with Civic and local Partners at many levels and multiple streams. Carbon Route Map (complete and in circulation)	NBT reports key sustainability measures quarterly to Greener NHS including carbon footprint is calculated and reported [1] ~~Sustainable Development Steering Group~~Green Plan Board and TMT / Trust Board approve annual Green Plan (ex-SDMP) which details carbon reduction efforts [2] Greener NHS national and regional teams take an overview of Trust SD activities [3] ERIC/Model Hospital comparative data [1] Possible ~~O~~occasional Internal Audit assessments [2] ICS Head of Sustainability, Carbon and Energy Manager~~, Senior Sustainability Partner and Sustainability~~ Partner (FM) posts [1]	Residual likelihood: **~~3~~4 (~~Possib~~Likely~~e~~)** Residual impact: **4 (Severe)** Residual risk rating: **16** **(~~Severe~~Extreme)** Previous residual risk rating: **~~N/A~~3x4=12** Residual risk rating last changed: **21/10/2022~~N/A~~** Forecast trajectory (next 12 months): ⇔	Requires Trust-wide buy-in to Green Plan actions and goals with sustainable leadership at every level of organisation. New governance structure required to achieve change and ownership of Green Plan actions held within divisions and directorate. Capital Plan funding will not be sufficient to meet the costs of energy plans to reduce carbon. Sustainable procurement requires significant resource to support change in supplier behaviour and national supply chain approach. Estimated carbon reporting of scope 3 emissions not able to identify when carbon reductions have been made through product, service, or project improvements. ~~Insufficient in-house expertise to identify and prioritise the full range of measures/actions required to achieve carbon neutrality by 2030, (including measures outside of our control.)~~ Climate Change Adaptation Action Plan, lead role and staff training on climate change adaptation required	Update October 2022: 2030 Carbon Route map completed and approved by Trust committees. Route map is being presented and communicated to all staff groups. The ICS Green Plan governance structure to be formalised with terms of reference, then ownership of actions supported at Div/Dir level. ICS Green Plan approved at ICS level and Trust committees. NBT adopted ICS Green Plan to enable system-wide delivery. Sustainability teams in NBT & UHBW merged to deliver synergy and productivity. Head of Sustainability appointed, and new/replacement roles being appointed to. Revised ICS Green Plan to be finalised and published. Using influence and networking at local and regional level to gain expertise. ~~Update July 2022: 2030 Carbon Route-map completed and approved by Trust committees. Action plans to be developed at division and workstream level including climate change adaptation. ICS Green plan approved at ICS level and passing through NBT governance processes. 2022/23 NBT Green Plan to integrate with ICS Green Plan to establish consistent delivery plans. Sustainability teams in NBT & UHBW to~~	Target likelihood: **~~2~~3 (~~Unlikely~~Possible)** Target impact: **~~2~~4 (~~Minor~~Extreme)** Target risk rating: **412** **(Moderate)**

Board Assurance Framework (BAF)

								~~merge to deliver synergy and productivity. Governance structure to be established jointly with UHBW and to cover ICS role. Head of Sustainability appointed and will start Sept 2022 to lead ICS work, Climate Change Action Plans to be developed.~~ **Owner: Sustainable Development Unit** **Due Date: March 2023**	
								£4.37M Public Sector Decarbonisation Scheme capital received January 2022. Update July 2022: progressing capital schemes to spend funding and drive energy efficiency. Update October 2022: Energy efficiency projects partially complete and some underway. NBT applied for PSDS Phase 3b funding for further energy efficiency improvements. **Owner: Sustainable Development Unit** **Due Date: March 2023**	

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Healthcare for the Future		NEW RISK – October 2022

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 17	**Glyn Howells, Chief Finance Officer** Last reviewed: 10/10/2022 Lead Committee: **Finance & Performance Committee** Last reviewed: New risk Risk added to BAF: October 2022	**Underlying Financial Position** There is a risk that if the Trust does not deliver its planned financial position sustainably, and reduce its underlying deficit, it will be subject to increased regulatory intervention. This may include a loss of decision-making autonomy, increased scrutiny, and increased reporting requirements.	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	**Internal:** Internal Planning Processes Divisional Reviews Business Case Review Group Financial Sustainability Reviews CIP Board oversight of plans Exceptions to Budgeted Establishment Group (VRP) Procurement controls Monthly Budget Monitoring **External:** ICS Directors of Finance (DoF) Group System Planning Processes System Finance & Estates Group Monthly Financial Returns and review with NHSE	Monthly Finance Report (Trust Board & FPC) [2] Divisional Reviews [2] Weekly CIP Monitoring Reports [1] Monthly consolidated System Finance Report [2] Annual Internal Audit Report – Financial Controls [3] External Audit – Value for Money Review [3] Model Hospital Benchmarking [3] Reference Costs Submission [3]	Residual likelihood: **4 (Likely)** Residual impact: **5 (Catastrophic)** Residual risk rating: **20** **(High)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): ↑	Identification and delivery of CIP across the organisation is significantly below plan (circa £8M) No recurrent funding for recurrent inflationary pressures and recurrent elective services recovery costs Culture of robust financial control has reduced during the Covid-19 pandemic due to different financial rules and leadership/staff turnover	Intervention, agreeing specific actions and divisional control totals to achieve 2022/23 financial plan. Revised CIP planning approach being developed. **Delivery date:** outputs visible by 31 March 2023 **Owner:** CFO Providing evidence of impact and lobbying national NHS leadership. Using longer term purchasing strategy to mitigate inflationary pressures. **Delivery date:** 31 March 2022 **Owner:** CFO Provide training and support to budget holders to support their CIP development / delivery. **Delivery date:** Framework by November 2022 **Owner:** CFO & Deputy CFO	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

APPENDIX A: RISK SCORING MATRIX

Every risk recorded within the Trust's risk registers is assigned a rating, which is derived from an assessment of its Impact Score (severity of potential hard) and its Likelihood Score (the probability that the risk event will occur). The risk grading criteria summarised below provide the basis for all risk assessments recorded within the Trust's risk registers, at strategic, operational and project level.

Impact Score (severity of potential harm)

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
Patient Experience	Unsatisfactory patient experience not directly related to patient care Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Unsatisfactory patient experience – readily resolvable Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Minor implications for patient safety if unresolved	Mismanagement of patient care Repeated failure to meet internal standards Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Major patient safety implications if findings are not acted on	Serious mismanagement of patient care Multiple complaints/ independent review Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service Inquest/ombudsman inquiry Gross failure of patient safety if findings not acted on
Patient Safety	Minimal injury requiring no/minimal intervention or treatment.	Low harm injury or illness, requiring minor/short-term intervention. Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days	Severe injury leading to long-term incapacity/disability Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects
Health & Safety	No time off work	Requiring time off work for <3 days	Requiring time off work for 4-14 days RIDDOR / MHRA / agency reportable incident	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects
Workforce	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality.	Late delivery of key objective / service due to lack of staff. Minor error due to insufficient training. Ongoing unsafe staffing level.	Uncertain delivery of key objective / service due to lack of staff. Serious error due to insufficient training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. Very high turnover. Critical error due to insufficient training.
Performance, Business Objectives	Interim and recoverable position Negligible reduction in scope or quality Insignificant cost increase	Partial failure to meet subsidiary Trust objectives Minor reduction in quality / scope Reduced performance rating if unresolved	Irrecoverable schedule slippage but will not affect key objectives Definite reduction in scope or quality Definite escalating risk of non-recovery of situation Reduced performance rating	Key objectives not met Irrecoverable schedule slippage Low performance rating	Trust Objectives not met Irrecoverable schedule slippage that will have a critical impact on project success Zero performance rating
Service Delivery & Business Continuity	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Financial	No or minimal impact on cash flow	Readily resolvable impact on cash flow Loss of 0.1–0.25 per cent of Trust's annual budget	Individual supplier put Trust "on hold" Loss of 0.26–0.5 per cent of Trust's annual budget	Major impact on cash flow Purchasers failing to pay on time Uncertain delivery of key objective Loss of 0.6–1.0 per cent of Trust's annual budget	Critical impact on cash flow Failure to meet specification/ slippage Non-delivery of key objective/ Loss of >1 per cent of Trust's annual budget
IM&T	Information system issue affecting one service user	Information system issue affecting one department Poor functionality of trust wide system, readily resolvable and not impacting service delivery	Information system issue affecting one division Poor functionality of trust wide system impacting service delivery, but readily resolvable.	Information system issue affecting more than one division. Poor functionality of trust wide system impacting service delivery, not readily resolvable	Complete failure of trust wide information system that directly impacts service delivery.
Reputational	Rumours	Local Media – short term	Local Media – long term	National Media < 3 days	National Media ≥ 3 days. MP Concern (Questions in House)
Statutory Duty & Inspections	No or minimal impact or breach of guidance/ statutory duty Minor recommendations	Non-compliance with standards reduced rating. Recommendations given.	Single breach in statutory duty Challenging external	Enforcement Action Multiple challenging recommendations	Prosecution Multiple breaches in statutory duty

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
			recommendation Improvement notice	Improvement notices Critical report	Complete systems change required Severely critical report

Likelihood Score

The Likelihood Score is calculated by determining how likely the risk is to happen according to the following guide. Scores range from 1 for rare to 5 for almost certain.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Broad descriptor	This will probably never happen/recur	Do not expect it to happen/recur	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1.1–10 per cent	11–50 per cent	>50 per cent

The **Risk Score** is determined by the Impact x Likelihood.

Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Severe	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Low	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Grade:

1-3	Low Risk
4-6	Moderate Risk
8-12	High Risk
15 - 25	Extreme Risk

Terms of Reference for the Audit & Risk Committee

Chair:	Non-Executive Director
Other Members:	The Committee will be appointed by the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Trust Board. At least one of the members of the Committee will have recent and relevant financial experience. The Chair of the Trust will not be a member of the Committee.
Other Attendance:	The Audit & Risk 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. In addition to members of the Audit & Risk Committee, the following shall normally attend all meetings and may contribute to discussions, but have no voting rights nor contribute to the quorum: • Chief Finance Officer • Assistant Director of Finance (Financial Services) • Director of Corporate Governance/Trust Secretary • Deputy Trust Secretary • Head of Internal Audit • Senior management representatives from the appointed external auditors • Counter Fraud Specialist • Director of Procurement (for relevant agenda items only) The Accountable Officer should be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the annual governance statement. The Accountable Officer should also attend when the Committee considers the draft annual governance statement and the annual report and accounts. Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager. Attendance at meetings is essential. In exceptional circumstances when an Executive Director cannot attend, they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Representatives from other organisations and other individuals may be invited to attend on occasion. The Trust Chair may be invited to attend meetings of the Committee in order that they can understand how the Committee works but will have no voting rights.

	The Head of Internal Audit, the representative of External Audit and the Counter Fraud Specialist have a right of direct access to the Chair of the Committee. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.
Quorum:	The quorum for the Audit & Risk Committee is at least two Non-Executive Director member.
Declaration of Interests	All members must declare any actual or potential conflicts of interest relevant to the work of the Audit & Risk Committee, which shall be recorded in the minutes accordingly. Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.
Frequency of Meetings:	The Audit & Risk Committee will meet at least five times a year, timed in accordance with the discharge of its key responsibilities. At least once a year the Committee will meet privately with the external and internal auditors.
Notice of Meetings:	The Chair may call additional meetings where these are deemed necessary. The Trust Board, Accountable Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and supporting papers, shall normally be forwarded to each member, and any other person required to attend, no later than five working days before the date of the meeting. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.
Inputs:	The Audit & Risk Committee will receive reports on issues within the remit of the meeting, so as to ensure timely discussion and decision-making. This will include: • Trust-Level Risks and BAF report • External Audit Progress Report • Internal Audit Progress Report & Recommendation Tracker • Counter Fraud Progress Report • Bi-Annual Conflict of Interest Report • Losses and Salary Overpayments

	• Single Tender Actions Individual members may also raise concerns/risks/issues relevant to the meetings remit on an ad hoc basis but will do so with sufficient notice to ensure that meeting agenda can be set and managed effectively. The Audit & Risk Committee can request a report on any subject or issue relevant to its terms of reference.
Outputs:	The Audit & Risk Committee shall produce a set of minutes and a log of actions arising. The Committee shall issue an upward report to Trust Board following each meeting. The Committee will provide the Trust Board with an Annual Report, timed to support finalisation of the accounts and the Annual Governance Statement, summarising its conclusions from the work it has done during the year and including the following: • The fitness for purpose of the Trust's assurance framework. • The completeness and 'embeddedness' of risk management in the Trust. • The integration of the governance arrangements. • The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existences as a functioning business. • The robustness of the processes behind the quality accounts. • A description of how the Committee has fulfilled its terms of reference. • Give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.
Responsible for the following Strategies and Policies:	Strategies: • Risk Policies: • Finance • Standing Orders • Risk
Sub-Committees:	N/A
Committee Secretary:	The Corporate Governance Team is responsible for: • Agreement of agenda and collation of papers. • Taking the minutes and keeping a record of actions arising and issues to be carried forward. • Provision of a highlight report of the key business undertaken to the Trust Board following each meeting

1. Purpose

1.1 The Audit & Risk Committee is established to be a sub-Committee of the Trust Board and is the Board assurance committee for .

2. Authority

2.1 The Audit & Risk Committee is a sub-group of the Trust Board from which it receives its authority. Its constitution and terms of reference shall be as set out in this document, subject to amendment.

3. Duties

3.1 The primary role and function of the Committee is as follows:

3.1.1 Integrated Governance, Risk Management and Internal Control

3.1.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

3.1.1.2 In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements, in particular the Annual Governance Statement attached to the Annual Report and Accounts, together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to submission to the Trust Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to counter fraud, bribery and corruption as set out in the NHS Standard Contract and as required by the NHS Counter Fraud Authority 7.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.1.1.3 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

3.1.1.4 The Committee shall also ensure that the Trust has robust risk management systems and processes in place and shall receive a regular report setting out all Trust Level Risks and the Board Assurance Framework. The Committee will actively seek assurance that:

- an up-to-date risk register is maintained, and that relevant staff are able to access the risk register to raise concerns and know that concerns will be reviewed and addressed.
- act as the forum for risk to be discussed, and ensure that where serious concerns are raised, action is taken, and that action plans are carried through to completion, and the reporting loops closed. This may be progressed directly by the Committee or via delegation to other key committees (see below). In doing so, the Committee will ensure that there are robust links with clinical and non-clinical directorates to ensure a culture of

effective risk management is present throughout the organisation. 7.6 As part of its integrated approach, the Committee will have effective relationships with other key committees - for example the four other assurance committees of the Trust Board - (Finance and Performance, People, Charity, Quality, and Patient and Carer Experience Committee) so that it understands processes and linkages. These other Committees must not usurp the Committee's role.

3.1.2 **Internal Audit**

3.1.2.1 The Committee will ensure that there is an effective internal audit function that meets the requirements of the Public Sector Internal Audit Standards 2017 and provides appropriate independent assurance to the Committee, Accountable Officer and the Trust Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Review and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework and with reference to the risk register.
- Considering the major findings of internal audit work; and management's response to recommendations made.
- Ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Carrying out an annual review of the effectiveness of internal audit.
- Regular monitoring of key performance metrics aligned to the delivery of the service.

3.1.3 **External Audit**

3.1.3.1 The Committee will review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved through:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee.
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Trust Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring there is in place a clear policy for the engagement of external auditors to supply non-audit services.
- Regular monitoring of key performance metrics aligned to the delivery of the service.

3.1.4 **Counter Fraud**

3.1.4.1 The Committee will satisfy itself that the Trust has adequate arrangements in place for counter fraud, bribery and corruption that meet NHS Counter Fraud Authority's standards and will review the outcomes of work in these areas.

3.1.4.2 Specifically it will:

- Approve the Trust's Counter Fraud strategy and Local Counter Fraud Specialist annual work plan, including the resources allocated for the delivery of the strategy and work plan.
- Receive and review progress reports of the Local Counter Fraud Specialist against the four principles of the overall NHS Counter Fraud Strategy.
- Monitor the implementation of management actions arising from counter fraud reports.

- Receive and discuss reports arising from quality inspections by the counter fraud service.
- Make recommendations to the Trust Board as appropriate in respect of counter fraud at the Trust.
- Receive, review and approve the annual report of the Local Counter Fraud Specialist.

3.1.5 **Other Assurance Functions**

3.1.5.1 The Committee will review the findings of other significant assurance functions, both internal and external to the Trust; and consider the implications to the governance of the Trust.

3.1.5.2 These will include, but will not be limited to:

- Any reviews by Department of Health and Social Care arm's length bodies, or regulators and inspectors, - for example the Care Quality Commission, NHS Resolution etc.
- Professional bodies with responsibility for the performance of staff or functions – for example, Royal Colleges and accreditation bodies.

3.1.5.3 The Committee will review the work of other committees within the Trust, where their work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the four other assurance committees of the Trust Board (Finance and Performance, People, Charity, Quality, and Patient and Carer Experience Committee).

3.1.5.4 In reviewing the work of the Quality Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

3.1.5.5 The Committee will review and make recommendations to the Trust Board for any changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

3.1.5.6 The Committee will examine the circumstances associated with each occasion when Standing Orders are waived.

3.1.6 **Management**

3.1.6.1 The Committee will request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.1.6.2 The Committee may also request specific reports from individual functions within the Trust, for example, clinical audit, as may be appropriate to the understanding of the overall arrangements.

3.1.7 **Financial Reporting**

3.1.7.1 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

3.1.7.2 The Committee will ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review for completeness and accuracy of the information provided.

3.1.7.3 The Committee will review the Trust Annual Report and financial statements before submission to the Trust Board. It will focus on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted misstatements in the financial statements.
- Significant judgements in preparation of the financial statements.

- Significant adjustments resulting from the audit.
- Letters of Representation.
- Explanations for significant variances.

4. Monitoring and Effectiveness

4.1 The Committee shall have access to sufficient resources to carry out its duties, including access to company secretarial assistance as required.

4.2 It will review its own performance, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

4.3 As per NHSE/I requirements the Committee will carry out an annual self-assessment to inform above review of its Terms of Reference.

Version:	1.4
Ratified by / responsible committee:	Trust Board
Date ratified:	TBC
Name of originator / author:	Trust Secretary
Lead for Executive Team Meeting:	Glyn Howells, Chief Finance Officer
Date issued:	November 2022
Review date:	November 2023

North Bristol NHS Trust

Terms of Reference for the Auditor Panel

Chair:	Non-Executive Director
Other Members:	The auditor panel will comprise the entire membership of the Audit & Risk Committee with no additional appointees. This means that all members of the auditor panel are independent Non-Executive Directors. The Chair of the Audit & Risk Committee will be appointed Chair of the auditor panel by the Trust Board. The Chair of the Trust will not be a member of the auditor panel. The auditor panel Chair and/or members of the panel can be removed in line with rules agreed by the Trust Board.
Other Attendance:	The auditor panel's Chair may invite executive directors and others to attend depending on the requirement of each meeting's agenda. These invitees are not members of the auditor panel.
Quorum:	To be quorate, independent members of the auditor panel must be in the majority AND there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest.
Declaration of Interests	Conflicts of interest must be declared and recorded at the start of each meeting of the auditor panel. A register of panel members' interests must be maintained by the panel's Chair and submitted to the Trust Board in accordance with the Trust's existing conflicts of interest policy. If a conflict of interest arises, the Chair may require the affected panel member to withdraw at the relevant discussion or voting point.
Frequency of Meetings:	The auditor panel will consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the Audit & Risk Committee.
Notice of Meetings:	The Chair may call additional meetings where these are deemed necessary. The Trust Board, Accountable Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary. Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed and supporting papers, shall normally be forwarded to each member, and any other person required to attend, no later than five working days before the date of the meeting. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.

Inputs:	Auditor panel business will be identified clearly and separately on the agenda and audit committee members will deal with these matters as auditor panel members NOT as Audit & Risk Committee members. The panel's Chair shall formally state at the start of each meeting that the auditor panel is meeting in that capacity and NOT as the audit committee.
Outputs:	The Chair of the auditor panel must report to the Trust Board on how the auditor panel discharges its responsibilities. The minutes of the panel's meetings must be formally recorded and submitted to the Trust Board by the panel's Chair. The Chair of the auditor panel must draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board, or which require executive action.
Responsible for the following Strategies and Policies:	N/A
Sub-Committees:	N/A
Committee Secretary:	The Corporate Governance Team is responsible for: • Agreement of agenda and collation of papers. • Taking the minutes and keeping a record of actions arising and issues to be carried forward. • Provision of a highlight report of the key business undertaken to the Trust Board following each meeting

1. Purpose

1.1 The Trust Board hereby resolves to nominate its Audit Committee to act as its auditor panel in line with schedule 4, paragraph 1 of the *Local Audit and Accountability Act 2014*.

1.2 The auditor panel is a Non-Executive Committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Authority

2.1 The auditor panel is authorised by the Trust Board to carry out the functions specified below and can seek any information it requires from any employees/relevant third parties. All employees are directed to co-operate with any request made by the auditor panel.

2.2 The auditor panel is authorised by the Trust Board to obtain outside legal or other independent professional advice – for example, procurement specialists, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any 'outsider advice' must be obtained in line with the organisation's existing rules.

3. Duties

The auditor panel's functions are to:

3.1 Advise the Trust Board on the selection and appointment of the external auditor. This includes:

- Agreeing and overseeing a robust process for electing the external auditors in line with the organisation's normal procurement rules.
- Making a recommendation to the Trust Board as to who should be appointed.
- Ensuring that any conflicts of interest are dealt with effectively.

3.2 Advise the Trust Board on the maintenance of an independent relationship with the appointed auditor.

3.3 Advise (if asked) the Trust Board on whether or not any proposal form the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.

3.4 Advise on (and approve) the contents of the Trust's policy on the purchase of non-audit services from the appointed external auditor.

3.5 Advise the Trust Board on any decision about the removal or resignation of the external auditor.

4. Monitoring and Effectiveness

4.1 The terms of reference will be reviewed on an annual basis.

Version:	0.3
Ratified by / responsible committee:	Trust Board
Date ratified:	TBC
Name of originator / author:	Trust Secretary
Lead for Executive Team Meeting:	Glyn Howells, Chief Finance Officer
Date issued:	November 2022
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