Due to the impact of Coronavirus COVID-19, the Trust Board will meet virtually but is unable to invite people to attend the public session. Trust Board papers will be published on the website and interested members of the public are invited to submit questions to trust.secretary@nbt.nhs.uk in line with the Trust's normal processes. A recording of the meeting will be made available on the Trust's website for two weeks following the meeting.

Trust Board Meeting – Public

Thursday 31 March 2022
10.00 – 12.25
Virtual via Microsoft Teams

A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcome and Apologies for Absence: *John Iredale, NED* *Kelvin Blake, NED* *Sandra Harding, Associate NED*	Information	Chair	Verbal	10.00
2.	Declarations of Interest	Information	Chair	Verbal	10.02
3.	Minutes of the Public Trust Board Meeting Held on 27 January 2022	Approval	Chair	Enc.	10.05
4.	Action Chart from Previous Meetings	Discussion	Trust Secretary	Enc.	10.06
5.	Matters Arising from Previous Meeting	Information	Chair	Verbal	10.08
6.	Chair's Business	Information	Chair	Verbal	10.10
7.	Chief Executive's Report	Information	Chief Executive	Enc.	10.20
KEY DISCUSSION TOPIC(S)					
8.	Staff Story: Medical Support Worker (MSW) NHS England project at NBT *Dr Emma Mitchell and Dr Heather Woodcraft attending to present*	Discussion	Chief Medical Officer	Pres.	10.30
PEOPLE					
9.	Equality, Diversity & Inclusion Committee Proposal *Liz Perry, Deputy Director of People and Transformation, attending to present*	Information	Chief People Officer	Enc.	10.50
10.	Gender Pay Gap Reporting	Information	Chief People Officer	Enc.	11.00
11.	Guardian of Safe Working (Junior Doctors) – Board Update *Dr Lucy Kirkham attending*	Information	Chief Medical Officer	Enc.	11.15
BREAK (10 mins)					**11.30**
FINANCE, IM&T & PERFORMANCE					

No.	Item	Purpose	Lead	Paper	Time
12.	Integrated Performance Report	Discussion	Chief Operating Officer	Enc.	11.40
13.	Finance & Performance Committee Upward Report 13.1. Finance Month 11 Report	Information	NED Chair	Enc.	12.00
14.	Audit Committee Upward Report	Information	NED Chair	Enc.	12.05
QUALITY					
15.	Quality Committee Upward Report including Quality Priorities 15.1. Ockenden Progress Update	Information /Approval	NED Chair	Enc.	12.10
16.	Patient & Carer Committee Upward Report	Information	NED Chair	Enc.	12.15
CLOSING BUSINESS					
17.	Any Other Business	Information	Chair	Verbal	12.20
18.	Questions from the Public in Relation to Agenda Items	Information	Chair	Verbal	12.22
19.	Date of Next Meeting: Thursday 26 May 2022, 10.00 a.m.				-
	Resolution: Exclusion of the Press and Public. It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, Section 1(2), the press and members of the public be excluded from further items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.				

NHS North Bristol NHS Trust

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.
Mr Tim Gregory	Non-Executive Director	• Employed by Derbyshire County Council – Director of Environment, Economy and Transport, commencing 03/08/2020. Likely to be until May 2021.
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 • Salaried GP, Sea Mills Surgery, 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 • 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, Datapharm Limited - Director, I4Health Limited - Director, Talking Health Ltd - Chair, EHC Holdings Topco Limited
Ms LaToyah McAllister-Jones	Associate Non-Executive Director	• Board member of Bristol Festivals • Executive Director St Pauls Carnival CIC • Board Trustee of United Communities
Ms Sandra Harding	Associate Non-Executive Director	• Founder, HCPG Ltd • Board Trustee, POhWER • Vice Chair of Governors, Marksbury Primary School • Councillor, Marksbury Parish Council

Name	Role	Interest Declared
Dr Ike Anya	Associate Non-Executive Director	• Locum Consultant in Public Health Medicine: NHS Lanarkshire, NHS Lothian, Berkshire East and Berkshire West Directorates of Public Health • 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)
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	• Independent Registered Nurse (Non-Executive Director), Surrey Heartlands Clinical Commissioning Group • 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.
Ms Jacqui Marshall	Director of People and Transformation (non-voting position)	• Nothing to declare.

DRAFT Minutes of the Public Trust Board Meeting held virtually on Thursday 27 January 2022 at 10.00am

Present:			
Michele Romaine	Trust Chair	**Maria Kane**	Chief Executive Officer
John Iredale	Non-Executive Director	**Jon Scott**	Outgoing Interim Chief Operating Officer
Kelly MacFarlane	Non-Executive Director	**Steve Curry**	Chief Operating Officer
Richard Gaunt	Non-Executive Director	**Helen Blanchard**	Director of Nursing & Quality
Sarah Purdy	Non-Executive Director	**Neil Darvill**	Director of Informatics
LaToyah McAllister-Jones	Associate Non-Executive Director	**Glyn Howells**	Chief Finance Officer
Sandra Harding	Associate Non-Executive Director	**Tim Whittlestone**	Medical Director
		Jacqui Marshall	Director of People & Transformation/ Chief People Officer
In Attendance:			
Xavier Bell	Director of Corporate Governance & Trust Secretary	**Isobel Clements**	Senior Corporate Governance Officer & Policy Manager *(Minutes)*
Aimee Jordan	Corporate Governance Officer (*Minutes)*	**Jeff Farrar**	ICS Chair
Presenters:			
Sue Mallett	Divisional Operation Director for NMSK	**Juliette Hughes**	Divisional Director of Nursing, Women & Children's Division

Observers: Due to the impact of Covid-19, the Trust Board met virtually via MS Teams, but was unable to invite people to attend the public session. Trust Board papers were published on the website and interested members of the public were invited to submit questions in line with the Trust's normal processes. A recording of the meeting was published on the Trust's website.

Action

TB/22/01/01 Welcome and Apologies for Absence

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 had been received from Tim Gregory, Non-Executive Director.

Michele welcomed Steve Curry as new Chief Operating Officer (COO). Michele also welcomed Juliette Hughes, Divisional Director of Nursing, Women & Children's Division who was shadowing the meeting and Jeff Farrar, ICS Chair who was attending NBT Board as part of his introduction to the ICS providers.

TB/22/01/02 Declarations of Interest

No declarations of interests were noted relating to the agenda.

An update was required to the Trust Board register of interests as currently published on the NBT website and annexed to the Board papers as follows:

- Tim Whittlestone, Medical Director, declared that his wife was an employee of North Bristol NHS Trust.

TB/22/01/03 Minutes of the previous Public Trust Board Meeting

RESOLVED that the minutes of the public meeting held on 25 November 2021 were approved as a true and correct record.

TB/22/01/04 Action Log and Matters Arising from the Previous Meeting

Xavier Bell, Director of Corporate Governance, presented the action log noting updates to the below:

- Action 61: IPR received in public and a further detailed report for review was scheduled at the private section of the meeting.
- Action 60: Juliette Hughes would share the fetal monitoring training information. If further discussion was required it would take place at the Quality Committee
- Action 62: Michele queried the progress of the debt action and Glyn Howells, Chief Finance Officer confirmed that it would be picked up through the Audit and Risk Committee.

RESOLVED that updates on the Action Log were noted. No matters arising were raised.

TB/22/01/05 Chair's Business

Michele Romaine, Trust Chair, reported the deaths of two NBT employees and passed on the condolences of the Board to their families and colleagues.

- Christine Fowler was the chair of the Patient Partnership Group and was a tenacious advocate for patients. Christine worked tirelessly for the best interests of the patients and the NHS.
- Lawrence Davis was a Manual Handling Advisor and was well-known and well liked across the whole organisation.
- The Board wanted to recognise the significant contributions made by both of them to NBT.

The Chair outlined guidance of new significant cyber security threats and requested that the Audit and Risk Committee undertake a review with the results reported to Trust Board to provide assurance that the risks had been mitigated. Further to this it was requested that the Board members receive regular training to understand the vulnerabilities and bi-annual cyber security updates.

It was noted that the 2019 regulatory enforcement undertakings had been lifted as NBT was now felt to be compliant with the financial undertaking. NBT would now move to Segment Two (Finance) of the System Oversight Framework, though remain in Segment Three overall and continue to receive support from NHS Improvement as appropriate.

The Trust Chair described her recent visit to the Urology department which was particularly focused on care pathways. The visit highlighted areas where bottlenecks occurred such as with diagnostics and handovers, and where work could be done with UHBW re the Oncology centre to ensure a seamless patient experience. Michele thanked the team for the informative visit and explained the team would be happy to welcome any Board members that wished to visit.

The Trust Chair noted that her next visit would be to the catering department.

RESOLVED that the Board:

- **Noted the Chair's update.**
- **Requested the Audit and Risk Committee undertake a review of cyber security threats.** **ND**
- **Requested a bi-annual cyber security update to Board.** **AJ**

TB/22/01/06 Chief Executive's Report

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

- Omicron: The challenges including the number of cases and staff absences between December and January were noted. Positively, it was highlighted that Covid-19 cases had plateaued in the region with 50 positive cases in the hospital and only 3 cases in ICU which is the lowest number of ICU patients during the pandemic.
- It was acknowledged that both Bristol hospitals had experienced high unscheduled care requirements and so mutual aid across UHBW and NBT was implemented to off-load ambulances in a timely way. It was noted that this remained a challenge.
- It was discussed that the NHS 10 priorities would be considered alongside progressing the NBT strategy.

RESOLVED that the Chief Executive's briefing was noted.

TB/22/01/07 Patient Story: Accessible information standards (AIS)

{slides distributed with following papers}

The Trust Chair welcomed Sue Mallett, Interim Divisional Director of Nursing for NMSK, who shared two patient scenarios that demonstrated the importance of meeting the AIS. Helen Blanchard noted that the internal audit for AIS resulted in partial assurance with high priority actions required. Furthermore, the Patient Experience Committee's focus would be on improving compliance as a quality standard for next year.

Sue Mallett highlighted that the stories evidenced how patient voice/feedback can contribute towards positive service change. Key learning points actioned following the patients feedback included:

- Ensuring that all letters sent to patients contained a contact number so a discussion can occur prior to an appointment if required.
- That virtual appointments were offered where applicable.

- An easy read guide created by the Epilepsy Specialist Nurses in relation to the medication risks and disseminated regionally.
- Other practitioners (not just consultants) to hold patient discussions re the risks of medications.
- Patient information leaflets were changed to give patients detailed information of what to expect when attending appointments.
- Additional training to booking clerks and updates to their checklist.
- Communication to the community to clarify alternative options for patients with mobility issues.

During the ensuing discussion the following points were noted:

- Kelvin Blake, NED, thanked Sue and noted how work on AIS can positively transform the patient journey. However, it was acknowledged that additional work was urgently required
- Sarah Purdy, NED, supported Kelvin's comments and queried if the process could be streamlined such as putting the instructions from GP newsletters onto ICE (referral system).
- Sandra Harding, Associate NED, queried if the information to patients could be standardised and if patients were involved in creating the documents. Sue Mallett confirmed there was engagement with patients re information for the patient leaflets.
- John Iredale, NED, noted the importance of reviewing patient information regularly to prevent missed follow up for patients. John noted that quality of care had been improved for the patients discussed.
- The Trust Chair noted that it was an illustration of how communication and feedback from patients can make a fundamental difference in the quality of the service provided.
- Helen Blanchard noted the internal audit action plan would go to Patient and Carer Experience committee for clear oversight. The Board supported this as a quality priority, but the timescale of the work plan was queried. Helen responded that as it was extensive programme which included cultural change there was no time scale currently.
- Maria Kane noted that there were national templates that could be used to aid the progression to meeting AIS standards. Helen also noted that they were learning from other organisations and CQC regulations.
- Kelly Macfarlane, NED, noted digital was an enabler for patients with complex needs and should be utilised.

RESOLVED that the Board noted the Patient Story, thanked Sue for attending and supported NBT's aim to meet the AIS as a quality priority.

Sue Mallett left the meeting

TB/22/01/08 Annual Emergency, Preparedness, Resilience & Response (EPRR) Report

Steve Curry, Chief Operating Officer, introduced the Annual Emergency, Preparedness, Resilience & Response (EPRR) Report and noted that the

report stated compliancy against NHS Core Standards was at 91% with full compliance to be achieved in approx. three months.

Kelly Macfarlane noted the significant testing on oxygen, medical devices and gases and questioned if this was the standard approach or due to Covid-19. Steve answered that routine testing was standard process, but additional checks had been undertaken as part of the Covid-19 response. Tim Whittlestone added that external contactors undertake the regular audit of oxygen capacity, failsafe, and checks. Tim clarified that further tests were undertaken as a result of Covid-19 as additional oxygen was brought in with new technology to regulate the temperatures. Checks would revert to the routine bi-monthly process.

Glyn Howells, Chief Finance Officer, noted that compliance for facilities, estates and Health and Safety would be reviewed, and a paper brought to Board for visibility in the upcoming months.

Following a query from Kelvin Blake, Steve confirmed NBT was working with partners regarding civil contingencies.

RESOLVED that the Board:

- **Noted the EPRR report and that the Trust was 'substantially compliant' with the NHS Core Standards for 2021.**
- **Requested that the Board be informed when NBT was fully complaint.** **SC**
- **Expected a compliance paper regarding estates and facilities in due course.** **GH**

TB/22/01/09 Integrated Performance Report (IPR)

Maria Kane presented the IPR for discussion and highlighted the format of the report was a work in progress to provide further detail re timelines for actions, learnings, and improvement priorities.

It was discussed that the urgent care performance deteriorated in December which followed the national trend but in comparison to other Trusts the deterioration was to a lesser extent.

It was noted that the priority to reduce the 104 week wait patients by the end of March remained. The reduction of the total bed occupancy to 94% was detailed with focus on reducing "No Criteria To Reside" (NCTR) patients.

Steve Curry highlighted the key operational performance elements of the IPR:

- The operating environment was challenging considering increased Covid-19 and Non-Covid-19 demand whilst balancing staff fatigue.
- Bed occupancy problems, driven by NCTR patients, had resulted in an increased length of stay. It was noted that achieving system flow would be the key focus to improve bed occupancy.
- Clinical leaders were balancing the risks for planned care activity and would reprofile the 104 week wait position to include mitigations.
- Cancer performance issues were noted.

Queries and comments from the Board were as follows:

- TheTrust Chair noted that the Board would use the report and operational pressures highlighted to determine priorities.
- Richard Gaunt, NED, queried how improvements re cancer and diagnostic wait times would be monitored and if NBT was still under CQC special measures. Xavier Bell responded that the CQC directives had been lifted and NBT was under segment 3 in the new system oversight framework. This was due to cancer performance which would be manged at a system level. Richard asked if there were any recommendations or reports regarding the support offered. Jon Scott, Outgoing Chief Operating Officer, noted that there were weekly Regional cancer meetings to review performance, but no reports were issued from this.

Helen Blanchard reported on key Quality and infection prevention control (IPC) elements:

- Maternity department had been monitored and scrutinised at the Quality Committee. It was noted that there were significant staffing challenges compounded by Covid-19 related absences, vacancies, and maternity leave in NICU and Maternity. The Quality committee had requested additional information re the workforce across the division to provide clarity on the risk.
- It was noted that Maternity coped well with the high numbers of women presenting with Covid-19 by reorganising pathways and adapting the estate.

Queries and comments from the Board were as follows:

- The Trust Chair requested an update re Maternity services at Cossham. Helen responded that due to staffing constraints and ambulance issues it had been agreed maternity services at Cossham would be closed until the end of January. It was noted that support was provided to patients having home births and patients wanting hospital births were encouraged to attend Southmead hospital.
- Following a query from the The Trust Chair, Helen confirmed the number of patients wanting a home birth had increased.

Tim Whittlestone highlighted key medical data in the IPR:

- The standard morality index was lower than expected for a Trust at this size and complexity which was positive.
- Disappointingly the venous thromboembolism (VTE) risk had worsened, and it was noted this was due to staff being diverted to clinical jobs to aid with workforce issues.
- John Iredale queried how other pressures on the system might adversely affect outcomes of home births for example if ambulances could not attend to rescue a home birth. Helen noted that midwifes always attended

home births and advised that staffing across Trusts, SWAST response times and pressures were reviewed as a system.

Jacqui Marshall reported on the IPR's key People elements including:

- Vacancies had increased to 7.5 with specific hot spots including radiographers, occupational therapists, band 2 and band 5 roles.
- Increased Covid-19 related absences and Stress, Anxiety and Depression absences which underpinned the staff burnout narrative. Positively, recurrent funding had been secured for the Staff Psychology team.

Queries and comments from the Board were as follows:

- Michele queried how actively the staff wellbeing teams' services were being used. Jacqui responded that the team were being fully utilised as well as implementing Start Well End Well Trust wide.
- Sandra queried if the volunteers from the mass vaccination sites were applying for the vacancies. Jacqui confirmed the Trust had a good conversion rate and staff were being absorbed into the system workforce.

RESOLVED that the Board noted the contents and key points of January's IPR and the above discussion.

TB/22/01/10 Finance Month 9 Report

Glyn Howells presented the Finance Report for Month 9, stating a forecast breakeven position by the end of the year with all Covid-19 costs recovered. It was noted that month 10 would reflect the funding information for the surge hub. The balance sheet and cash position remained strong, with the cash position sitting at over £100 million. It was highlighted that the capital plan position was slightly behind due to access constraints re Covid-19, but achievement of the overall capital plan was optimistic.

The Trust Chair raised a concern that the finance position was artificial due to Covid-19 funding and queried if there was clarity regarding future financial frameworks. Glyn responded that the Directors of Finance (DoF's) were working through planning guidance for 2022/23 and the new regime requirements. It was noted that the PFI elements of the underlying deficit had been absorbed into the system funding. The suspension of PbR resulted in work to clarify activity efficiency requirements and income levels prior to budget sign off.

TheTrust Chair queried if the efficiency requirements would be reconciled against cost improvement programmes (CIP). Glyn confirmed this and noted approx. £5million CIP delivery would be delivered in 2021/22 and would be worked through as a system. TheTrust Chair added finance and strategic priorities would need to be viewed at system level as well as Trust level. It was also noted that system work was required to land a system wide bed model.

John Iredale questioned if there were mitigations for the increased inflation rates re the direct costs of energy. Glyn answered that there would be two Trust level risks coming to the Board in February re the increased power bill from £8million to £15million and the management of energy procurement costs. The Trust Chair queried if the rise in inflation costs had been discussed nationally. Glyn noted that the national DoF call raised the issue, but the response indicated no additional funding would be provided.

RESOLVED that the finance month nine report and above discussion was noted.

TB/22/01/11 Continuity of Carer

Helen Blanchard introduced the Continuity Of Carer (COC) paper and provided clarity that no investment approval was being sought as this was not a business case. COC was detailed as a midwife organisation model to ensure that women were provided with a small consistent team to care for them during and after pregnancy. It was noted that NBT had a low percentage of women that received this type of care and discussion was ongoing with the system to improve this.

NHSEI requested that COC was achieved by March 2023. The plan to achieve COC in five phases was detailed to the Board, noting that it would take 3 years to roll out. Juliette Hughes described the divisional response and noted the big impact it would have on workforce recruitment and retention.

John Iredale noted the positive move to bridge the gap between community and hospital care and the importance of patients having individualised care.

Sandra Harding raised concerns regarding recruitment to roles. Helen was confident COC would improve appeal of roles. Juliette noted that this would be used as measure of success against the model.

Kelly Macfarlane queried if a system conversation was required to understand the challenges and risks. Helen responded that system discussions were underway in the Local Maternity System forum and at Healthier Together. Kelly suggested achievement against COC should be under continual review and queried if it was a system priority. Helen confirmed that it was the right priority to invest in.

RESOLVED that the Board noted the report and supported the ambition to achieve COC model.

TB/22/01/12 Quality Committee Upward Report

John Iredale presented the Quality Committee (QC) Upward Report, noting the focus was on Maternity. QC received reassurance on the status of Ockenden update but noted concerns re recruitment particularly in NICU and Sonography. QC requested that an overarching document be discussed at the next deep dive meeting to give a clear strategic view of the problems.

Helen Blanchard highlighted the efforts and hard work the division had undertaken to stabilise the department. John acknowledged and recognised the progress made and noted that the overarching document was requested for transparency re where support was needed and how this could be achieved. It was noted that this would also provide an opportunity to have a detailed conversation regarding the amount of progress that had been made.

RESOLVED that the QC Upward Report was noted.

TB/22/01/13 **Any Other Business** – None raised.

TB/22/01/14 **Questions from the public** – None received**.**

TB/22/01/15 **Date of Next Meeting**

The next Board meeting in public was scheduled to take place on Thursday 31 March 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 11:50am

Members of the Trust Board received the mandatory annual Adult Safeguarding Update from the Head of Safeguarding, Prevent and MCA Lead.

The following members were in attendance:

- Maria Kane, Chief Executive Officer
- Tim Whittlestone, Medical Director
- Jacqui Marshall, Director of People & Transformation
- Helen Blanchard, Director of Nursing & Quality
- Glyn Howells, Chief Finance Officer
- Steve Curry, Chief Operating Officer
- Neil Darvill, Director of IMT
- Xavier Bell, Director of Corporate Governance
- Michele Romaine, Trust Chair
- Richard Gaunt, Non-Executive Director
- John Iredale, Non-Executive Director
- Kelly Macfarlane, Non-Executive Director
- Kelvin Blake, Non-Executive Director
- Sarah Purdy, Non-Executive Director
- Latoyah McAllister-Jones, Associate Non-Executive Director
- Sandra Harding, Associate Non-Executive Director

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

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	Chair's Business	TB/22/01/05	63	Audit and Risk Committee to undertake a review of cyber security threats and feedback to Board for assurance.	Neil Darvill, Director of Informatics	Mar-22	Yes	Closed	Received at March ARC meeting, included in the upward report to March Board	16/03/2022
27/1/22	Chair's Business	TB/22/01/05	64	Bi-annual cyber security update to be scheduled on the Trust Board work plan	Corporate Governance team	Mar-22	Yes	Closed	Scheduled on ARC and Trust Board planners for March and August 2022 and Feb 2023	24/02/2022
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	Apr-22	Yes	Open		
27/1/22	Annual Emergency, Preparedness, Resilience & Response (EPRR)	TB/22/01/08	66	A paper to be received at Board regarding compliancy of facilities, estates and Health and Safety	Glyn Howells, Chief Finance Officer	May-22	Yes	Open		

Report To:	Trust Board Meeting		
Date of Meeting:	31 March 2022		
Report Title:	Chief Executive's Briefing		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance		
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.		

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.	
Strategic Theme/Corporate Objective Links	**1. Provider of high-quality patient care** **2. Developing Healthcare for the future** **3. Employer of choice** **4. An anchor in our community**
Board Assurance Framework/Trust Risk Register Links	Does not link to any specific risk.
Other Standards Reference	N/A
Financial implications	None identified.

Other Resource Implications	No other resource implications associated with this report.
Legal Implications	None noted.
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	None

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.

2. Background

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

3. Current Pressures

The Trust continues to experience significant operational pressures particularly in the urgent and emergency care patient pathway. A key factor underpinning these pressures continues to be the high bed occupancy within the hospital, driven by high numbers of patients who no longer meet the criteria to reside. High bed occupancy makes it more difficult to admit patients through the Emergency Zone in a timely manner, resulting in patients waiting a long time, and queuing ambulances. Part of our Provider Collaborative ambition, as well as our internal strategy focus will be to address this long-standing situation.

We continue to work with system partners to increase discharges as well as focus on our own actions to ensure that we minimise the number of discharges that are delayed for internal reasons. Additionally, with the support of our partners and regulators, we are working to ensure that our use of space and resource in the Emergency Zone is as efficient and effective as possible.

4. Emergency Zone Major Incident

On 10 March 2022 a suspect package was discovered in the Southmead Hospital Emergency Zone, resulting in the declaration of a Major Incident and the activation of system contingency plans, and coordination at a regional level. On advice from the Police, the Emergency Zone was evacuated, allowing the police to assess the package via a robotic device and ultimately declare the area safe.

I would like to reiterate my thanks to everyone for responding so calmly and professionally on behalf of our patients to what was a challenging and frightening situation. We have initiated a formal review and evaluation of our emergency response and resilience plans, and I am impressed with the commitment to learn and improve based on our experience.

5. Planned Care

Our focus is on achieving zero patients waiting 104 weeks by the end of June 2022, in line with national guidance. To this end, I was able to participate in a in a roundtable meeting with Sir Jim Mackey, the National Director of Elective Recovery for the NHS Elective Programme, and as an organisation we have submitted a bid for Targeted Investment Funds (TIF) to support additional ward and theatre capacity.

6. Provider Collaborative

In March we met with UHBW as part of our Provider Collaborative, and agreed the following areas of combined and collaborative focus:

- Waiting lists and elective recovery (acknowledging long patient waiting lists)

- Emergency care and access to Emergency Departments (including ambulance handover delays)
- Use of hospital beds (noting the high number of patients in both hospitals awaiting discharge, who do not fit the national "criteria to reside)

We also agreed an ambition to develop a joint clinical strategy, ensuring that acute hospital services across Bristol are seamless and offer the best possible care at the best location for our patients.

7. Patient First Workshop

On 23 March 2022 the Executive Team participated in a further workshop with colleagues from University Hospitals Sussex, discussing our emerging Patient First methodology and finding out more about how we develop this in NBT. Further workshops are planned in April, and a joint Board-to-Board meeting with partners at University Hospitals Bristol & Weston in June, looking for alignment where we have shared priorities.

8. Response to the war in Ukraine

I would like to thank all our staff and their families who have contributed to relief efforts for the people of Ukraine by donating vital personal supplies, including sleeping bags, nappies, first aid kits, paracetamol, wet wipes, sanitary items, scarfs, gloves, hats, hot water bottles, toiletries, hand gel, roll mats, blankets, batteries, candles, and torches.

As an organisation we are engaged with the national NHS Emergency Response team, ensuring that should any patients in Ukraine require treatment in Bristol, we will be best placed to respond in a coordinated manner.

With respect to refugees, we hope that some will be accommodated in the South West and anticipate that they will require primary care, women's health and mental health services.

9. Bristol Race Equality Strategic Leaders Group

The Trust is a member of the Bristol Race Equality Strategic Leaders Group, made up of leaders from 12 public sector agencies in Bristol. At a recent meeting we were able to showcase our organisation's Equality, Diversity & Inclusion (EDI) initiatives. This included sharing our plans for an EDI Committee, reporting through to Trust Board, alongside the Staff Equality Networks we support, the various training programmes and toolkits provided to our staff and managers, and our work leading the BNSSG Heathier Together EDI workstreams, including an inclusive Recruitment Action Plan.

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, gaining a better understanding of the challenges and opportunities faced in different specialties and practices across the Trust. In February and March, I met with colleagues from Rheumatology, Gastroenterology, Gynaecology, Renal Medicine, Respiratory Medicine, Stroke/Neurology, Acute Medicine and NICU.

11. Organ Utilisation Group Visit

On 22 March 2022 we hosted a visit from Professor Stephen Powis, NHS England & Improvement Medical Director, and members of NHS Blood and Transplant and the Organ Utilisation Group, in our capacity as a Centre for Organ Transplantation.

Members of the Executive Team and clinical staff had the opportunity to hear about the work and remit of the Organ Utilisation Group, which has been established to make recommendations on how to improve organ transplant services nationally. We were also able to showcase the fantastic work undertaken at NBT by our organ donation service.

12. Trust Lead for Organ Donation

I would like to congratulate Dr Ian Thomas, ICU Consultant, for his appointment as the Trust Lead for Organ Donation, following a competitive process overseen by NBT and NHS Blood & Transplant. This is an incredibly important and life changing programme for patients and their families.

13. Consultant Recruitment

Since I last reported on consultant recruitment in January 2022, the Trust has appointed the following consultants across several key specialities:

Name:	**Specialty:**
William Cooper	Cardiothoracic Radiology
Jonathan Potts	Dermopathology
Vipin Gupta	Gastroenterology
Mazin Abdelaziz	Interventional Radiology
Martin Mariappan	Interventional Radiology
Monika Beauchamp	Gastrointestinal Histopathology

14. Summary and Recommendations

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

Report To:	Public Trust Board		
Date of Meeting:	31 March 2022		
Report Title:	Trust Board Briefing Staff Story		
Report Author & Job Title	Su Monk, Deputy Chief Nursing Officer		
Executive/Non-executive Sponsor (presenting)	Tim Whittlestone, Chief Medical 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:	The Board is asked to receive the update on Medical Support Worker programme at NBT		
Report History:	No previous reports.		
Next Steps:	N/A		

Executive Summary
The MSW role is suitable for international medical graduates / refugee doctors who may not have GMC registration and offers the potential to provide the healthcare system with a credible alternative access to Medical Staff. The role provides an opportunity to develop NHS experience and support transition into future NHS jobs. Since November 2021, 29 Medical Support Workers (MSW's) have been employed at NBT. Dr Emma Mitchell & Dr Heather Woodcraft, have been leading the introduction of MSW's to North Bristol NHS Trust and will attend to provide an update on the programme and experience of staff.

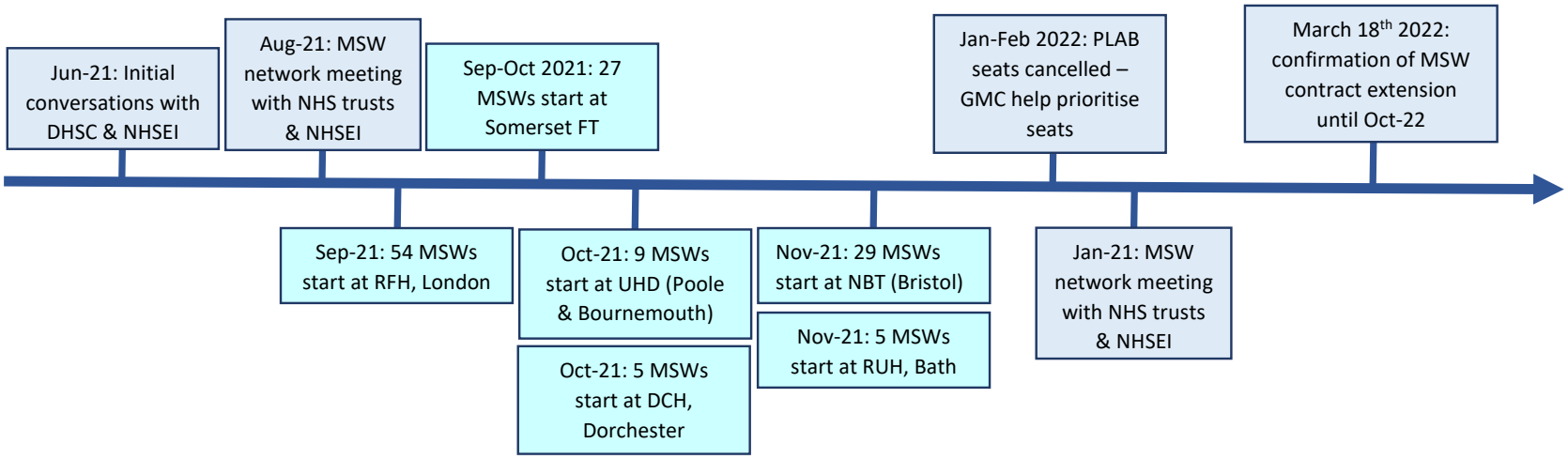
Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services c. A Centre of Excellence for specialist healthcare **2. Developing Healthcare for the future** a. Training, educating and developing out workforce b. Support development & adoption of innovations

	3. Employer of choice a. A great place to work that is diverse & inclusive b. Empowered clinically led teams c. Support our staff to continuously develop d. Support staff health & wellbeing **4. An anchor in our community** a. Create a health & accessible environment b. Developing in a sustainable way
Board Assurance Framework/Trust Risk Register Links	None
Other Standards Reference	
Financial implications	None
Other Resource Implications	
Legal Implications	
Equality, Diversity and Inclusion Assessment (EIA)	Not required
Appendices:	Situation Update: Medical Support Workers (MSWs) at NBT

Situation Update: Medical Support Workers (MSWs) at NBT

18th March 2022

Since November 2021, 29 MSWs have been employed at NBT. This recruitment has formed part of a larger and ongoing piece of work to support doctors from Myanmar who have been displaced since the military coup took place in February 2021. This work has mitigated the doctors having to apply for refugee status in the UK / return home and be faced with severe safety risks. Key organisations involved in this are: Department of Health and Social Care (DHSC), the Home Office, General Medical Council (GMC) and NHS England and Improvement (NHSEI). Burmese healthcare diaspora in the UK have supported the MSWs in their preparation for interviews and in CV writing. The six NHS trusts employing 127 MSWs from Myanmar have maintained an open dialogue to share ideas/troubleshoot/learn from one another.



Situation Update: MSWs from Myanmar
Dr Emma Mitchell, North Bristol NHS Trust

What is an MSW?

- In 2021-22, the MSW programme received £15 million funding by NHSEI to support medical workforce, providing a rapid pipeline of staff in response to the COVID-10 pandemic.
- The MSW role is suitable for international medical graduates / refugee doctors who may not have GMC registration.
- It offers the potential to provide the healthcare system with a credible alternative route to train doctors at scale.
- The role provides an opportunity to develop NHS experience and support transition into future NHS jobs (a specific job description has been created).
- To date, around 450 MSWs have been appointed (following 2 waves of recruitment).
- We are awaiting final confirmation of future national recruitment and expect this will start in Summer 2022.

Current outline of costs:

- Salaries are paid by NHSEI, band 6 Agenda for Change (37.5h per week [no OOH/nights]).
- NHSEI provide financial support for educational supervision, study budget and relocation costs.

MSWs at NBT

At NBT, a bespoke induction, training and supervision package has been designed to support the specific needs of the MSWs taking into consideration their personal and professional development as they begin their NHS careers in Bristol. This has included QI training, sessions provided by the regional GMC team and support from the clinical psychology department.

MSWs completed a diary after being in post for one month to describe their experiences. This will be repeated towards the end of their contracts.

Supervisors and other key members of staff will soon be contacted to complete a survey regarding their experience of working alongside MSWs to inform future development/improvement. Informal feedback at our supervisor meetings has been positive, suggesting the MSWs have shown rapid development and are contributing effectively within their clinical teams.

Situation Update: MSWs from Myanmar
Dr Emma Mitchell, North Bristol NHS Trust

Next steps:

- Out of 29 MSWs, 6 have secured clinical fellow positions (2 of which will continue working at NBT).
- On 18th March, we received confirmation from NHSEI regarding contract extension for current MSWs until October 14th 2022.
- We await confirmation from NHSEI regarding details of recruitment of new MSWs in Summer 2022 and are exploring NBT capacity for this.
- Meanwhile, a business case is being prepared to consider longer-term implementation of the MSW role at NBT as a new cadre of healthcare professional.

Please do not hesitate to get in touch should further information be needed or should you have any questions.

Dr Emma Mitchell, Consultant Geriatrician, North Bristol NHS Trust.

Email: emma.mitchell2@nbt.nhs.uk

Dr Heather Woodcraft, Consultant Geriatrician, North Bristol NHS Trust.

Email: heather.woodcraft@nbt.nhs.uk

Situation Update: MSWs from Myanmar
Dr Emma Mitchell, North Bristol NHS Trust

NHS North Bristol NHS Trust

Report To:	Trust Board		
Date of Meeting:	31 March 2022		
Report Title:	Establish Equality, Diversity and Inclusion Committee and Strategic Priorities		
Report Author & Job Title	Monira Chowdhury Head of Equality, Diversity, and Inclusion		
Executive/Non-executive Sponsor (presenting)	Jacqui Marshall, Chief People Officer		
Does the paper contain: [enter a X in any box applicable box]	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose: [enter a X in the correct box]	**Approval**	**Discussion**	**To Receive for Information**
	x		
Recommendation:	Approve the establishment of an Equality, Diversity and Inclusion (EDI) Committee under the proposed Terms of Reference along with the accompanying documents. Approve the Five Strategic Outcomes for EDI as a framework for a proposed EDI Priorities Action Plan to be monitored and reviewed by the new EDI Committee on an ongoing basis. Progress to be reported back to the Board through the People Committee.		
Report History:	Follow up to the Annual EDI Update to Board on 30 September 2021		
Next Steps:	Agree detailed EDI Strategic Objectives, to be developed into an Action Plan along with previously agreed Priorities and key performance indicators. Progress updates to be reported back to Board and People Committee Establish EDI Committee as per terms of reference to meet for the first time in April 2022		
Executive Summary			
Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services c. A Centre of Excellence for specialist healthcare d. A powerhouse for pathology & imaging **2. Developing Healthcare for the future** a. Training, educating and developing our workforce		

<table>
<tr><td></td><td>
b. Increase our capability to deliver research
c. Support development & adoption of innovations
d. Invest in digital technology
3. Employer of choice
a. A great place to work that is diverse & inclusive
b. Empowered clinically led teams
c. Support our staff to continuously develop
d. Support staff health & wellbeing
4. An anchor in our community
a. Create a healthy & accessible environment
b. Expand charitable support & network of volunteers
c. Developing in a sustainable way
</td></tr>
<tr><td>Board Assurance Framework/Trust Risk Register Links</td><td></td></tr>
<tr><td>Other Standards Reference</td><td></td></tr>
<tr><td>Financial implications</td><td>
Source of funding :
<table>
<tr><td>Option</td><td>[X]</td><td>Please provide additional information</td></tr>
<tr><td>Existing budget</td><td></td><td>• NBT has an Equality Diversity & Inclusion Team consisting of 2.2 substantive posts when fully staffed (approximately) £123,000 per annum
• If any identified priorities can’t be delivered within existing resources, then a required business case for additional resources will be submitted as necessary.</td></tr>
<tr><td>Cost Pressure</td><td></td><td></td></tr>
<tr><td>External Funding</td><td></td><td>• NHS Charities Together provided £50,000 in 2020-21 to address the disproportionate impact on Black, Asian and Minority Staff and other marginalised groups, a balance amount is still outstanding to be carried forward into 2021/22 to allow for contracted support from an external consultant (Blue Tulip Consultancy Ltd) to support various initiatives under our EDI Priority action Plan</td></tr>
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			• NHS England and Improvement has given additional funding of £58k to BNSSG via North Bristol Trust from their Retention Programme to fund a race equality talent development project manager post for 12 months January – December 2022, line managed by NBT Head of EDI • BNSSG has obtained additional £55k funding from Health Education England to provide project management support to the EDI Leads Group and its projects includer inclusive recruitment, for 12 months January – December 2022, 2 post holders appointed to start January 0222 and to be line manged by NBT Head of EDI
	Other		
Other Resource Implications	Delivery of the Trust's EDI Priorities are dependent within existing resources of teams and services across the Trust and also within Bristol, North Somerset & South Gloucestershire Healthier Together (Shadow Integrated Care System) resources.		
Legal Implications	The Trust has legal responsibility under its Public Equality Sector Duty under the Equality Act 2010.		
Equality, Diversity and Inclusion Assessment (EIA)	N/A.		
Appendices:	• Draft NBT Equality Diversity and Inclusion Committee Terms of Reference and accompanying documents. • Draft NBT Equality Diversity & Inclusion Strategic Outcomes, Baseline and Key Indicators January 2022.		

1. Purpose

1.1 The Purpose of this paper is to seek the approval of the Trust Board to establish an Equality, Diversity and Inclusion Committee which will oversee and monitor the implementation of the Trust's Equality, Diversity and Inclusion (EDI) Strategic Outcomes.

1.2 Approval is also sought for the proposed EDI Strategic Outcomes and Indicators to be included in an associated Action Plan.

2. Background

2.1 In September 2021 the Trust Board noted the latest data from the various equalities standards and reports as of March 2021 and agreed priorities for action and key indicators for the upcoming twelve months until September 2022.

2.2 While the Trust continues to meet its specific obligations under the Workforce Race Equality Standard (WRES) and Model Employer, the Workforce Disability Equality Standard (WDES) and Gender Pay Gap (GPG) by continuing to collect the required data, it is also striving to develop and deliver several relevant initiatives including those already identified as Trust wide priorities.

2.3 The Trust has been leading the EDI work of BNSSG Healthier Together for the last 15 months and co-chairs the EDI Leads Group. There has been an increasing focus nationally within the NHS on EDI to be delivered more collaboratively and collectively at an integrated care system level rather than just at individual organisational level.

2.4 As part of this approach a BNSSG Inclusive Recruitment Programme and action plan has been developed along with a BNSSG Race Equality Talent Development Programme for Black, Asian, and Minority Ethnic staff to move through medium level bands (5-7) into upper bands at 8a and above.

2.5 Over the last two years NBT workforce data, staff survey results and staff personal lived experience continues to demonstrate and highlight the lack of positive experiences and the continuing barriers for many staff from different equalities backgrounds around recruitment processes, progression, disciplinaries and grievances, and harassment and bullying. These continuing disparities now need urgent short to medium term focus in order to ensure longer term improvements.

3. Focused Strategic Outcomes

3.1 NBT has already agreed to focus over the upcoming year on a number of priorities ranging from strategic and cross cutting to specific priorities around race equality, disability equality, sex/gender equality, and lesbian, bisexual, gay and transgender equality.

3.2 In order to ensure a strategic focus for the proposed EDI Committee, five overarching strategic priority themes have been identified for Trust Board approval, which will give clear direction to achieving our outcomes. These are:

I. Design and implement a governance framework and mechanism for:

- effectively delivering and monitoring EDI across NBT
- ensuring effective integration with the BNSSG EDI agenda
- enabling our staff to have accountability in improving experience and outcomes for themselves and their colleagues

II. Improve outcomes in recruitment processes for our staff in protected characteristic groups, which achieve fairness and a representative workforce at all levels, across departments, divisions and staff groups.

III. Improve opportunities for advancement and development for our staff in protected characteristic groups, particularly into upper/senior levels 8a and above.

IV. Improve staff experiences especially through employee processes and in receiving appropriate support.

V. Empower staff voice and engagement and celebrate positively the benefits of a diverse workforce.

3.3 These five strategic focuses have arisen as a result of recurring workforce equalities data, staff survey outcomes and from shared ongoing lived experiences of staff from equalities groups. For example, our data shows decreasing representation of Black, Asian, and Minority Ethnic staff above Band 5 and extremely low numbers at 8a, 8b and 8c with no known staff at very senior management level. The Staff Survey continues to show much higher proportion of disabled staff who feel they are discriminated against. Formal and informal reporting of staff experiences and casework highlights disparity of experiences and outcomes.

3.4 These strategic themes are closely aligned to BNSSG and the recently agreed three high level priorities of fairer recruitment, Black, Asian, and Minority Ethnic staff improved talent development opportunities, and more support for staff networks.

3.5 Those priorities that were agreed by the NBT Board in September 2021 will form the basis of the Action Plan aligned to agreed key indicators to deliver the overarching strategic priority themes, as outlined above.

3.6 Priorities covered in the Action Plan will include: revised EDI statement and policy, new vision, re-launching harassment and bullying helpline and advisors, supporting staff wellbeing, training for senior leaders and managers, reciprocal mentoring, tackling racist abuse, culturally appropriate support for grievances and disciplinaries, supporting neurodiverse staff, improving self-declaration by disabled and neurodiverse staff, improving menopause support and revising LGB and Trans standards.

3.7 Here at NBT we are very committed to celebrating the diversity of our staff (and patients) through targeted History months, e.g., Black, Disability Equality, and LGBT, and also through other celebratory and commemorative occasions i.e., International Women's Day, Holocaust Memorial, Chinese New Year, Mental Health Awareness Week etc These will continue, all of which contribute will contribute to achieving our fifth outcome.

3.8 NBT has been leading the way locally in supporting and empowering our three equalities staff networks by providing protected time. This coming year, that support will be extended from just chairs and vice-chairs to protected time for other lead activists. NBT will also be endeavouring to support Staff Networks to further empower themselves and to work together with other staff networks across BNSSG, the South West region, and as necessary nationally.

4. Equality, Diversity, and Inclusion Committee

4.1 Terms of Reference have been developed for an EDI Committee to report to the Trust

Board through the People Committee, though the remit of the Committee will not be solely workforce related. It will also look at patient experience from an EDI perspective and address any issues of access to services where raised.

4.2 The EDI Committee will be chaired by the Executive Director with responsibility for EDI within the Trust (People & Transformation) and supported by a Non-Executive Vice-Chair and the NBT Corporate Executive EDI Champion. The Committee will have delegated authority from the Board to monitor and review the annual workforce data reports and monitor all relevant action plans, in particular the EDI Priorities Action Plan including the agreed key indicators.

4.3. The EDI Committee Terms of Reference Paper includes a full set of roles and responsibilities along with the indicative membership list. In the short term the EDI Committee will report at least once annually to the Board, but the longer-term aspiration is twice yearly reports.

4.4. The draft EDI Committee Terms of Reference document includes the proposed revised EDI Statement for the Trust, along with a proposed EDI Vision/Aspiration along with a role profile for Corporate EDI Champions including the Executive EDI Champion. In agreeing the EDI Committee Terms of Reference, the Board will be giving an indication that they are supporting the revised Statement and proposed Vision to be approved formally at the first meeting of the new EDI Committee. A revised EDI Policy will be produced in due course before that first meeting, to complement these documents.

5. Summary and Recommendations

5.1 The Trust Board is asked to:

- Approve the establishment an EDI Committee under the proposed Terms of Reference along with the accompanying documents.
- Approve the Five Strategic Outcomes and Associated Indicators for EDI as a framework for a proposed EDI Priorities Action Plan to be monitored and reviewed by the new EDI Committee on an on-ongoing basis. Progress to be reported back to the Board through the People Committee

North Bristol NHS Trust

Equality, Diversity and Inclusion Committee

Terms of Reference

1. Aim Summarised from Vision/Aspiration/Statement
(to be agreed – see Appendix A&B)

- North Bristol NHS Trust (NBT) is committed to ensuring it delivers inclusive health services for all. Respect, dignity, civility, compassion, and care are at the core of how we treat each other and all our partners at NBT as patient safety, experience and outcomes are all improved when staff are valued, empowered, and supported.
- As an organisation, we are committed to eliminating individual and institutional discrimination, harassment and victimisation relating to the protected characteristics set out in the Equality Act 2010. We are also committed to achieving all legal responsibilities under the Public Sector Equality Duty.
- North Bristol NHS Trust seeks to be a progressive organisation, that leads the way to vigorously tackle inequalities for all individuals and communities. This will enable us to become a more inclusive and diverse organisation, which is both representative of and active within our communities.

2. Objectives:

- On behalf of the Trust Board, provide leadership and strategic direction on the Equality, Diversity and Inclusion (EDI) agenda for the Trust, both in regard to workforce and service delivery, and provide updates through the People Committee.
- Support the Trust in meeting its statutory obligations regarding its Public Sector Duty under the Equality Act 2010 and oversee the Trust's compliance with legislation.
- Support the Trust in ongoing change to its culture to demonstrate its journey to becoming a more inclusive and anti-racist organisation.
- Review the Trust's Valuing You (EDI) Strategy), and EDI Policy, Statement and Vision as required.
- Set the Trust's EDI priorities for the short, medium and long term along with the support necessary to deliver them, monitor progress and report at least once annually back to the Board (aspiration longer term to report twice a year).
- Monitor Workforce Race Equality Standard, Model Employer Goals, Workforce Disability Equality Standard, Equality Delivery Scheme, Gender Pay Gap, Accessible Information Standard, Learning Disability Improvement Standard, Sexual Orientation Monitoring Standards and any other relevant data reports and actions plans (as directed nationally or locally).
- Ensure that the Trust's EDI work and commitment align with and occur within the Trust's overall frameworks and strategies i.e. People Strategy, Patient First.

- Review and monitor the impact of other relevant related policies, initiatives or programmes i.e. Freedom To Speak Up, Restorative Just Culture, Learning & Organisational Development, Staff Wellbeing, Harassment & Bullying, Dignity & Respect, Staff Voice.
- Support awareness campaigns and initiatives which promote the EDI agenda across all areas of the Trust, including patient experience.
- Ensure that matters of EDI are highlighted, identified and addressed in all areas of the Trust's business, including negotiations with Commissioners and Contractors.
- Enable the voice of staff equalities networks to influence change and help co-produce solutions and ensure an inclusive workplace where all staff can flourish, including staff from diverse backgrounds.
- Consider Equality Impact Assessments which relate to policies, programmes or projects which are deemed to have high impact on either the organisation or on any equalities protected characteristic group(s) of patients or staff.
- To take reports from any EDI groups operating within the Trust i.e. divisional or service inclusion groups or patient council or groups.
- To request the required attendance of any Director or Service Lead as considered relevant by the Committee.
- Support, collaborate, and where necessary lead Bristol, North Somerset and South Gloucestershire Integrated Care System initiatives and programmes that relate to or impact on EDI i.e. workforce, health inequalities, community engagement and report back as appropriate.

3. Membership

Core Members:

- Nominated Executive Director – Chair (People & Transformation – Jacqui Marshall)
- Nominated Lead Non-Executive Director – Vice Chair – Kelvin Blake)
- Non-Executive or Associate Non-Executive Director – Latoyah McAllister-Jones?
- Executive Director (NBT Corporate Executive EDI Champion – see Appendix C for clarity on role – Glyn Howells
- Nominated Representative of Chief Medical Officer (appropriate Deputy)
- Nominated Representative of Chief Nursing Officer (appropriate Deputy)
- Nominated Representative of Director of Communications (appropriate Deputy)
- Head of Equality, Diversity & Inclusion (also representing Director of People) – Monira Chowdhury
- Head of Patient Experience – Gifty Markey
- 2 Staff Side - Chair & Secretary (or nominated representatives)
- 3 Staff Equalities Networks – up to 2 representatives per Network (6 in total)
- Patients & Carers representatives (with equalities lived experience) – 2 representatives

Others – To attend at request of Committee (to report at least twice yearly):

- Freedom to Speak Up Lead Guardian
- Learning & Organisational Development Lead
- Staff Voice & Engagement Lead
- Staff Wellbeing Lead
- People Team Lead
- Resourcing Lead
- Workforce Planning Lead
- Lead Chaplin
- Director of Southmead Charity
- Departmental & Divisional EDI Leads (on a rotation basis)

4. Meeting Arrangements

- Meet at least four (4) times a year (quarterly).
- Quorum of at least five (5) including Chair.
- To be serviced by the Trust Governance Team (Secretary's Office).
- Agenda and papers to be circulated 7 days in advance.
- The Chair & Vice Chair will be supported by the Head of Equality, Diversity and Inclusion.
- Exceptionally members of the Group can nominate a deputy to represent them in their absence, who should be able to act in their place as required.
- The Terms of Reference will be reviewed annually.

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Appendix A – Equality, Diversity and Inclusion Vision/Aspiration – Where we want to be (to be agreed)

North Bristol NHS Trust seeks to be a progressive organisation, that leads the way to vigorously tackle inequalities for all individuals and communities. This will enable us to become a more inclusive and diverse organisation, which is both representative of and active within our communities.

We will work together, pro-actively, to be a model of good practice by creating an organisation which aims to:

- Be actively anti-racist and anti-discriminatory, by not tolerating racism, racial discrimination, and other types of discrimination, harassment and victimisation
- Welcome and celebrate diversity and difference, so that we promote and foster an inclusive environment
- Advance equality of opportunity for all, by identifying and addressing any barriers to inclusion
- Ensure everyone is treated with dignity, respect, civility, compassion, and care
- Foster good relations between different people and groups
- Strive towards eliminating racism, discrimination, and victimisation against all equality communities and particularly protected characteristic groups
- Work tirelessly to call out, interrupt and prevent individual, institutional and systemic discrimination, harassment and victimisation, as well as conscious and unconscious bias
- Ensure equality of access through meeting the needs of individuals and communities, and in ensuring that all groups are aware of their rights
- Use our role as an anchor organisation to challenge inequalities and promote social justice and equity for all communities
- Work together with other organisations and partners in tackling health inequalities and related socio-economic and other social determents of health
- Recognise diversity and inclusion to enable better services and outcomes for patients and the population we serve

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Appendix B – Equality, Diversity and Inclusion Statement (to be agreed)

North Bristol NHS Trust (NBT) is committed to ensuring it delivers inclusive health services for all. Respect, dignity, civility, compassion, and care are at the core of how we treat each other and all our partners at NBT as patient safety, experience and outcomes are all improved when staff are valued, empowered, and supported.

As an organisation, we are committed to eliminating individual and institutional discrimination, harassment and victimisation relating to the protected characteristics* set out in the Equality Act 2010. We are also committed to achieving all legal responsibilities under the Public Sector Equality Duty. We expect everyone who interacts with the Trust to observe this statement.

All individuals have a number of characteristics such as their age, gender, and race*. NBT acknowledges that there are other vulnerable, marginalised, or excluded groups not covered by the Equality Act 2010 and aspires to be inclusive of their requirements within services, policies, and practices and our interactions with all our stakeholders.

NBT values all people as individuals and strives to meet their requirements. This includes the population we serve, including patients, their families, carers, and friends, staff (including apprentices and staff side representatives), students, volunteers, contractors, anyone who comes on site and our key partners across Bristol, North Somerset, and South Gloucestershire.

In our role to advance equality of opportunity we aim to be an anti-discriminatory organisation both in employment and in delivering services. We also recognise our role to foster good relations between different people when carrying out our activities.

We reaffirm that discriminatory behaviour is unacceptable and, in relation to the protected characteristics, may be unlawful.

The protected characteristics* set out in the Equality Act 2010 are in historical order: Race; Sex; Disability**; Sexual Orientation; Religion and Belief; Gender Reassignment; Age; Marriage and Civil Partnership; and Pregnancy and Maternity.

**Equality Act 2010 generally defines a disabled person as someone who has a mental or physical impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.

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Appendix C – Corporate Equality, Diversity & Inclusion Champions

(To be agreed)

North Bristol Trust is committed to ensuring there are Corporate Equality, Diversity and Inclusion Champions. These are people at Executive Director, Director or other senior levels within NBT, who volunteer outside of their day-to-day job role to support and promote EDI at NBT by going 'above and beyond', removing blocks and having a 'can do' attitude towards EDI issues. There will be at least one Corporate Executive EDI Champion who attends Trust Board and Executive Team and who is the lead Corporate EDI Champions representative on the Trust's EDI Committee.

Corporate EDI Champions will act as leaders and as role models, taking actions when appropriate and addressing behaviours when and where necessary. Champions can decide to promote or support only one area of EDI (i.e. race, disability, sex/gender, LGBT+, faith etc) or across all protected characteristic areas or across equality, diversity and inclusion in its broadest sense. Champions will be expected to ask questions to check that EDI, is being recognised, understood and considered as integral to the decision making and evaluation processes of the Trust. Corporate EDI Champions will operate as a network and will look to the Corporate Executive EDI Champion as their informal lead.

An EDI Champion doesn't need to have lived experience themselves of the area(s) they promote and do not need to know all the answers, but a Champion does need to be prepared to spend some time developing their own personal competencies and understanding on equality, diversity and inclusion, in order, to become an effective Champion and ally.

Role

The suggested role of Corporate EDI Champions could encompass the following, but this is not a definitive list.

- To promote and support NBT's EDI vision/aspiration and EDI statement and to ensure effective implementation of these and our EDI Policy
- To take a key role in promoting equality and diversity inside the Trust and where appropriate at Board, other strategic and/or operational levels
- To take a role in promoting EDI outside of NBT especially within the wider NHS, across the Integrated Care System (Bristol, North Somerset and South Gloucestershire) and wider South West Region
- To drive forward equality initiatives at organisational, local, regional or national levels, as appropriate
- To raise awareness and increase understanding of equality, diversity and inclusion
- Recognise that equality, diversity and inclusion are intrinsic to the success and performance of the organisation and promote this to key service leads and/or managers
- Promote dignity, respect, civility and compassion

- Challenge and identify strategies to overcome obstacles to promoting equality, diversity and inclusion
- Communicate the benefits of EDI and our organisational successes
- Promote equality and diversity when representing the Trust in public and bring ideas back to the organisation
- Proactively engage with and support staff equality networks
- To operate as an informal network and look to the Corporate Executive EDI Champion as their lead
- To work with and co-ordinate with the Head of EDI and NBT EDI team individually and/or collectively
- To support and participate in an EDI Allies Network, once established

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Equality, Diversity & Inclusion: Outcomes & Indicators: January 2022

Strategic outcome	Baseline Data	Proposed Indicators	Target date
I. Design and implement a governance framework and mechanism for: • effectively delivering and monitoring EDI across NBT • ensuring effective integration with the BNSSG EDI agenda • enabling our staff to have accountability in improving experience and outcomes for themselves and their colleagues		EDI Committee Established	April 2022
II. Improve outcomes in recruitment processes for our staff in protected characteristic groups, which achieve fairness and a representative workforce at all levels, across departments and divisions and across all	NBT Disparity in Shortlisting & Recruitment (2021 WRES/WDES): NBT BAME disparity 1.46 v 1.6 nationally. NBT disabled staff disparity 1.38 V 1.23 nationally.	Reduce disparity in shortlisting and recruitment for different equalities staff groups (especially BAME and disabled staff) to: • Year 1 within 1.25 • Year 2 within 1.0	 March 2023 March 2024

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staff groups.			
III. Improve opportunities for advancement and development for our staff in protected characteristic groups, particularly into upper/senior levels 8a and above.	NBT BAME staff proportion is: - 17.1% overall - 20% at lower bands (B5 and below) - 10.3 % at middle bands (B6&7) - 4.9% at B8a and above	Reduce race disparity year on year at middle and upper levels of the Trust towards the organisational average for BAME staff (currently 17.1%): Year 1: 8.0% B6&7, 3.9% B8a and above Year 2: 6.0% B6&7, 2.9% B8a and above Year 3: 4.0% B6&7, 1.9 % B8a and above Year 4: 2.0% B6&7, 1% B8a and above Year 5 – Organisational average To increase retention and/or recruitment of women at VSM and Consultant levels towards parity of 50:50.	March 2023 March 2024 March 2025 March 2026 March 2027 March 2025
IV. Improve staff experiences especially through employee processes and in receiving appropriate support.	Likelihood of NBT disabled staff entering the formal capability process compared to non-disabled staff is 7.09, significantly higher than the national rate of 1.1. Likelihood of NBT BAME staff entering formal	Reduce disparity in employee processes i.e. sickness, capability, disciplinary, grievance for both BAME and disabled staff; specifically: • Reduce likelihood of disabled staff by 2.0 to 5.09 year 1 • Reduce likelihood of disabled staff by 2.0 to 3.09 year 2 • Reduce likelihood of BAME staff to 1.20 in line with the national rate of 1.19	March 2023 March 2024 March 2023

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	disciplinaries is 1.44 compared to white staff, against the national rate for Acute Trusts of 1.19		
V. Empower staff voice and engagement and celebrate positively the benefits of a diverse workforce.	2021 SAS: - NBT overall disabled staff for staff engagement is 6.8, v 7.2 for non-disabled staff - Disabled believing the organisation provides equal opportunities 80.4% v 85.7% (for non-disabled staff) - Proportion of disabled staff who have felt pressure from their manager to come to work 29.8% v 21.7% for non-disabled staff - BAME staff believing the organisation provided equal opportunities for career progression or profession, at 64.8% v to 88.2% for white staff. - BAME experiencing discrimination at work	Improve staff satisfaction on engagement for different equalities protected characteristic groups to meet the average for all NBT staff. Improve year on year staff survey results towards parity for WRES & WDES to meet average results for all staff relating to harassment, bullying or abuse; staff believing organisation provides equal opportunities; and improving figures where staff believe that there is discrimination by their manager or colleagues.	December 2023 December 2023

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	from manager/team leader or other colleagues, 17.6% v 5.9% for white staff 1.8% of NBT staff at NBT currently identified as disabled, but over 25% of staff have their disability status unknown. National rate is 3.6% for non-clinical and 2.9% for clinical staff (excluding medical and dental staff)	To increase self-identification of disabled staff: - to at least 3.5% in year one and - level with the national rate of 5% in year 2	 March 2023 March 2024

Report To:	Public Trust Board		
Date of Meeting:	31 March 2022		
Report Title:	Annual Gender Pay Gap Return 2021		
Report Author & Job Title	Monira Chowdhury Head of Equality, Diversity & Inclusion		
Executive/Non-executive Sponsor (presenting)	Jacqui Marshall, Chief People 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:	To note the key findings from the Trust's March 2021 Gender Pay Gap return and gender workforce profiles, agree submission of data to Equalities and Human Rights Commission and publication of data on Trust website		
Report History:	Annual Equality, Diversity and Inclusion Update and Action Plans (including Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap Returns) September 2021		
Next Steps:	Publish Gender Pay Gap Return by uploading onto Equalities & Human Rights Commission Portal and NBT website		

Executive Summary

The Trust, as an employer with more than 250 employees, must provide a Gender Pay Gap (GPG) return to the Equalities & Human Rights Commission. The Trust has an obligation to publicly publish its GPG Data Reports; this year the Trust has also produced a workforce data report by gender to complement its GPG data and other equalities data under the Workforce Race Equality and Disability Equality Standards (WRES & WDES). As part of its 2021-2022 EDI Outcomes, Priorities and Indicators a small number relate specifically to gender (sex) equality.

Our Trust co-leads the Integrated Care System BNSSG Healthier Together Equality, Diversity & Inclusion (EDI) Group, which has developed its own collaborative EDI action plan based on the combined WRES and WDES data and now intends to include gender workforce data. In 2021 there was also a requirement by NHS England & Improvement for each ICS to provide an Overhauling (Inclusive) Recruitment Action Plan. This is now the national key priority and BNSSG has sought some additional 12 month resources to delivery on 3 main priorities which

<table>
<tr><td colspan="2">will include actions relating to gender parity and equality especially within the inclusive recruitment programme.</td></tr>
<tr><td>Strategic Theme/Corporate Objective Links</td><td>Employer of choice
a. A great place to work that is diverse & inclusive
b. Empowered clinically led teams
c. Support our staff to continuously develop
d. Support staff health & wellbeing</td></tr>
<tr><td>Board Assurance Framework/Trust Risk Register Links</td><td></td></tr>
<tr><td>Other Standards Reference</td><td></td></tr>
<tr><td>Financial implications</td><td>Source of funding:
<table>
<tr><td>Option</td><td>[X]</td><td>Please provide additional information</td></tr>
<tr><td>Existing budget</td><td></td><td>NBT has an Equality Diversity & Inclusion Team consisting of 2.2 substantive posts when fully staffed (approximately £123,000 per annum)
£5,000 pa contribution towards Bristol Race Equality Strategic Leadership Group</td></tr>
<tr><td>Cost Pressure</td><td></td><td></td></tr>
<tr><td>External Funding</td><td></td><td>• BNSSG has sought funding for Health Education England to provide project management officer support to the EDI group for and an Inclusive EDI Workforce Project Manager and project officer posts for 12 months January – December 2022
• NBT EDI team has access to some £35k additional research & innovation funding (externally sourced) allocated for EDI work which will contribute towards funding workshops and focus groups with staff from gender communities</td></tr>
<tr><td>Other</td><td></td><td></td></tr>
</table></td></tr>
<tr><td>Other Resource Implications</td><td></td></tr>
</table>

Legal Implications	The Trust has legal responsibility under its Public Equality Sector Duty under the Equality Act 2010.
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	Appendix 1: Gender Pay Gap Data Return Report 2020 – 2021 Appendix 2: Gender Workforce Data 2020 - 2021

1. Purpose

1.1 The purpose of this paper is to update the Trust Board on our required data returns, to highlight progress as part of our journey on Equality, Diversity and Inclusion (EDI) at NBT and reconfirm priority areas of work and actions for the upcoming year.

2. Background

2.1 The Trust provides annual data returns to NHS England & Improvement for Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and from on Race Disparity (Model Employer); the Trust also needs to provide an annual Gender Pay Gap (GPG) return to the Equalities & Human Rights Commission. The Trust has an obligation to publish equalities data and action plans every year.

2.2 The Trust Board adopted a number of priorities and objectives at its meeting in September 2021 and as well as cross-cutting priorities, three (3) related specifically to gender (sex) equality.

2.3 BNSSG Healthier Together (Integrated Care System) has established an Equality Leads Group working on mainly workforce issues, this group is co-chaired by NBT. The Group has developed a collaborative BNSSG Action Plan and submitted an Overhauling (Inclusive) Recruitment Action Plan to NHS England and Improvement. BNSSG has obtained funding from HHE to set up an EDI workforce team for 12 months to deliver the ICS EDI priorities and action plan, which will include improved outcomes for staff by gender.

3. Summary Gender Pay Gap and Gender Workforce 2021 Data

3.1 Women (females) made up almost 76% of the workforce in 2021, up very slightly from 2018-2019's 75% and in line with the Trust's figure in 2020 and the national 2018 NHS workforce data of 77%. This compares with the 2018 overall aged 16+ England population in employment of 47% women and 53% men.

3.2 In 2021 at NBT, the average hourly rate for male staff is 21.85% (£4.70) more than the average rate paid to female staff, though this gap isn't significant, the fact that one quarter of the workforce have a higher gender pay gap over the majority female workforce, does show that wider issues related to gender pay do still need to be addressed.

3.3 Gender workforce data from the March 2021, shows the proportion of men Trust wide as 24.22%; the following divisions Core Clinical (26.04%), Facilities (46.47%), and Corporate (25.85%) have higher than the Trust average male employees. The only division with a significantly much lower proportion of men, 3.99%, in its workforce is

women's and Children. One area to be kept under review needs to be the recruitment of men in under-represented clinical divisions or specific staff groups.

3.4 In most Bands (including 8c and except 8d) women make up the majority of staff workforce and have a resulting mean average positive Gender Pay Gap (GPG) hourly rate of between £0.03 to £3.78 over men and for a very small number of non AfC staff it is £5.42 in favour of women. In a smaller number of Bands (2, 8b, 8d & 9) and medical staff groups, men outnumber women, then the average mean GPG in favour of men range from £0.21 to £5.11. This data also confirms the higher proportion of men in senior AfC grades compared to their proportion in the workforce as a whole, compared to a corresponding reduction in women in more senior roles.

3.5 The main difference in NBT's gender pay gap is specifically due to more male medical and dental staff (54.29%) compared to female medical staff (45.71%). At NBT the most significant gender pay gap disparity lies for the award of Clinical Excellence Awards (CEA), which as of 2020 is 28.24% in favour of male medical staff and the equivalent of £3,441.

3.6 In this latest year more women consultants were successful in attaining a CEA (18.18%) compared to their male/men counterparts (7.98%), which is a significant improvement from the 2018-19 figure of 12.35%. There is still a disparity of eligible female Consultants receiving the CEA (23.81%) compared to eligible male Consultants (30%). The awarding of CEA needs to be continued to be reviewed to ensure the continuing reduction in gender parity between women/female and men/male Consultants.

3.7 The ongoing gender pay gap data and gender workforce data at NBT needs to continue to be reviewed, in particular, to identify potential causes for the disparity and to work towards reducing the differing gaps between men and women both in the workforce and in pay. Clinical divisions have a clear role to consider both the gender workforce, pay differential and also look at achieving greater parity in the award of CEAs.

4. Identified Priorities for Action:

4.1 Previously Agreed Gender (Sex) Equality Priorities 2021-2022:Review sex/gender disparity for women at NBT, especially progression into senior levels and within medical staff, on the basis that these are the areas to be redressed.

a. Review particular areas of under-representation for both men and women within the Trust and take actions to address continuing under-representation through improving inclusive recruitment practices.
b. Improve menopause support, which is identified as a particular barrier for older women in the workforce.

4.2 Additional Gender Equality Actions Identified up to September 2022:

a. Conduct workshops/focus groups with staff by gender to identify barriers and continuing support.
b. Establish gendered staff networks and support groups to enable peer support.

4.3 Additional commitments and actions from the Gender Pay Gap Report 2021:

5. Reducing the Gender Pay Gap

5.1 Trust is committed to ensuring an equitable workforce and we will continue to work towards achieving the following actions. Monitoring of progress will be through the Equality, Diversity and Inclusion Committee:

- Continue the development of the Trust's talent management programme to support all employees to progress, with consideration given to supporting all staff in protected characteristic groups, including gender
- Explore how we can attract more men into the organisation at the lower bands, to create a more even gender balance in that level of the organisation.
- Raise awareness of shared parental leave entitlements and flexible working opportunities through our training and communications
- Continue to take into account gender in the development and delivery of the Trust leadership programme
- Undertake an annual review of gender split across all bands as part of the annual Public Sector Equality Duty process and take action where appropriate
- Undertake focus groups with both women and men separately on their ongoing barriers and challenges in the workforce, to contribute to setting new goals and actions
- Offer workshop sessions to women medics to determine their particular challenges to progression, including encouraging Consultants to submit Clinical Excellence Awards applications from across the workforce so gender disparity is reduced

Further investigation into data and recommended ways forward on any proposed actions that may reduce the gap to be considered through the Equality, Diversity and Inclusion Committee.

6. Summary and Recommendations

6.1 The Trust Board is asked to:

- note the key findings from the Gender Pay Gap and Gender Workforce data reports, identified priorities and planned actions.
- agree publication of Gender Pay Gap data.

Introduction

This report presents the gender pay gap for North Bristol NHS Trust and provides information to inform the Trust's ongoing commitment to equality and diversity. In calculating the gender pay gap the Trust has had the opportunity to consider how the gap at organisation level differs from that seen in certain staff groups or within individual pay bands which has supported the identification of areas for improvement. The gender pay gap is the difference in average hourly earnings between men and women. This is different to pay inequality, which compares the wages of men and women doing the same job.

Summary

Overall, the average hourly rate that North Bristol NHS Trust pays its' male employees is 21.8% higher than the average hourly rate it pays its female employees, this is higher than the wider health and social care sector which was reported as 20.4% in November 2021 (Office of National Statistics (ONS) Annual Survey of Hours and Earnings). However, this gender pay gap is largely because far more of the Trust's highly paid doctors and other medical staff are men than women, as is the case across the NHS. There has already been a lot of progress and in the past 10 years the proportion of female medical staff at the Trust has already increased from 39% to 45%, including a rise in female consultants from 25% to 37%. Of the Trust's other employees, including nursing, midwifery, scientific, therapeutic, technical, administrative and ancillary staff, women are on average paid 1.13% more per hour. The Trust's executive team, as at 31 March 2021 was made up of four women and four men, including a female chief executive, is absolutely committed to having an equitable workforce and is taking a series of actions to achieve this.

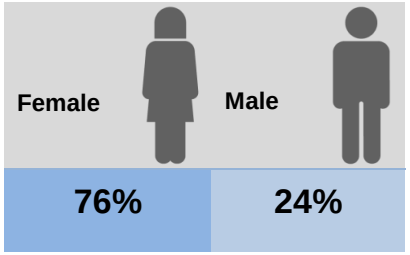
Report Content

Gender Pay Gap legislation now requires all employers of 250 or more employees to publish their gender pay gap as at 31st March 2021. The statutory requirements are set out in the tables in Sections 1 – 3. The Trust has also provided additional information in Section 4 and in the narrative to highlight the understanding gained from looking at the gender pay gap in more detail. Section 4 contains information on the pay gap set out by the national NHS Agenda for Change pay bands and for medical staff as an individual group. All pay gap percentages in this report are calculated based on the mean or median male pay for the relevant category. NBT Extra (Bank) staff have not been included in this report.

NHS Context – Terms and Conditions

The Trust uses the national job evaluation framework for Agenda for Change staff to determine appropriate pay bandings; this provides a clear process of paying employees equally for the same or equivalent work. Each grade has a set of pay points for annual progression, the longer period of time that someone has been in a grade the higher their salary is likely to be irrespective of their gender. It is important to recognise that the gender pay gap differs to equal pay. Equal pay is in relation to pay differences between men and women who carry out the same job for different pay, which is unlawful. The gender pay gap shows the difference in average pay of all men and the average pay of all women employed by the Trust. It is therefore possible to have genuine pay equality but still have a significant gender pay gap.

Gender Profile



1. **Gender Split and Pay Gap by Quartiles**

All staff irrespective of gender have been ordered based on average hourly rate of pay and then separated into four quartiles. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries.

The table below shows the split of males and females in each quartile. If medical staff are removed from the calculation all quartiles change, with the proportion of females to males in quartile four changing the most to 80% and 20% respectively. This shows the impact of medical staff on the overall Trust profile. The Trust employs more women than men in every quartile.

Quartile	Female	Male
1	75%	26%
2	78%	22%
3	83%	17%
4	67%	33%

2. Gender Pay Gap (ordinary pay)

The gender pay gap shown in the table below is for all staff in the Trust including medical staff. For non-medical staff only the mean gender pay gap is -1.14% and median gap is -11.88%. The medical workforce has a higher proportion of male staff, particularly at consultant level, which leads to the positive percentage gap. This is particularly reflected in the mean gender pay gap which can be influenced by small numbers of staff such as the medical staff.

2020-21 Mean and Median Difference

	Female	Male	Pay Gap	% Gap
Mean	£16.82	£21.53	£4.70	21.85%
Median	£15.31	£15.67	£0.37	2.34%

The table above shows the mean and median figures for NBT female and male staff. In 2019-20 the mean gap was £4.80 (22.7%) and the median gap was £0.92 (5.92%). The above figures exclude the Clinical Excellence Awards payments that are paid to eligible medical staff and these payments are shown separately under point 3.

3. Clinical Excellence Awards (CEA)

	Female	Male	Pay Gap	% Gap
Mean	£8,554.66	£11,921.76	£3,441.91	28.24%
Median	£6,032.04	£8,290.60	£2258.56	27.24%

The above calculations are for local CEA's paid to medical staff in 202020/21, these figures include award recipients from previous years who are receiving payments over several years. Under the national Medical & Dental terms and conditions, permanent and fixed-term contract medical consultants are eligible to apply for CEAs. This recognises and rewards individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role, with a commitment to the continuous improvement of the NHS.

	Female	Male
% of Eligible Consultants receiving Local CEA in 2019/20	23.81%	30.00%

The figures above are for local CEA's awarded in 2020/21. The Local CEA's are administered within the Trust on an annual basis. In the 2019/20 round 18.18% of female applicants received an award and 7.98% of male applicants received a local award.

4. Pay Gap by Band – Additional to Statutory Requirements

On a mean average, women earn more in these pay bands than men

	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8C	Non AFC
Gap Per Hour	-£0.26	-£0.08	-£0.54	-£0.64	-£0.75	-£0.03	-£3.78	-£5.42
%	-2.35%	-0.70%	-3.49%	-3.56%	-3.56%	-0.11%	-12.20%	-7.60%

On a mean average, men earn more in these pay bands than women

	Band 2	Band 8B	Band 8D	Band 9	Medical & Dental
Gap Per Hour	£0.21	£1.79	£0.19	£3.94	£5.11
%	1.88%	6.08%	0.48%	7.59%	13.31%

Reducing the Gender Pay Gap

The Trust is committed to ensuring an equitable workforce and we will continue to work towards achieving the following actions. Monitoring of progress will be through the Equality and Diversity Committee:

- Continue the development of the Trust's talent management programme to support all employees to progress, with consideration given to supporting all staff in protected characteristic groups, including gender
- Explore how we can attract more men into the organisation at the lower bands, to create a more even gender balance in that level of the organisation.
- Raise awareness of shared parental leave entitlements and flexible working opportunities through our training and communications
- Continue to take into account gender in the development and delivery of the Trust leadership programme
- Undertake an annual review of gender split across all bands as part of the annual Public Sector Equality Duty process and take action where appropriate
- Undertake focus groups with both women and men separately on their ongoing barriers and challenges in the workforce, to contribute to setting new goals and actions
- Offer workshop sessions to women medics to determine their particular challenges to progression, including encouraging Consultants to submit Clinical Excellence Awards applications from across the workforce so gender disparity is reduced

Further investigation into data and recommended ways forward on any proposed actions that may reduce the gap to be considered through the Equality and Diversity Committee.

Gender Split Head Count and Percentage Tables –

All Figures as at 31 March 2021 and excludes NBT Extra (Bank staff).

North Bristol NHS Trust Wide

	Head Count	Head Count %
Female	6912	75.78%
Male	2209	24.22%
Grand Total	**9121**	**100.00%**

Female to Male Headcount By Staff Group – All NBT Divisions

Staff Group	Female Head Count	Male Head Count	Female Head Count %	Male Head Count %	Head Count Total
Add Prof Scientific and Technic	184	56	76.67%	23.33%	240
Additional Clinical Services	1412	342	80.50%	19.50%	1754
Administrative and Clerical	1455	384	79.12%	20.88%	1839
Allied Health Professionals	460	96	82.73%	17.27%	556
Estates and Ancillary	410	382	51.77%	48.23%	792
Healthcare Scientists	262	135	65.99%	34.01%	397
Medical and Dental	473	570	45.35%	54.65%	1043
Nursing and Midwifery Registered	2200	234	90.39%	9.61%	2434
Students	56	10	84.85%	15.15%	66
Grand Total	**6912**	**2209**	**75.78%**	**24.22%**	**9121**

Female to Male Headcount By Job Band – All NBT Divisions

Staff Group	Female Head Count	Male Head Count	Female Head Count %	Male Head Count %	Head Count Total
Band 2	1202	501	70.58%	29.42%	1703
Band 3	982	218	81.83%	18.17%	1200
Band 4	688	148	82.30%	17.70%	836
Band 5	1501	255	85.48%	14.52%	1756
Band 6	1090	227	82.76%	17.24%	1317
Band 7	690	161	81.08%	18.92%	851
Band 8A	168	58	74.34%	25.66%	226
Band 8B	61	28	68.54%	31.46%	89
Band 8C	26	17	60.47%	39.53%	43
Band 8D	10	14	41.67%	58.33%	24
Band 9	9	7	56.25%	43.75%	16

Staff Group	Female Head Count	Male Head Count	Female Head Count %	Male Head Count %	Head Count Total
Medical & Dental	480	570	45.71%	54.29%	1050
Non AFC	5	5	50.00%	50.00%	10
Grand Total	**6912**	**2209**	**75.78%**	**24.22%**	**9121**

Anaesthesia, Surgery, Critical & Renal Division

Female to Male Headcount By Job Band – ASCR

Staff Group	Female Head Count	Male Head Count	Female Head Count %	Male Head Count %	Head Count Total
Band 2	160	42	79.21%	20.79%	202
Band 3	166	44	79.05%	20.95%	210
Band 4	149	18	89.22%	10.78%	167
Band 5	498	78	86.46%	13.54%	576
Band 6	221	42	84.03%	15.97%	263
Band 7	89	24	78.76%	21.24%	113
Band 8A	14	2	87.50%	12.50%	16
Band 8B	6	1	85.71%	14.29%	7
Band 8C	1		100.00%	0.00%	1
Band 8D	1		100.00%	0.00%	1
Band 9		1	0.00%	100.00%	1
Medical & Dental	156	223	41.16%	58.84%	379
Grand Total	**1461**	**475**	**75.46%**	**24.54%**	**1936**

Core Clinical Services Division

Female to Male Headcount By Job Band – CCS

Staff Group	Female Head Count	Male Head Count	Female Head Count %	Male Head Count %	Head Count Total
Band 2	187	96	66.08%	33.92%	283
Band 3	216	49	81.51%	18.49%	265
Band 4	109	36	75.17%	24.83%	145
Band 5	192	55	77.73%	22.27%	247
Band 6	275	90	75.34%	24.66%	365
Band 7	181	40	81.90%	18.10%	221
Band 8A	56	15	78.87%	21.13%	71
Band 8B	14	12	53.85%	46.15%	26
Band 8C	11	5	68.75%	31.25%	16
Band 8D	1	4	20.00%	80.00%	5
Band 9	3		100.00%	0.00%	3
Medical & Dental	47	53	47.00%	53.00%	100
Grand Total	**1292**	**455**	**73.96%**	**26.04%**	**1747**

Medicine Division

Female to Male Headcount By Job Band – Medicine

Staff Group	Female Head Count	Male Head Count	Female Head Count %	Male Head Count %	Head Count Total
Band 2	295	64	82.17%	17.83%	359
Band 3	143	24	85.63%	14.37%	167
Band 4	129	18	87.76%	12.24%	147
Band 5	393	48	89.12%	10.88%	441
Band 6	128	30	81.01%	18.99%	158
Band 7	128	22	85.33%	14.67%	150
Band 8A	17	4	80.95%	19.05%	21
Band 8B	4	1	80.00%	20.00%	5
Band 8C	1	2	33.33%	66.67%	3
Band 8D	1		100.00%	0.00%	1
Band 9	1		100.00%	0.00%	1
Medical & Dental	142	115	55.25%	44.75%	257
Grand Total	**1382**	**328**	**80.82%**	**19.18%**	**1710**

Neurosciences & Musculoskeletal Division

Female to Male Headcount By Job Band – NMSK

Staff Group	Female Head Count	Male Head Count	Female Head Count %	Male Head Count %	Head Count Total
Band 2	128	20	86.49%	13.51%	148
Band 3	144	17	89.44%	10.56%	161
Band 4	123	22	84.83%	15.17%	145
Band 5	161	28	85.19%	14.81%	189
Band 6	74	15	83.15%	16.85%	89
Band 7	105	14	88.24%	11.76%	119
Band 8A	21	6	77.78%	22.22%	27
Band 8B	7	1	87.50%	12.50%	8
Band 8C	4	1	80.00%	20.00%	5
Band 8D	2	2	50.00%	50.00%	4
Band 9		2	0.00%	100.00%	2
Medical & Dental	64	138	31.68%	68.32%	202
Grand Total	**833**	**266**	**75.80%**	**24.20%**	**1099**

Women and Children's Division

Female to Male Headcount By Job Band – WaCH

Staff Group	Female Head Count	Male Head Count	Female Head Count %	Male Head Count %	Head Count Total
Band 2	66		100.00%	0.00%	66
Band 3	117	1	99.15%	0.85%	118
Band 4	37	1	97.37%	2.63%	38
Band 5	112	2	98.25%	1.75%	114
Band 6	231		100.00%	0.00%	231
Band 7	79		100.00%	0.00%	79
Band 8A	19	1	95.00%	5.00%	20
Band 8B	5		100.00%	0.00%	5
Band 9	1		100.00%	0.00%	1
Medical & Dental	54	25	68.35%	31.65%	79
Grand Total	**721**	**30**	**96.01%**	**3.99%**	**751**

Facilities Division

Female to Male Headcount By Job Band – Facilities

Staff Group	Female Head Count	Male Head Count	Female Head Count %	Male Head Count %	Head Count Total
Band 2	336	270	55.45%	44.55%	606
Band 3	42	45	48.28%	51.72%	87
Band 4	25	33	43.10%	56.90%	58
Band 5	11	11	50.00%	50.00%	22
Band 6	6	6	50.00%	50.00%	12
Band 7	12	9	57.14%	42.86%	21
Band 8A	4	2	66.67%	33.33%	6
Band 8B	3	1	75.00%	25.00%	4
Band 8C		4	0.00%	100.00%	4
Band 8D	1		100.00%	0.00%	1
Band 9		1	0.00%	100.00%	1
Grand Total	**440**	**382**	**53.53%**	**46.47%**	**822**

Corporate Divisions

Female to Male Headcount By Job Band – Corporate Divisions

Staff Group	Female Head Count	Male Head Count	Female Head Count %	Male Head Count %	Head Count Total
Band 2	30	9	76.92%	23.08%	39
Band 3	154	38	80.21%	19.79%	192
Band 4	116	20	85.29%	14.71%	136
Band 5	134	33	80.24%	19.76%	167
Band 6	155	44	77.89%	22.11%	199
Band 7	96	52	64.86%	35.14%	148
Band 8A	37	28	56.92%	43.08%	65
Band 8B	22	12	64.71%	35.29%	34
Band 8C	9	5	64.29%	35.71%	14
Band 8D	4	8	33.33%	66.67%	12
Band 9	4	3	57.14%	42.86%	7
Medical & Dental	17	16	51.52%	48.48%	33
Non AFC	5	5	50.00%	50.00%	10
Grand Total	**783**	**273**	**74.15%**	**25.85%**	**1056**

Report To:	Public Trust Board		
Date of Meeting:	31 March 2022 (Report covering 01/11/21 – 28/02/22)		
Report Title:	Guardians of Safe Working (Junior Doctors)		
Report Author & Job Title	Dr Lucy Kirkham Trust Guardian for Safe Junior Doctor Working		
Executive/Non-executive Sponsor (presenting)	Direct to Trust Board		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	X
Recommendation:	The Board of Directors will discuss current pandemic Junior Doctor contract issues and as a public authority must, in the exercise of its functions, have due regard to the need to: • All contractual obligations in place • Be satisfied that the role of Trust Guardian is being fulfilled • Exception Reports being acted upon • Gaps on Junior Rotas being filled as a priority • Risks to Trust considered – Guardian fines; accountability; staffing		
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 • Consideration of converting some Clinical Fellow positions to Physicians Associate posts to stabilise and support NBT's workforce		

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 JDF

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 Junior Doctor Forum – 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.

Strategic Theme/Corporate Objective Links	• Junior Contract 2016 conditions with amendments under discussion by NHS Employers and BMA • Follow the timelines for implementation of the 2019 and 2020 contract refreshes • Trust aim should be for all rotas to be fully staffed
Board Assurance Framework/Trust Risk Register Links	• eRostering to alert contract breaches and enable leave booking for trainees. • Exception's alert ISCs

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

Total number of trainees and Clinical Fellows = **571** (194 are Clinical Fellows)
All are on the 2016 T&Cs including the Clinical Fellows

1. **ROTA GAPS** - All gaps are detrimental to patient care and JD training; every effort should be made to fill them

NBT has done well to have so few rota gaps due in part due to a successful CF appointment process. NBT is however an outlier as 1/3 of junior doctors are Clinical Fellows – making NBT more vulnerable to seasonal departure of CFs to go travelling before taking up a numbered post

Seasonal departure leads to increased locum requests, cost and workload on remaining trainees leading to an increase in Exception reporting

Medicine Bank	Mar 2021	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb 2022
Hrs requested	**2408**	**2524**	**3028**	**2850**	**4308**	**2769**	**1933**	**1536**	**2055**	**2354**	**2832**	**3227**
Hours filled	**2257**	**2307**	**2775**	**2300**	**2490**	**2340**	**1579**	**1268**	**1762**	**2079**	**2587**	**2849**
Deficit	**151**	**217**	**253**	**550**	**1818**	**429**	**354**	**268**	**358**	**275**	**245**	**378**

Unfilled trainee and Clinical Fellow gaps March:

DIVISION	Trainee gaps	CF gaps
ASCR	6	22
NMSK	0	6
Core Clinical	2	0
W&C	0	1
Medicine	7	8
TOTAL	15	37

2. **GAP MANAGEMENT**

A. CF Adverts

- Recruitment into CF gaps is continuous and ongoing
- 11 new starters recruited into April gaps.
    - 7 of these are currently Medical Support Workers (MSW)
        - All bar one will be 100% clinical
        - Once in the role of a clinical fellow a MSW can work as a doctor, within their competency. All have passed the English language test for GMC registration.

B. Medical Support Workers

- 29 Doctors from Myanmar started at NBT Nov 2021 – 1 year contract
- MSW lead looking to put together a business case for extending MSW use at NBT.

C. Optimising NBT locum reach

- JDF suggestion of using 'Locum Nest' app – successfully used at Gloucester/Cheltenham
- A pilot of LocumNest was approved at NBT Workforce Transformation Programme Board on 17/2/22
- Finance Dept meeting scheduled this month to approve the £18k initial revenue needed for the pilot
- A demo for piloting Locum Nest occurred on 9/3/22 with representatives from NBT Emergency Zones

D. Decrease dependence on CFs by converting more CF posts into Physicians Associate posts

- Potential conversion of 2-3 CF into substantive PA posts in April on COTE
- 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.
- If supported by the Execs the conversion of further CF posts would **need support at a specialty level to ensure appropriate uptake and integration of the PAs into the team**

Advantages of PAs:

- Already have 8 working at NBT with calls currently for up to 8 more across the Divisions
- We train 24 a year so have an in-house pool familiar with NBT ways of working
- Permanent experienced member of the team – helps with JD changeover time
- Can train juniors
- Work at Junior Doctor level – admitting, discharging, examining, taking blood, forming a differential, can transcribe drug charts
- Not subjecting NBT to seasonal departure gaps
- Work clinically 100% (majority of current CFs are 80% clinical)
- Can work out of hours

Disadvantages of PAs:

- Currently cannot order X-ray or CT or prescribe – this will change once under GMC regulation >2023
- Not on 2016 JD T&Cs so integration into JD minimal ward staffing levels and leave allocation needs consideration

3. LOCUM USAGE - BANK AND AGENCY – 01/11/21 – 28/02/22

BY DIVISION: Biggest user of Bank – Medicine

Locum Bookings (Bank) by Department	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
ASCR Division	462.00	4327.00	3700.50	£250,921.60
Clinical Governance Division	37.00	225.50	225.50	£11,852.50
Core Clinical	17.00	249.50	206.50	£17,092.50
HR Division	3.00	22.00	22.00	£735.00
Medicine Division	1162.00	10469.65	9278.65	£538,922.65
NBT Extra Bank Division	26.00	173.25	172.25	£8,368.75
Neuro & MSK Division	742.00	7475.75	4755.75	£406,013.75
People & Transformation Division	8.00	64.50	48.50	£3,487.50
W&C Division	77.00	731.75	718.75	£45,139.25
Winter Pressures	1059.00	8910.50	6859.50	£398,707.50
Grand Total	**3593.00**	**32649.40**	**25987.90**	**£1,681,241.00**

Previous 4 month (Summer -July-Oct) spend: £1,361,491

Locum Bookings (Agency) by Department	Requested Shifts	Requested Hours	Agency Filled	Estimated Cost
Neuro & MSK Division	61	587.5	587.5	£41,025.00
Grand Total	**61**	**587.5**	**587.5**	**£41,025.00**

BY GRADE: Commonest grade is F2/ST1-2

Locum Bookings (Bank) by Grade	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
Locum CF	8	92	67	£4,387.50
Locum F1	82	654.25	448.75	£26,103.75
Locum F2-ST1-2	2479	21807.82	17345.07	£1,002,395.40
Locum ST3+	1024	10095.33	8127.08	£648,354.35
Grand Total	**3593**	**32649.4**	**25987.9**	**£1,681,241.00**

Locum Bookings (Agency) by Grade	Requested Shifts	Requested Hours	Agency Filled	Estimated Cost
Locum ST3+	61	587.5	587.5	£41,025.00
Grand Total	**61**	**587.5**	**587.5**	**£41,025.00**

BY REQUEST REASON – Commonest reasons are additional capacity and then vacancy

Locum Bookings (Bank) by Request Reason	Requested Shifts	Requested Hours	Agency Filled	Estimated Cost
Additional Capacity	1878	17000.98	12608.23	£869,830.65
Annual Leave	71	547	503	£32,690.00
Bereavement Leave	15	161.25	125.75	£8,163.75
Covid 19	141	1281.75	875.75	£65,841.40
Emergency Domestic Carer Leave	3	38	25.5	£2,125.00
Sickness	211	1948.5	1518	£111,218.00
Study Leave	16	155.5	102.5	£6,822.50
Vacancy	1217	11140.42	9906.17	£560,377.20
Waiting List Initiative	20	145.5	134.5	£10,162.50
Parental Leave	20	222	180	£13,570.00
Allocate on Arrival	1	8.5	8.5	£440.00
Grand Total	**3593**	**32649.4**	**25987.9**	**£1,681,241.00**

Locum Bookings (Agency) by Request Reason	Requested Shifts	Requested Hours	Agency Filled	Estimated Cost
Additional Capacity	61	587.5	587.5	£41,025.00
Grand Total	**61**	**587.5**	**587.5**	**£41,025.00**

4. EXCEPTION REPORTS - 01/11/21 – 28/02/22

Exception Reports (ER) over past 4 months		Number flagged as immediate safety concern (ISC)
Number relating to hours of working	100	0
Number relating to pattern of work	1	0
Number relating to educational opportunities	5	0
Number relating to service support available to the doctor	3	0
TOTAL NUMBER OF EXCEPTION REPORTS	**109**	**0**

175 reports in previous 4-month period

BREAKDOWN OF REPORTS

IMMEDIATE SAFETY CONCERNS - 0

Previous 4 months had 3 ISCs relating to Med reg rota:

Discussed at JDF, med reg rota now in improved position, well managed by Dr Richards. No further ISCs

EDUCATIONAL EXCEPTION REPORTS - 5

Number of exceptions	Rota	Issues
2	F1 Medicine* cardiology	Not able to attend mandatory F1 teaching due to workload/staffing on ward Unable to attend mandatory F1 teaching due to workload - 3 doctors on ward
1	F1 Surgery* vascular	Unable to attend compulsory foundation teaching. Ward staffing was 2xF1 and 1x clinical fellow. Both F1s expected to go to teaching. Both F1s leaving ward would have meant jobs not getting done on time or not at all. Decision made for one F1 to stay on the ward to complete jobs and one to go to teaching. Multiple discharges on the day and dealing with acutely unwell patients
1	Neurosci F2*	Doctors being unable to go to clinic or acute bleep days due to staffing numbers and high patient load
1	F2/CT acute block*	Unable to attend scheduled teaching. Ward short of consultants this week so ward round having to take place across both sides of the ward. Very unwell patients on my side, WR finished 14:15.

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

'HOURS' EXCEPTION REPORTS BY ROTA AND OUTCOME Most reports from medicine rotas

Rota	Outcome TOIL	Outcome Payment	Pending	No further action	TOTAL Reports
F1 Medicine	4	18	11	2	**35**
F2/CT Acute Block A	3	9	5	3	**20**
Renal Medicine F1 NWD	5	6	3		**14**
Clinical Fellow CT1-2 Medicine	2	2	2	2	**8**
Renal Medicine F2-CT		5			**5**
General Surgery F2 - CT	2	3			**5**
Medicine ST3+ 22 doctor			3		**3**
Vascular CT NWD		3			**3**
Neurosci F2 - C/ST2 15		2			**2**
Urology CT1/2 ST1/2 2021			2		**2**
T&O F2 CT x 14	1	1			**2**
T&O F1			1		**1**
TOTAL					**100**

5. **JUNIOR DOCTOR FORUM** – Held in person and via Teams in Jan 2022 and Mar 2022
   - Format change after D/W junior reps – 30 – 40min JDF, Exec joins; 10 min Trust update & 10 min questions
     - Improved attendance 10-20 trainees each JDF
   - Terms of reference refreshed in Jan – outlining attendance after leaving NBT
   - Re-instated Reps as of August – currently 22 reps across specialties
   - Ideas generated in JDF – app for locum contacts, regular meeting with med rota/management to feedback real time

Other issues arising:

1. **Possible lack of awareness of process/value of exception reporting**
   - → New hyperlink to Allocate on Trust all apps intranet space – May 2021
     - Signposted via posters in Mess
   - →Refreshed video for junior induction for August
   - →Lecture delivered to Foundation doctors – plan to deliver each August
   - → Reps appointed - part of role to champion exception reporting
   - →Monthly GOSW update newsletter with tips on exception reporting
   - →Monthly 'You said, we did' exception reporting element in a new GOSW newsletter to all trainee doctors

2. **Anecdotal evidence that exception reporting is seen as 'complaining' by some consultants and trainees**
   - →New video for educational supervisor update days recorded asking them to signpost and encourage exception reporting at their first trainee meetings
   - More needs to be done to change the culture around exception reporting
     - Exception reporting championing by consultants in departments?

3. **Rota pattern issues discussed with the departments and HR since last Board presentation**
   - Gaps on Med Reg on-call rota – unable to be filled
     - Triggered ISCs – actions taken outlined earlier in report

4. **Allocate not very user friendly/does not 'encourage' exception reporting**
   - Consideration when Allocate contract expires (18 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 trainees rota if agreed
     - Shows trainee what they are paid if payment is agreed
     - Calculates fines
     - Greater end user refinement in defining exception types

Networking

- The Guardian is in contact by WhatsApp and Zoom with national and regional groups
- NHS-Employers remote meetings to network with them and other Guardians
- Allocate training sessions x 3
- Webinar GOSW conference – Dec 9th 2021 - attended
- Benchmarking data from other local GOSW:

	Glos	GWH	NBT
Number of 'Doctors in Training' DiT	**487**	**295**	**570**
Trainees	417	199	400
Clinical Fellows	70	96	170
Hours Exceptions per DiT/QTR	0.22	0.5	0.21

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

SUMMARY

NBT is compliant with:

- BMA contract rules
- Electronic reporting system in place (eAllocate)
- Junior Doctor Forum – meetings being held as required by New Contract
- Exception Reporting Policy
- LNC involvement
- All national requirements as listed by NHS Employers

Concerns:

- Unfilled gaps in rotas remain a concern.
- Are the current levels of exception reporting a true representation of junior doctor hours/breaks?
- Is Allocate the best system for encouraging exception reporting?
- Management of seasonal departure of CFs and the gaps that leaves on the rota

Recommendations:

1. The Board are asked to read and note this report from the Guardian of Safe Working
2. The Board are asked to note ongoing Junior Doctor Contract changes.
3. The Board are asked to consider the appointment of PA to previously held CF posts
4. The Board are asked to look competitively at other providers of exception reporting software when the current contract expires

Dr Lucy Kirkham, Trust Guardian for Safe Junior Doctor Working

Report To:	Public Trust Board		
Date of Meeting:	31 March 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 page six of the Integrated Performance Report.	
Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services c. A Centre of Excellence for specialist healthcare d. A powerhouse for pathology & imaging **2. Developing Healthcare for the future** a. Training, educating and developing our workforce b. Increase our capability to deliver research c. Support development & adoption of innovations d. Invest in digital technology **3. Employer of choice** a. A great place to work that is diverse & inclusive

	b. Empowered clinically led teams c. Support our staff to continuously develop d. Support staff health & wellbeing
Board Assurance Framework/Trust Risk Register Links	The report links to the BAF risks relating to internal flow, staff retention, staff engagement, productivity and clinical complexity.
Other Standard Reference	CQC Standards.
Financial implications	Whilst there is a section referring to the Trust's financial position, there are no financial implications within this paper.
Other Resource Implications	Not applicable.
Legal Implications including Equality, Diversity and Inclusion Assessment	Not applicable.
Appendices:	Not applicable.

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

March 2022 (presenting February 2022 data)

CONTENTS

North Bristol Integrated Performance Report

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Trend	Benchmarking (in arrears except A&E & Cancer as per reporting month)		
																			Peer Performance	Rank	Quartile
Responsive	A&E 4 Hour - Type 1 Performance	R	95.00%	65.00%	73.33%	81.05%	74.26%	72.71%	64.38%	54.36%	61.47%	61.75%	60.82%	60.18%	61.80%	60.78%	51.53%		51.66%	6/10	
	A&E 12 Hour Trolley Breaches	R	0	0	7	0	6	0	4	97	14	38	29	59	20	295	367		0-723	9/10	
	Ambulance Handover < 15 mins (%)		100.00%	-	60.97%	58.17%	50.28%	51.07%	48.46%	39.75%	37.84%	41.26%	36.19%	24.32%	20.33%	22.25%	28.72%				
	Ambulance Handover < 30 mins (%)	R	100.00%	-	92.75%	89.36%	79.42%	80.43%	73.44%	60.62%	66.21%	64.67%	56.62%	53.71%	50.34%	47.71%	48.49%				
	Ambulance Handover > 60 mins		0	-	57	83	272	199	346	636	471	418	621	664	645	827	684				
	Stranded Patients (>21 days) - month end				129	136	272	116	123	277	144	149	148	177	189	210	204				
	Right to Reside: Discharged by 5pm	R	50.00%		29.43%	30.89%	35.87%	31.83%	33.53%	33.25%	28.27%	29.57%	27.50%	24.49%	23.79%	23.89%	22.21%				
	Bed Occupancy Rate			93.00%	92.74%	92.49%	95.25%	95.23%	96.63%	95.96%	95.32%	97.20%	97.26%	97.12%	96.92%	98.16%	97.91%				
	Diagnostic 6 Week Wait Performance		1.00%	31.56%	27.20%	24.72%	29.45%	31.99%	36.13%	38.91%	42.55%	42.83%	41.80%	40.32%	44.30%	45.45%	40.00%		34.32%	8/10	
	Diagnostic 13+ Week Breaches		0	0	1358	1364	1513	1779	2054	2183	2180	2724	3029	2913	3501	3948	3951		59-3948	10/10	
	Diagnostic Backlog Clearance Time (in weeks)				0.8	0.8	0.9	1.1	1.3	1.3	1.4	1.6	1.5	1.5	1.7	1.8	1.6				
	RTT Incomplete 18 Week Performance		92.00%	-	70.65%	71.64%	73.59%	74.29%	74.98%	73.78%	73.16%	71.87%	70.37%	69.68%	66.67%	65.61%	65.17%		58.67%	4/10	
	RTT 52+ Week Breaches	R	0	2337	2108	2088	1827	1583	1473	1544	1770	1933	2068	2128	2182	2284	2296		35-11262	5/10	
	RTT 78+ Week Breaches	R		-	-	-	363	424	448	532	656	659	577	497	469	501	511		0-3926	5/10	
	RTT 104+ Week Breaches	R		59	-	-	5	12	19	28	34	55	93	138	158	184	177		0-1479	5/10	
	Total Waiting List	R		41279	29716	29580	31143	31648	32946	34315	35794	36787	37268	37297	37264	37210	38498				
	RTT Backlog Clearance Time (in weeks)				2.5	2.5	2.7	3.3	2.6	1.8	1.5	1.7	1.7	1.8	1.9	2.0	2.2				
	Cancer 2 Week Wait	R	93.00%	90.51%	70.87%	63.24%	39.53%	36.58%	36.44%	53.40%	66.58%	51.22%	42.70%	53.75%	58.38%	41.42%	-		68.54%	10/10	
	Cancer 2 Week Wait - Breast Symptoms		93.00%	96.15%	36.17%	15.20%	6.18%	9.21%	17.19%	71.23%	84.35%	74.64%	28.13%	6.15%	11.54%	6.90%	-		24.41%	9/10	
	Cancer 31 Day First Treatment		96.00%	96.69%	95.96%	96.62%	94.40%	97.38%	95.48%	95.77%	93.00%	91.89%	88.51%	86.94%	79.59%	79.18%	-		90.01%	10/10	
	Cancer 31 Day Subsequent - Drug		98.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.45%	96.30%	100.00%	100.00%	92.31%	-		95.56%	8/10	
	Cancer 31 Day Subsequent - Surgery		94.00%	97.95%	84.44%	85.48%	81.18%	86.73%	84.62%	90.80%	72.84%	80.90%	69.62%	65.77%	65.59%	55.66%	-		77.05%	10/10	
	Cancer 62 Day Standard	R	85.00%	86.39%	74.34%	76.09%	75.00%	77.11%	62.74%	68.59%	68.60%	56.98%	57.34%	74.07%	67.52%	56.88%	-		64.24%	8/10	
	Cancer 62 Day Screening		90.00%	80.00%	86.79%	68.18%	73.68%	54.72%	73.33%	86.36%	52.54%	75.00%	42.55%	68.75%	53.25%	50.00%	-		63.46%	8/10	
	Cancer 28 Day Faster Diagnosis	R	75.00%	90.25%	-	-	66.39%	54.73%	43.56%	65.46%	66.77%	56.07%	59.95%	66.29%	57.52%	47.10%	-		62.02%	10/10	
	Cancer PTL >62 Days			280	-	-	-	-	-	-	-	-	501	663	899	781	528				
	Cancer PTL >104 Days		0	-	57	67	64	64	100	162	139	170	158	108	140	197	135				
	Mixed Sex Accomodation		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
	Electronic Discharge Summaries within 24 Hours		100.00%		83.58%	84.72%	84.43%	82.53%	83.25%	82.91%	83.13%	81.59%	82.08%	83.02%	82.01%	81.17%	83.35%				

Please note Ambulance Handover data (<15 mins, <30 mins, >60 mins) for November 2021 onwards is provisional

North Bristol Integrated Performance Report

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Trend
Quality Patient Safety & Effectiveness	5 minute apgar 7 rate at term			0.90%	0.51%	0.43%	0.70%	0.95%	0.69%	1.51%	1.15%	0.62%	1.26%	0.22%	1.15%	0.73%	0.00%	
	Caesarean Section Rate			28.00%	38.69%	40.28%	37.44%	33.11%	40.09%	39.36%	34.88%	38.74%	37.35%	39.23%	40.60%	39.15%	38.14%	
	Still Birth rate			0.40%	0.23%	0.00%	0.43%	0.22%	0.00%	0.20%	0.00%	0.57%	0.39%	0.21%	0.21%	0.22%	0.00%	
	Induction of Labour Rate			32.10%	33.80%	33.81%	35.24%	37.14%	35.29%	37.35%	35.31%	33.40%	29.05%	34.12%	35.21%	33.56%	38.39%	
	PPH 1500 ml rate			8.60%	3.94%	3.23%	3.07%	4.03%	5.17%	2.00%	2.11%	2.10%	3.94%	3.59%	3.02%	2.01%	2.44%	
	Never Event Occurrence by month		0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	
	Commissioned Patient Safety Incident Investigations				-	-	-	-	-	2	2	3	2	1	1	5	1	
	Healthcare Safety Investigation Branch Investigations				-	-	-	-	-	1	2	-	1	-	-	1	0	
	Total Incidents				878	1005	1034	1071	1027	1173	985	1058	982	993	998	1129	1107	
	Total Incidents (Rate per 1000 Bed Days)				45	46	46	44	43	48	40	43	39	42	41	44	206	
	WHO checklist completion			95.00%	99.84%	100.00%	99.84%	99.84%	99.93%	99.80%	99.70%	99.71%	99.32%	99.84%	99.87%	99.72%	99.40%	
	VTE Risk Assessment completion	R		95.00%	95.10%	95.38%	95.46%	95.46%	95.38%	95.52%	94.83%	94.85%	94.44%	93.19%	91.03%	93.47%	-	
	Pressure Injuries Grade 2				27	7	9	10	15	17	22	24	19	12	16	16	19	
	Pressure Injuries Grade 3			0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Pressure Injuries Grade 4			0	0	0	0	0	0	0	0	0	0	0	1	0	1	
	PI per 1,000 bed days				0.82	0.19	0.30	0.29	0.48	0.51	0.72	0.75	0.51	0.32	0.35	0.41	0.75	
	Falls per 1,000 bed days				8.63	8.44	8.33	8.70	8.53	8.36	7.84	7.24	7.33	7.48	8.29	9.88	8.72	
	#NoF - Fragile Hip Best Practice Pass Rate				69.05%	78.38%	57.78%	53.49%	68.00%	68.18%	76.32%	34.62%	35.71%	100.00%	65.00%	78.13%	-	
	Admitted to Orthopaedic Ward within 4 Hours				54.76%	44.68%	71.11%	48.84%	44.00%	51.11%	28.95%	38.46%	28.57%	40.00%	20.00%	18.75%	-	
	Medically Fit to Have Surgery within 36 Hours				80.95%	89.36%	71.11%	65.12%	80.00%	71.11%	86.84%	42.31%	36.36%	100.00%	85.00%	78.13%	-	
	Assessed by Orthogeriatrician within 72 Hours				97.62%	97.87%	93.33%	81.40%	92.00%	93.33%	100.00%	84.00%	77.78%	100.00%	95.00%	93.75%	-	
	Stroke - Patients Admitted				61	96	91	100	91	75	92	83	90	85	73	103	62	
	Stroke - 90% Stay on Stroke Ward			90.00%	83.33%	81.08%	98.26%	86.76%	80.82%	87.30%	81.43%	77.94%	78.13%	68.06%	75.00%	67.07%	-	
	Stroke - Thrombolysed <1 Hour			60.00%	44.00%	78.00%	100.00%	50.00%	70.00%	85.71%	90.91%	50.00%	27.27%	66.67%	100.00%	84.62%	-	
	Stroke - Directly Admitted to Stroke Unit <4 Hours			60.00%	60.00%	48.68%	47.89%	52.00%	49.33%	46.20%	39.19%	34.29%	40.58%	45.95%	30.16%	40.66%	-	
	Stroke - Seen by Stroke Consultant within 14 Hours			90.00%	91.55%	90.00%	85.14%	90.36%	92.11%	95.45%	88.00%	95.95%	97.18%	84.21%	80.88%	81.25%	-	
	MRSA	R	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
	E. Coli	R		4	1	6	4	5	4	1	5	3	8	3	2	6	1	
	C. Difficile	R		5	9	4	10	6	10	6	2	5	4	1	6	6	1	
	MSSA			2	3	0	4	1	5	2	5	4	1	0	5	3	2	
Quality Caring & Experience	Friends & Family - Births - Proportion Very Good/Good				-	94.26%	95.51%	95.51%	94.74%	92.68%	95.95%	91.30%	98.53%	91.53%	93.75%	93.85%	94.37%	
	Friends & Family - IP - Proportion Very Good/Good				95.72%	93.68%	92.90%	94.52%	91.79%	92.85%	91.94%	92.16%	92.25%	92.52%	91.50%	93.28%	93.51%	
	Friends & Family - OP - Proportion Very Good/Good				95.29%	94.63%	94.90%	95.09%	94.40%	94.65%	94.54%	93.77%	94.80%	94.21%	95.26%	94.37%	94.11%	
	Friends & Family - ED - Proportion Very Good/Good				89.21%	87.24%	84.86%	82.00%	73.19%	71.84%	72.87%	74.81%	73.94%	74.24%	80.64%	80.10%	70.24%	
	PALS - Count of concerns				71	79	108	88	127	127	123	123	100	93	86	100	102	
	Complaints - % Overall Response Compliance			90.00%	84.38%	85.11%	79.07%	83.33%	77.03%	85.71%	87.72%	77.36%	69.12%	72.13%	69%	69.23%	80.85%	
	Complaints - Overdue				0	0	0	0	0	2	1	8	10	10	6	11	4	
	Complaints - Written complaints				43	42	56	67	51	65	48	52	55	59	44	52	58	
Well Led	Agency Expenditure ('000s)				544	1042	#N/A	816	1029	1374	1061	1492	1576	1350	1321	1363	1147	
	Month End Vacancy Factor				3.65%	3.62%	#N/A	4.81%	5.53%	6.52%	6.55%	6.28%	6.53%	6.13%	7.55%	6.97%	7.18%	
	Turnover (Rolling 12 Months)	R		12.00%	12.56%	12.36%	13.37%	13.60%	13.81%	12.97%	14.21%	13.92%	15.35%	15.57%	15.80%	16.26%	15.28%	
	Sickness Absence (Rolling 12 month -In arrears)	R		-	4.48%	4.42%	4.32%	4.31%	4.31%	4.36%	4.42%	4.46%	4.53%	4.55%	4.59%	4.67%	-	
	Trust Mandatory Training Compliance				85.91%	85.40%	85.17%	84.95%	84.55%	82.82%	82.58%	82.32%	82.12%	81.97%	82.13%	82.23%	82.27%	

EXECUTIVE SUMMARY
March 2022

Urgent Care
Four-hour performance deteriorated in February with performance of 51.53% in line with deterioration across peers for the same period; the Trust ranked sixth out of ten reporting AMTC peer providers. The Trust recorded 684 (provisional data) ambulance handover delays over one hour. There was an in 12-hour trolley breaches with 367 reported in month; there were over 16,000 reported nationally. Four hour performance and ambulance handover times were impacted by high bed occupancy at an average of 97.91% for the month. The COO has commissioned a deep dive into the high occupancy position as a primary driver of current UEC performance. Key drivers include increased volume of bed days for patients no longer meeting the right to reside criteria, awaiting discharge on D2A pathways. Trust-wide internal actions are focused on improving the timeliness of discharge, achieving Internal Professional Standards, maximising SDEC pathways and weekend discharge rate improvements. The low level of complex discharges for the next quarter remains a risk, but is subject to a new national reduction target.

Elective Care and Diagnostics
The overall RTT waiting list increased to 38498 in February; long waiting times are resulting from reduced elective capacity due to earlier COVID-19 waves and operational pressures on the bed base, but continues to compare favourably with combined national Acute provider growth. There were 2,296 patients waiting greater than 52-weeks for their treatment in November, 511 of these were patients waiting longer than 78-weeks and 177 were waiting over 104-weeks. When compared nationally, the Trust's positioning was static in January and remains in the third quartiles for 18-week and 78-week performance, and the fourth quartiles for 52-week and 104-week performance. The Trust continues to treat patients based on their clinical priority first, followed by length of wait. Diagnostic performance deteriorated in February with performance of 40.00%. The Trust is sourcing additional internal and external capacity for several test types to support recovery of diagnostic waiting times.

Cancer Wait Time Standards
There were a number of movements in the position for Cancer with TWW and 62-Day standards deteriorating to 41.42% and 56.88% respectively. However, the 31-Day broadly held its position. However, significant progress was made on the on the total backlog with 528 patients breaching compared with the peak of c.900 patients in December. In addition, the patients waiting over 104-Days also improved. Instances of clinical harm remain low month-on-month and the Trust has only identified one moderate harm in the last 12-months as a result of delays over 104-Days.

Quality
In maternity, workforce gaps across specialities continue to be challenging, exacerbated by staff absence related to COVID-19. The Trust has continued to have Outbreaks in clinical areas and have managed this with outbreak management and hierarchy of controls. There have been no MRSA cases reported since February 2021, C. Difficile rate remains higher than trajectory, though there has been a slower projected growth of cases.The rate of VTE Risk Assessments performed on admission fell and is below the national target of 95% compliance. For mortality rates, NBT remains nationally in the lowest quartile for SHMI indicating a lower mortality rate than most other Trusts, with no current Mortality Outlier alerts.

Workforce
Temporary staffing demand decreased by 2.72% (34.18wte) in February, however bank hours worked reduced by a greater amount -10.20% (-78.34 wte); this reduction in bank hours worked was predominantly seen in registered nursing and midwifery (-18.92 wte) and in unregistered nursing and midwifery (-42.78wte). Average hours worked were consistent each week in February meaning half term did not impact on bank hours worked . The vacancy factor increased slightly to 7.05% in February from 6.93% in January, driven by decreases in staff in post (-9.52wte). Rolling 12 month sickness absence increased to 6.13% in January from 5.20% in December. The initial view of the February absence position shows a 7.09% decrease in days lost, predominantly driven by a decrease in absence due to Infectious Diseases (COVID-19 related absence).

Finance
The financial framework for 2021/22 requires the Trust to deliver core operations within an agreed financial envelope and, manage costs incurred in dealing with the COVID-19 pandemic in line with COVID-19 funding provided. The financial performance for the year 2021/22 remains to breakeven as set out in the Trust Board approved budget paper. The Half 2 financial plan has been developed and shows a plan to breakeven, this plan includes non-recurrent income and expenditure. The actual result for Month 11 is a breakeven position and for year to date is also breakeven. The forecast outturn is that the Trust will achieve the breakeven plan at year end, as well as delivering the capital plan.

RESPONSIVENESS
SRO: Chief Operating Officer
Overview

Urgent Care

The Trust reported four-hour performance of 51.53% in February. Ambulance handover delays were lower than the previous month with 684 handovers exceeding one hour reported (provisional data). The Trust reported a significant increase in 12-hour trolley breaches with 367 in month. Bed occupancy varied between 95.05% and 99.67% of the core bed base. Ambulance arrivals remain consistent with pre-pandemic levels and continued to be particularly challenged due to multifactorial issues including the impact of COVID-19 admissions on flow and capacity, low morning discharge rates and reduced discharges to post acute community and domiciliary care. The current Urgent Care work stream plan is being re-reviewed by clinical and operational teams, to refocus efforts into a single urgent and emergency care plan for 2022/23 and beyond.

Planned Care

Referral to Treatment (RTT) – The number of patients exceeding 52-week waits in February was 2,296 the majority of breaches (963; 41.94%) being in Trauma and Orthopaedics. The overall proportion of the wait list that is waiting longer than 52-weeks is 5.95% which is marginally down compared to the previous month. The Trust is focussing on the treatment of patients who are waiting over 104-weeks or are at risk of waiting that long for their treatment; this is whilst maintaining timely access to treatment for those with the greatest clinical need. In February, there was access to an additional Elective Care ward, which enabled the Trust to work towards further reducing the number of patients waiting greater than 104-weeks for their treatment. The predicted 104-week wait position at year-end is 99 patients, including those who have chosen to further defer their treatment for social reasons.

Diagnostic Waiting Times – Diagnostic performance improved in February with performance of 40.00%, though failed to meet the improvement trajectory of 31.56%. The number of patients waiting longer than 13-weeks was static in February at 3,951 (3,948) in January. The current improvements have been mainly driven within Endoscopy, CT and Non-Obstetric Ultrasound A high level review continues to be completed for patients exceeding 13-weeks to ensure no harm has resulted from the extended wait times. In December, NBT ranked 8th amongst 10 peer providers for 6-week performance and 10th for 13-week performance.

Cancer

The TWW and 62-Day CWT standards and trajectories saw an overall drop on last month's performance. The Trust continues to carry backlogs in Breast and Colorectal which is impacting on TWW and in Skin and Urology within the 62-Day pathways. Breast services continue to run waiting list initiative sessions as part of the internal recovery plan. 62-Day PTL tracking is ongoing with the current reported position at 485 (a significant improvement from the peak position of c.900). The 104-Day reduction trajectory is expected to achieve a position of 30 – 60 patients breaching by year-end; this is within the pre-pandemic range.

Areas of Concern

The main risks identified to the delivery of national Responsiveness standards are as follows:

- Lack of community capacity and/or pathway delays fail to support bed occupancy requirements.
- The ongoing impact of COVID-19 Infection Prevention and Control measures and Clinical Prioritisation guidance on the Trust's capacity and productivity and therefore, ability to deliver national wait times standards.
- The continued pressure of unfilled nursing shifts to safely manage escalation capacity in times of high bed demand.

QUALITY PATIENT SAFETY AND EFFECTIVENESS
SRO: Chief Medical Officer and Chief Nursing Officer
Overview

Improvements

Infection control: There were no cases of MRSA bacteraemia reported in February 2022 (last one for Trust reported in February 2021). Whilst the *C. Difficile* rate remains higher than trajectory, we have noted a slower projected growth of cases.

Mortality Rates/Alerts: NBT remains nationally in the lowest quartile for SHMI indicating a lower mortality rate than most other Trusts, with no current Mortality Outlier alerts. High completion rates of mortality reviews continue, with Medical Examiner reviews and referrals into Trust governance processes operating effectively to address family concerns and integrate with coronial cases.

Areas of Concern

Infection control: NBT has continued to have Outbreaks in clinical areas and have managed this with outbreak management and hierarchy of controls. We have seen Outbreaks in NMSK Division in a number of areas that have required specific input and escalation to DMT due to the nature of the patient group and ward visits from multiple staff. The planned re-focus on MRSA , MSSA , C.Diff and E. Coli has proved to be a challenge due to the COVID position and Outbreak situation but will actively commence as we move into Q1 of the 2022/23 financial year.

Maternity: Workforce gaps across all specialities continue to be challenging. The biggest impact on staffing is related to staff absence due to COVID precautions, impacting on quality improvement work. A range of actions are underway for Midwifery and medical staff recruitment, with a number of Band 5 & 6 midwives successfully recruited to start from March 2022.

VTE Risk Assessment: The rate of VTE Risk Assessments performed on admission remains below the national target of 95% compliance (latest data for January 2022). This reflects the impact of our ongoing operational challenges on education, training and related data capture to support compliance in this area. A review of performance and assessment of whether this reflects actual changes in clinical practice, or data capture issues is planned.

WELL LED
SRO: Director of People and Transformation and Chief Medical Officer
Overview

Corporate Objective 4: Build effective teams empowered to lead

Vacancies

Trust vacancy factor increased slightly to 7.05% in February from 6.93% in January. This was driven by decreases in staff in post (-9.52wte). The decrease in staff in post was led by Allied Health Professionals; predominantly *Physiotherapy (-3.00wte) and Occupational therapy* (-1.60wte), and Registered Nursing and Midwifery; Birthing Centre (-6.96wte), Ward 34A (-4.15wte) and Women's Specialist Nurses (-3.57wte).

Turnover

Rolling 12month staff turnover decreased to 15.28% in February from 16.26% in January. Excluding the COVID-19 and mass vaccination workforce, the turnover rate decreased from 15.59% in January to 14.62% in February. This is higher than the February 2020 figure of 13.79%.

Prioritise the wellbeing of our staff

Rolling 12month sickness absence increased to 4.70% in January from 4.62% in December. The initial view of the February absence position shows an 7.09% decrease in days list to absence (adjusted for February being a shorter month than January), this was predominantly driven by a decrease in absence due to *Infectious Diseases* (COVID-19 related absence).

Continue to reduce reliance on agency and temporary staffing

Temporary staffing demand decreased by 2.72% (34.18 wte) in February and this is partly attributable to February being a shorter month; bank hours worked reduced by a greater amount -10.20% (-78.34 wte), despite the use of incentive bank rates of +30% in line with BNSSG partners, with a +50% rate for allocate on arrival continuing throughout February. The reduction in bank hours was predominantly seen in registered nursing and midwifery (-18.92 wte) with largest reduction in Women and Children's teams, and in unregistered nursing and midwifery (-42.78wte) predominantly in inpatient wards. Average bank hours worked were consistent each week in February meaning half term did not impact on bank hour worked. Agency RMN use saw an increase of 15.46 wte (of which 7.93 wte was tier 1, predominantly in wards 34A, EEU & 9A), tier 4 RMN use increased by 5.57 wte.

Actions

*Actions removed from the table below from last month have been delivered

Theme	Action	Owner	By When
Vacancies	Health care support worker assessment centres have increased for the remainder of the year and to May-22 in line with NHSi funding to reach 0 vacancies underpinning H2 Recovery – including wider, paid for advertising to counter labour market challenges for band 2 and band 3 roles (Dec-21 to Feb-22)	Head of Resourcing	May-22
Turnover	Focus on a clear link with staff well-being activities to address issues of fatigue and well-being Re-promotion and expansion of our Itchy Feet campaign – with more resources developed around career coaching conversations and working flexibility, aiming to support staff **before** they decide to resign	Head of People	Feb-22 – Apr-22
Temporary Staffing	System wide review of Waiting List Initiative Rates to support capacity management across system - Work continues across UHBW, NBT and Sirona to develop a system incentive pay framework with a target implementation date for April. This was postponed from the original December target due to operational pressures.	Director of People and Transformation	Apr-22

FINANCE
SRO: CFO
Overview

The actual result for the Month 11 and year to date is a breakeven position.

The Trust continues to deliver break-even position as per plan and updated forecast despite under-delivery of CIP targets, which is offset by delay in implementation of recurrent and non-recurrent service developments and changes.

The financial performance for the year 2021/22 remains to breakeven as set out in the Board approved budget paper.

A phased plan was developed and submitted to NHS England & Improvement (NHSEI) in Month 2, with a further Half 2 update submitted in Month 8.

The forecast outturn shows that the Trust will achieve the breakeven position at year end, as well as delivering the capital plan.

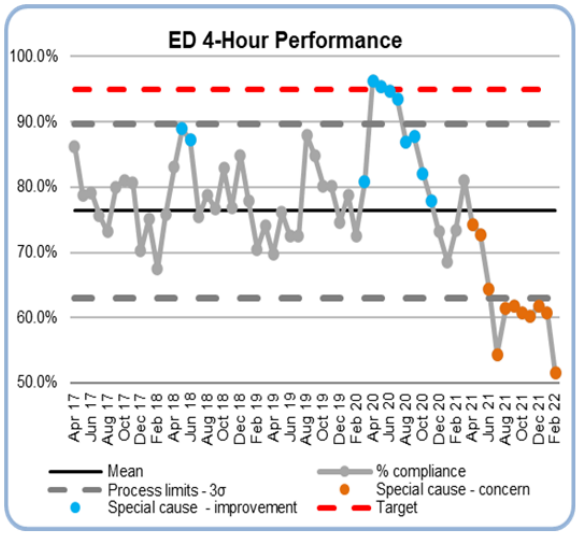
The income reported in Month 11 is based on notified allocations from BNSSG system and it was £62.9m (£56.4m Contract and £6.5m other) and the year to date figure is £700.8m (£620.0m Contract and £80.8m other).

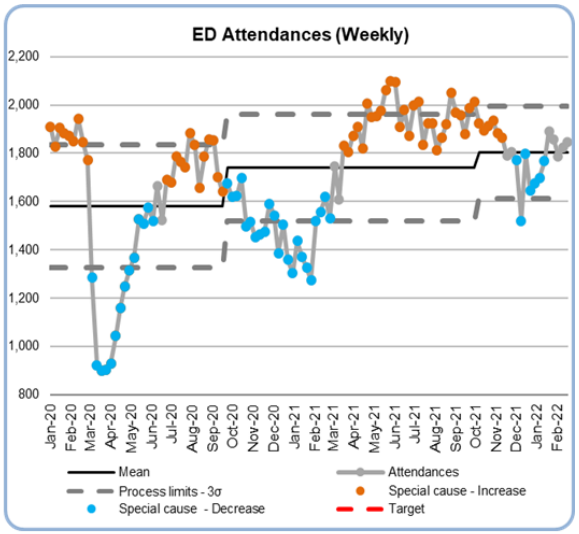
Cash at 28 February amounts to £125.9m.

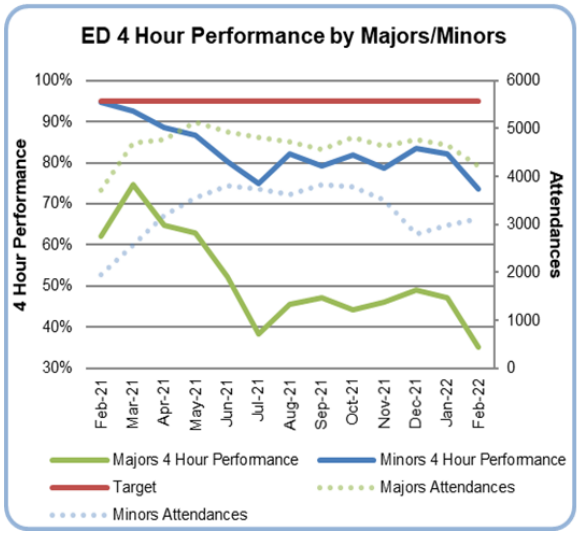
Total capital spend to date is £17.9m, compared to a plan of £19.9m for the first eleven months of the year.

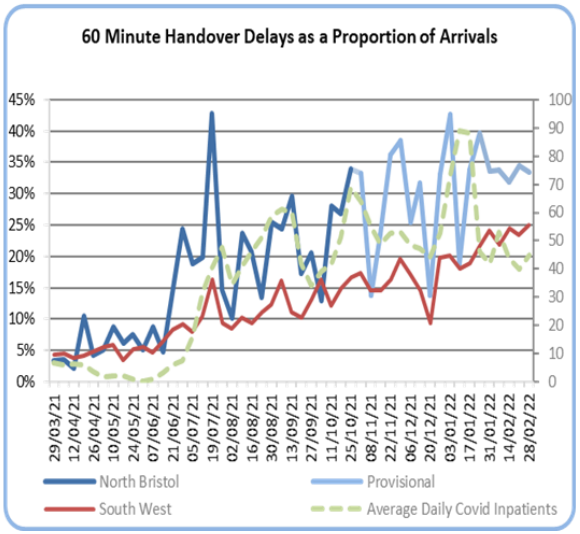
Responsiveness

Board Sponsor: Chief Operating Officer
Steve Curry









Unscheduled Care – Front Door

What does the data tell us?

Four-hour performance deteriorated in February with performance of 51.53%. Compared to our AMTC peers, the Trust ranked sixth out of ten reporting centres. When compared nationally, Trust positioning deteriorated, moving into the fourth quartile from the third. ED performance for the NBT Footprint stands at 59.35% and the total STP performance was 67.04% for February.

For February, ED attendances were similar to 2019/20 levels. There was a significant increase in 12-hour trolley breaches compared to the previous month, with the Trust recording 367; nationally there were over 16,000 with 42 trusts reporting over 100.

Ambulance handover times continued to be challenged with provisional (unvalidated) data showing the Trust recorded 684 ambulance handover delays over one-hour in February, though this was a decrease on the number reported in January.

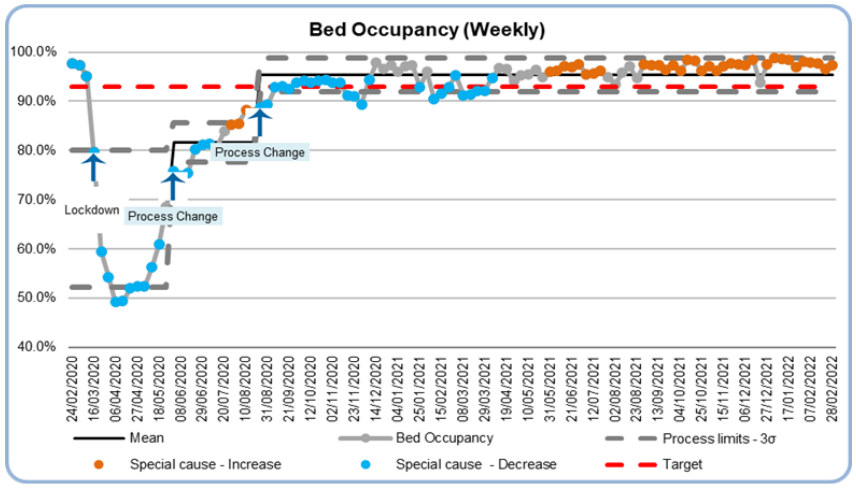
Numbers of COVID-19 inpatients peaked at 101 on 19th January but have since fallen, with numbers at the end of February being similar to December 2021.

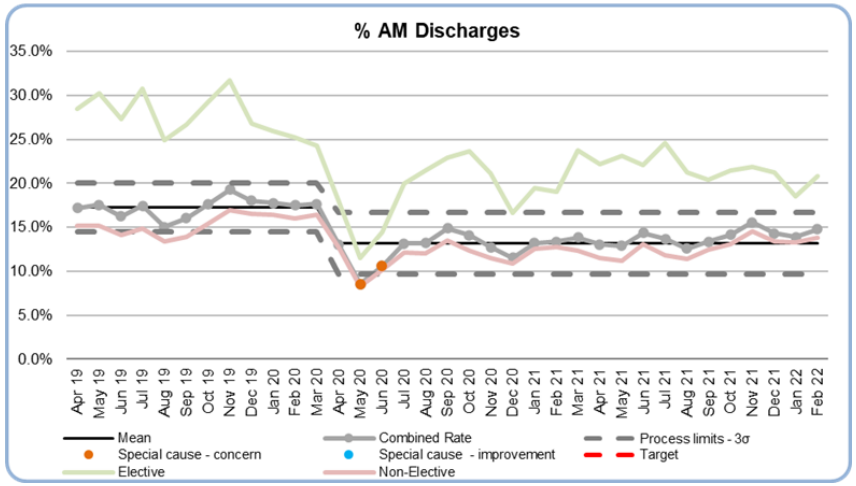
What actions are being taken to improve?

A Trust Ambulance improvement plan including BNSSG and SWASFT actions for out of hospital care has been presented to Region, but in light of the high levels of occupancy performance remains challenged.

The Emergency Flow Plan aimed at improvements in three areas (front door, time in hospital, and discharge). Attempts to relocate medical SDEC to increase core capacity has been delayed until April 2022 due to workforce and space constraints.

The system-wide project to provide reduction of 20% of ED minors patients through enhanced streaming is underway; although there has been slippage due to workforce availability and plans are limited to Monday to Friday only. A “perfect week” took place at the end of February to test the future model.





NB: The method for calculating bed occupancy changed in June and September 2020 due to reductions in the overall bed base resulting from the implementation of IPC measures.

Unscheduled Care - In Hospital

What does the data tell us?

Waiting for assessment in ED continued to be the predominant cause of breaches at 54.12%, with the second highest cause due to waits for a medical bed at 17.22%.

The vast majority of breaches of the admitted pathway is related to increasing bed occupancy which remains challenged. All days in February reported above the 93% target, varying between 95.05% and 99.67% against the core bed base.

In February, 14.81% of patients were discharged between 08:00-12:00; which was up on the previous month.

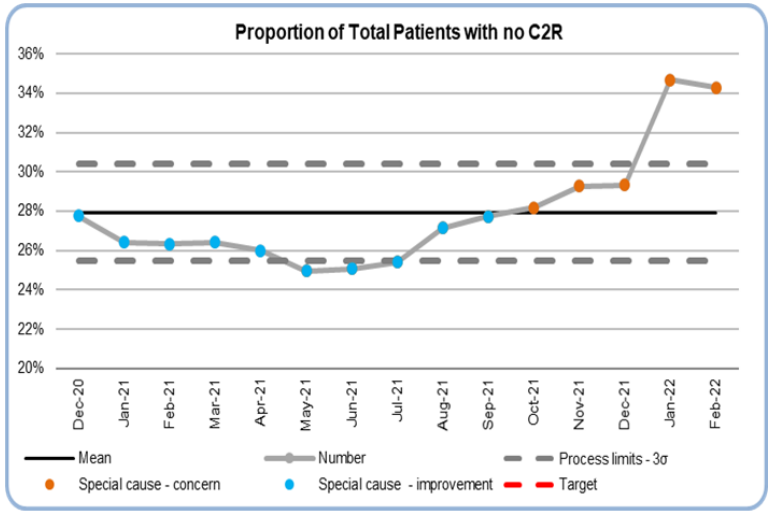
What actions are being taken to improve?

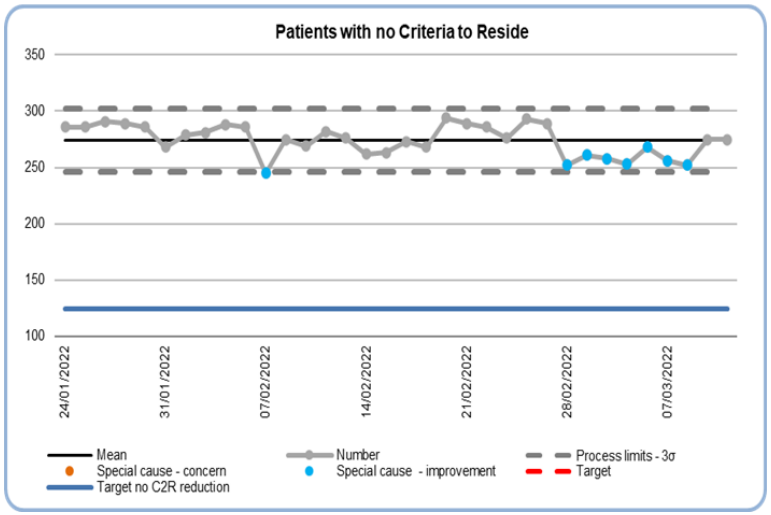
The Trust wide plan to improve emergency patient flow is made up of three components:

1. Front door (incl. Ambulance Turnaround Plan), decompressing ED and increasing use of SDEC pathways. The Trust has engaged Alamac to process map Emergency Zone pathways and identify improvement actions.

2. Time in Hospital including a focus on early decision making using nationally recognised Modern Ward Rounds, AM discharge, improved weekend discharge rates, implementing Internal Professional Standards and Improved PDD and Discharge Summary completion.

3. Discharges including implementation of the "Hospital Discharge and Community Support policy and operating model" and addressing BNSSG shortfalls in complex discharge rates (especially in P1 Home First capacity) through alternative models including Care Hotel and Family and Voluntary Sector supported discharge.





Unscheduled Care - No Criteria to Reside (No C2R)

What does the data tell us?

In February, the number of delayed bed days for medically fit patients awaiting Pathway 1 (P1) increased by 508; the number of days increased slightly for P2 by 40 days and by 245 days for P3. Overall the delayed bed days rose by 793 compared to January 2022.

P1 discharges remain impacted by insufficient staff capacity for Local Authority (LA) domiciliary care and Sirona D2A care worker capacity. Patients waiting discharge to the north Bristol locality wait much longer than patients in other localities. There continues to be insufficient community beds for patients with dementia and perceived behavioural challenges, also stroke patients with high care needs.

The top graph shows that at the end of February the overall month average of patients ready for discharge was 34.27% of total patients.

The bottom graph shows that at midnight on 28th February, 252 patients had no criteria to reside of which 19 were waiting repatriation to another acute hospital, 210 were waiting other external discharge pathway start dates, mainly D2A P1;2;3 and CHC Fast Track. 23 patients with no criteria to reside were waiting for internal reasons, predominantly the completion of single referral form (SRF). At least 20 new SRFs are expected to be generated each day, though this tends to be lower at weekends.

During February, a high number of care homes remained closed to admission due to COVID-19 explaining the continued rise in patient bed days for those waiting D2A P3.

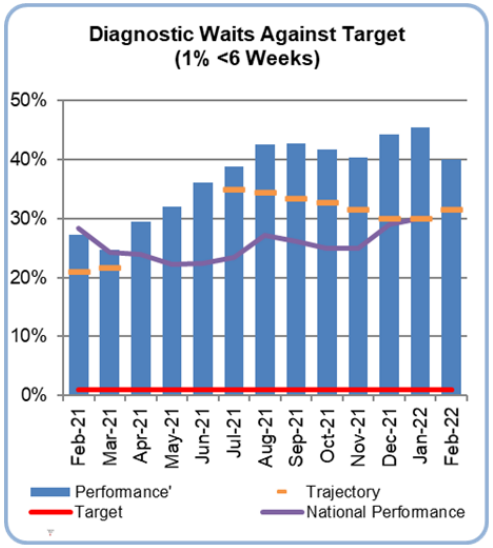
What actions are being taken to improve?

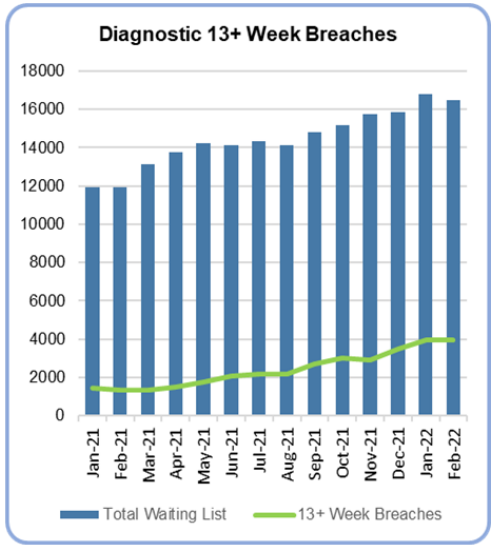
At the point of reporting NBT transferred 45 patients waiting D2A P1 to the Care Hotel since it opened 23 December 2021, as an interim step for patients on discharge P1. The hotel will close on 31 March 2022.

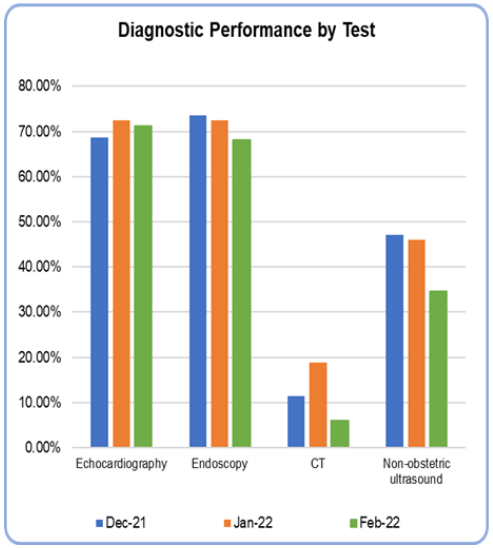
Role out of the *Flow Programme* continues in the Medicine Division with the aim of reducing LoS for patients with no criteria to reside. The introduction of a discharge tracker in AMU is showing early positive results with completion of social and admission assessments that support early accurate SRF completion, reducing the time from admission to SRF acceptance bed days. The rejection rate for SRF's was 2.4% in February; a significant reduction from January's rejection rate of 9%. Quality assurance measures have been introduced with the aim of maintaining this reduced rate.

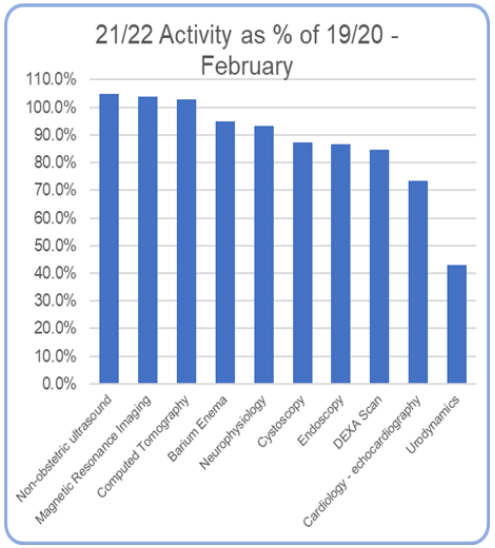
37 patients were discharged early during February, with family support bridging care at home, whilst awaiting P1 commencement, equating to 2 beds saved.

The whole system D2A Board and programme workstreams were established in month with priorities being agreed and improvement work commenced. This is a medium to long term plan to reduce the long delays for the D2A pathways.









Diagnostic Wait Times

What does the data tell us?

In February, diagnostic 6-week performance improved to 40.00%, though failed to meet the improvement trajectory of 31.56%. 13-week performance was static on the previous month. There was a decrease of 1.91% in the overall waiting list in February, with an increase of 2.05% in overall activity on the previous month. Seven test types reported over 85% of their activity compared to the same month in 2019/20.

The current improvements have been mainly driven within Endoscopy, CT and Non-Obstetric Ultrasound. There has been backlog clearance across all Endoscopy modalities, though wait list growth also contributed to improved performance. CT and Non-Obstetric Ultrasound have both reported improvement with reductions in both the backlog and the wait list.

What actions are being taken to improve?

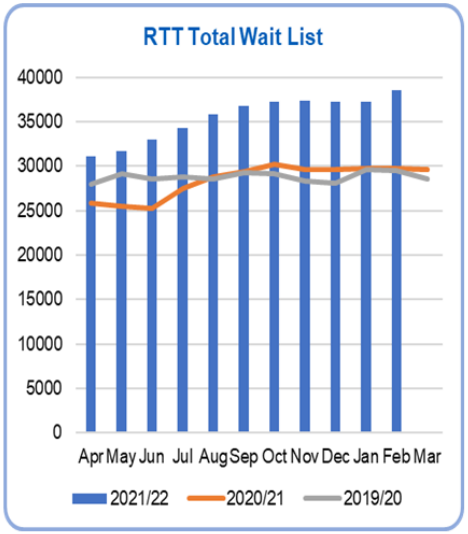
Endoscopy – Interviews for three Consultant Gastroenterologists were held in March 2022 with two successful appointments. In February, the service has seen the anticipated improvement in ability to book patients and make effective use of capacity, enabling plans for additional utilisation of weekend capacity to be implemented in the new financial year. Work is ongoing across the system to produce a shared PTL and to provide mutual aid to equalise wait times across organisations. There has been a focus on reducing the maximum waits times across the Endoscopy modalities with two out of the three modalities now reporting under 90 weeks.

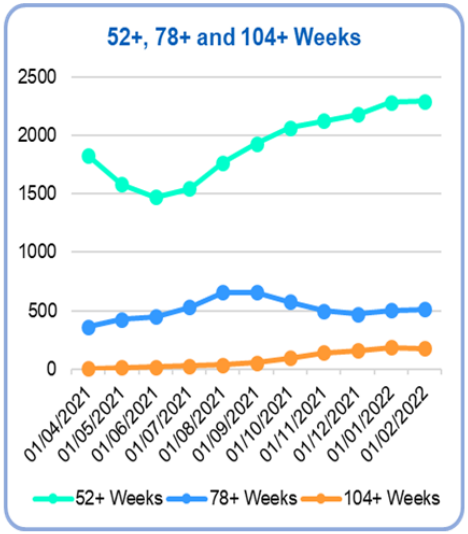
Non-Obstetric Ultrasound – The Trust continues to seek additional capacity to support backlog clearance. In addition, the Trust continues to send 45 patients every other week to Emersons Green Treatment Centre.

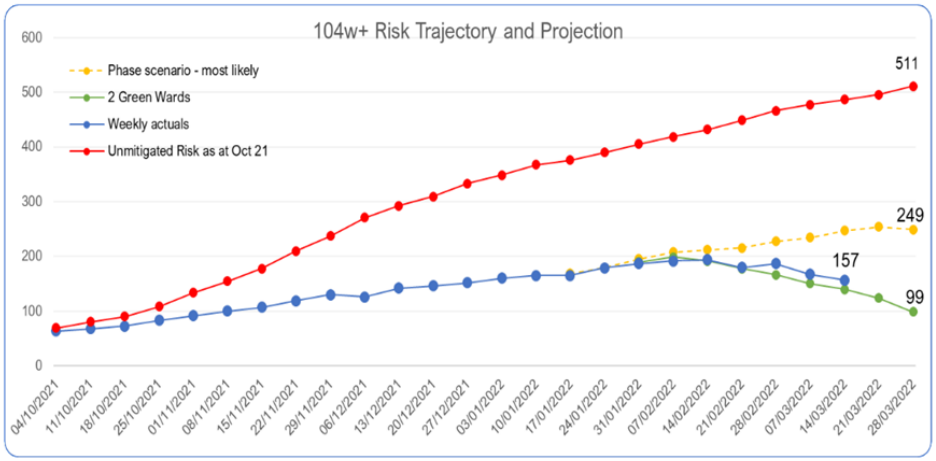
CT – Use of the demountable CT scanner based at Weston General Hospital continues.

MRI – The Trust continues to use the BioBank MRI research facility for additional MRI capacity until Easter. There are plans to resume use of IS capacity at Nuffield from April, plus potential to extend the working day on Cossham Suite B scanner.

Echocardiography – Access to Xyla insourcing capacity continues to be limited, however 48 slots have been agreed for the end of March 2022. The Trust is seeking further opportunities to equalise wait times with neighbouring organisations and with the support of NHSE/I.







Referral to Treatment (RTT)

What does the data tell us?

The overall RTT waiting list increased to 38498 in February, representing an increase of 3.46% on the previous month. The Trust has reported a small increase in 52-week wait breaches with 2,296 patients waiting greater than 52-weeks for their treatment; 511 of these were patients waiting longer than 78-weeks and 177 were waiting over 104-weeks. The majority of 52 breaches (963; 41.94%) are in Trauma and Orthopaedics (T&O) and typically have the lowest level of clinical prioritisation against the national guidance (P4).

February has been the first month where a reduction in 104-week waits has been reported and has been the highest volume of Admitted patient clock stops across all long-waiting time bands this year to date. The residual risk of 104-week breaches at the end of March 2022, is now 99 patients awaiting treatment predominately in T&O including patients choosing to defer their treatment.

When compared nationally, Trust waiting list growth continues to compare favourably to national waiting list growth for Acute providers. In January, Trust positioning for long waiting patients was similar to the previous month, remaining in the third quartile for the 78-week cohort, and the fourth quartiles for the 52 and 104-week cohorts.

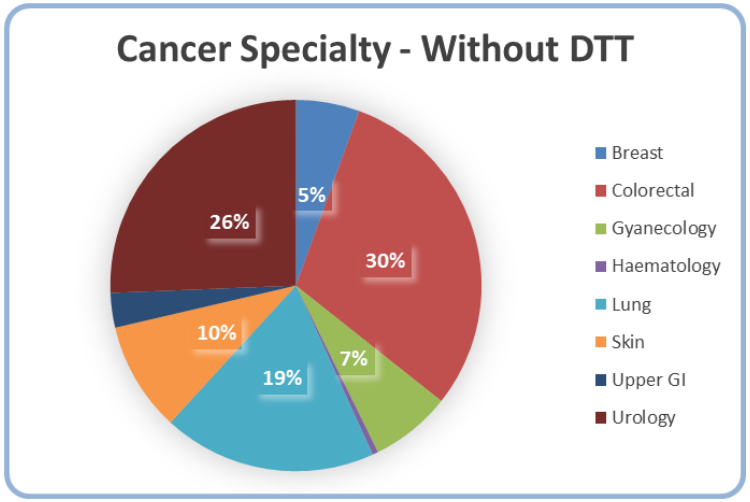
What actions are being taken to improve?

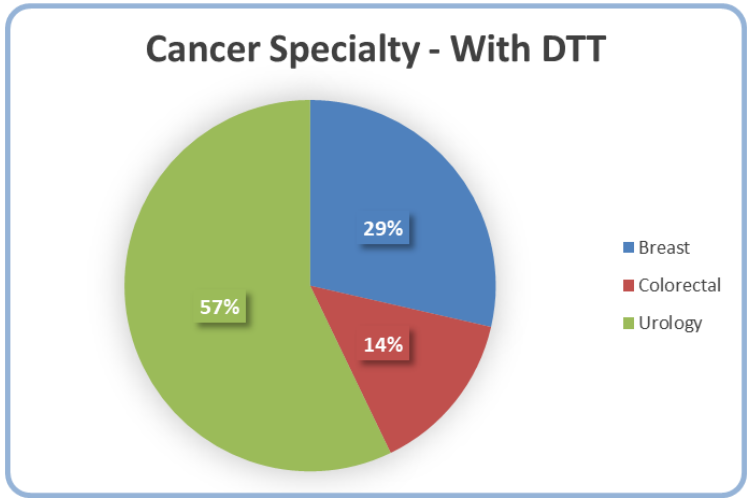
An Elective Care Recovery Board has been established and has developed a comprehensive plan to manage the waiting list to required levels with positive delivery against actions to date.

The Trust is undertaking regular patient level tracking and proactive management of long waiting patients and specific engagement with patients at risk of exceeding 104-week waits., with the majority of patients now having a date for treatment prior to year-end. The largest proportion of patients remaining undated are those choosing to defer their treatment into 2022/23 rather than capacity driven breaches.

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: 104-Day Patients

What does the data tell us?

January 2022 uploaded position

The Trust had 15 104-Day breaches this month that required Datix compared to the seven last month. This is the highest number of 104-Day breaches reported in the last 12 months. There have been no reported instances of clinical harm to any of the 104-Day breaches in the last 12 months. Six patient breaches were due to late transfers into NBT, seven due to complex pathways and two patient choice delays.

Live PTL snapshot as of 14/03/2022

There has been an increase in the 104-Day breach numbers from 161 to 213. The sites attributed to the increase are Colorectal with 29% of the overall 104-Day breaches, Lung, Gynae and Urology.

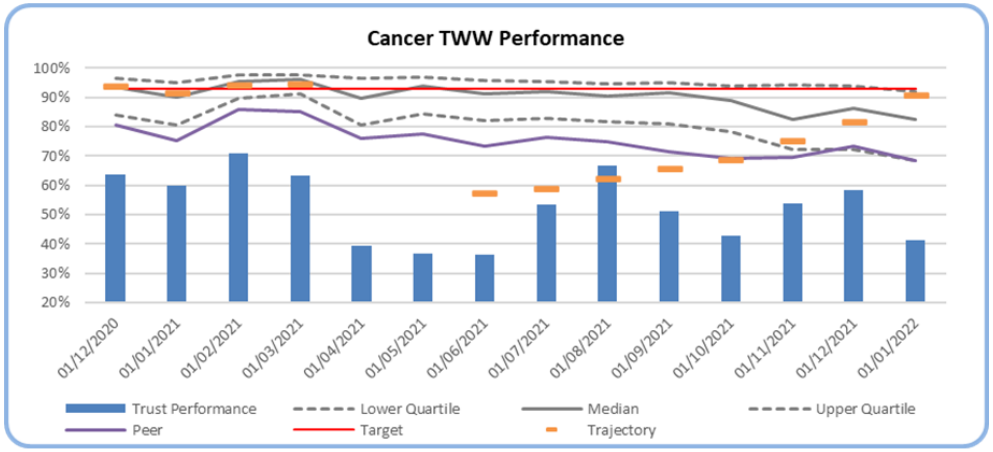
The 104-Day PTL has 30 patients with a confirmed Cancer diagnosis, but no treatment planned. There are 14 patients with a confirmed Cancer diagnosis and treatment planned in a breach position and 169 patients with no confirmed Cancer diagnosis (an increase of 50 from last month); all have been escalated to the relevant specialties for review.

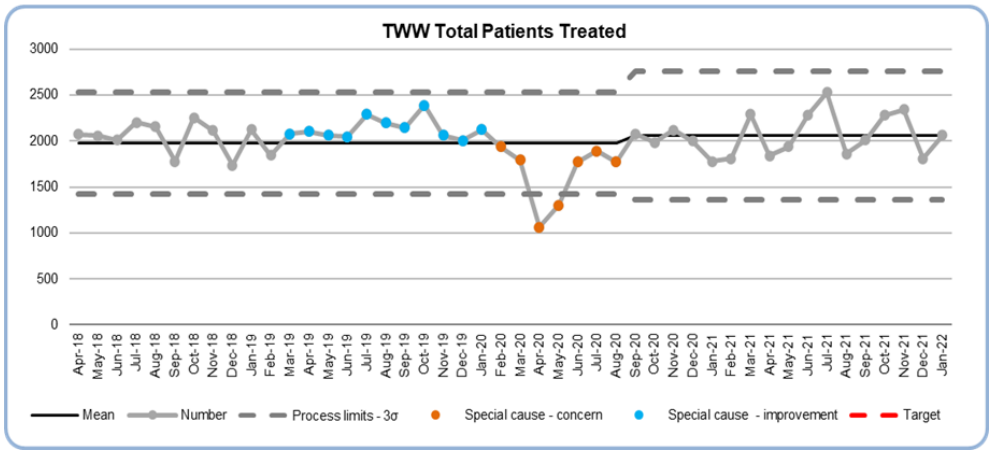
The patients without a diagnosis of Cancer or non-Cancer are accounting for approximately 79% of the patients over 104-Days on their pathway. Most of these patients are under Colorectal, Urology and Lung.

What actions are being taken to improve?

Targeted approach to the 104-Day patient PTL in conjunction with the Divisional admin teams has improved the management of the patient pathway. This has resulted in a significant improvement in the overall 104-Day PTL being maintained.

Cancer: Two Week Wait (TWW)





What does the data tell us?

The Trust reported a performance of 41.42% in January compared to 58.38% in December. The Trust saw 2058 patients in January compared to 1809 patients in December. Most of these patients are under Colorectal, Urology and Lung and underperformance has been due to increases in referral volumes, workforce and capacity challenges.

Of the 2058 patients seen, 847 patients were seen within two weeks, 1211 patients breached the TWW target. The Breast breaches accounts for 58% of the total breaches this month, with their performance of 5.49% being a slight improvement from 5.23% in December. Breast will continue to be in recovery well into the 1st Quarter of 2022/23.

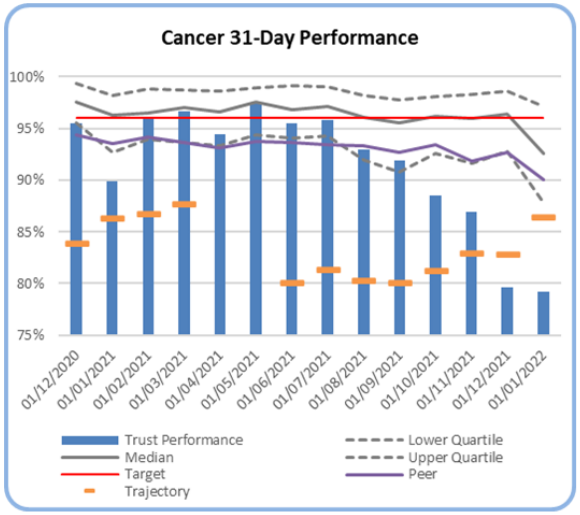
All specialties other than Brain (100%) and Lung (95.83%) failed the TWW standard this month. Gynaecology were very close with a performance of 92.93%.

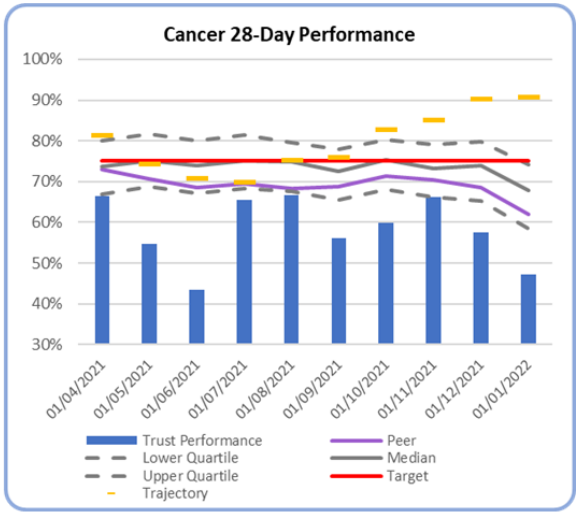
Skin dropped their position in January from 83.89% in December to 27.40% in January. The Skin service saw 489 patients with 355 seen in a breach position. This was due to backlog clearance.

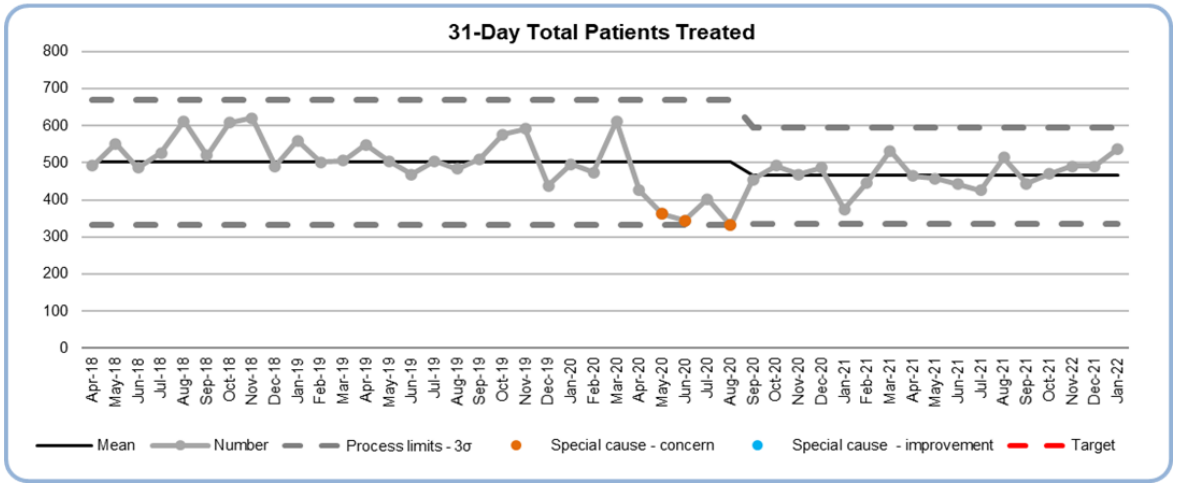
What actions are being taken to improve?

The Trust has signed off cancer trajectories for 2022/23. Fluctuations in referral volumes, especially in Gynaecology, Breast, Lung and Urology, continue to make performance against the Cancer Wait Times standards volatile.

SWAG investment has been secured to provide Skin and Gynaecology with additional kit and workforce to support the TWW pathway recovery plans.







Cancer: 31-Day Standard

What does the data tell us?

In January, the Trust missed the first treatment standard of 96.00% with a performance of 79.18% compared to the 79.59% achieved in December. This is the third consecutive month with a drop in performance due to surgical capacity issues; the Trust was in ICI for most of January. 272 patients were treated in month; 59 of them within a breach position.

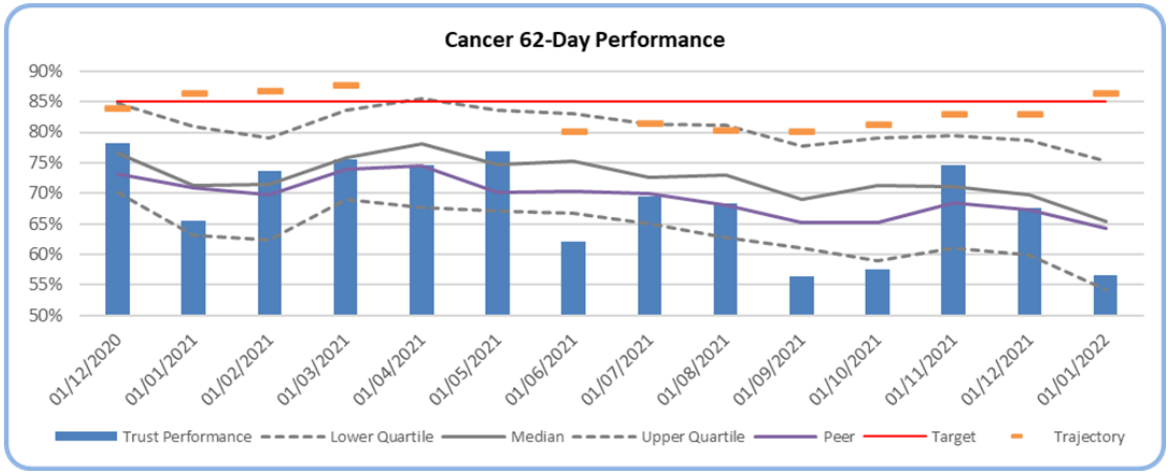
The specialties that failed the 31-Day first treatment standard were Breast, Skin, and Urology, which accounted for 96% of the breaches. Skin performance improved from 48.48% in December to 86.17% this month.

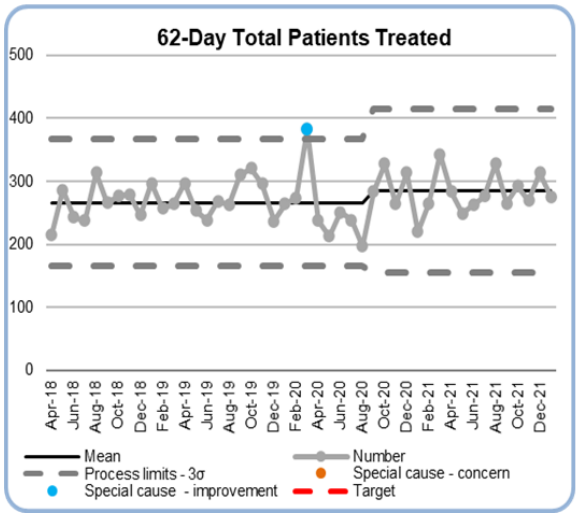
28-Day Performance
The Trust failed the standard in January with a performance of 47.10% The performance in December was 57.52%. 2068 patients had their diagnosis discussion; of those 1209 breached the 28-Day standard. Breast had 701 reportable patients of which 539 were unable to have their diagnosis before day 28. Recovery of this standard will only be possible once the TWW challenges are reliably resolved into 2022/23.

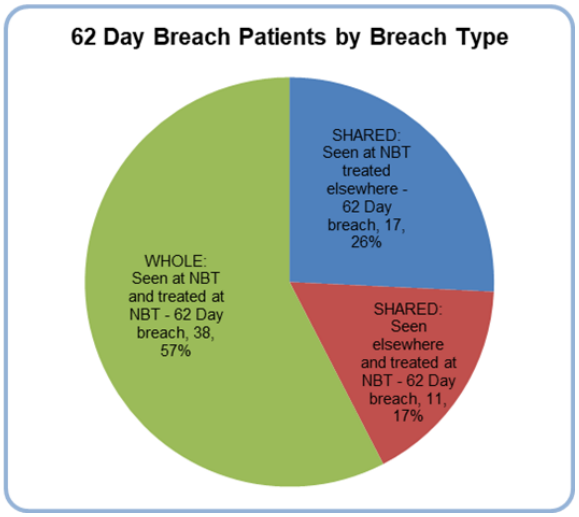
What actions are being taken to improve?

The recruitment programme of the Band 3 workforce has been completed and new staff on site with an extensive training programme in place.

Pathway review and recovery action plan work is underway with all the specialties that have failed this standard for the last two-months to ensure all delay issues are identified and improvement actions put in place to address the issues.







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

Cancer: 62-Day Standard

What does the data tell us?

The reported 62-Day performance for January was 56.88% compared to 67.52% in December; 140 patients were treated within the standard with 61 breaches.

Urology had the majority of the breaches (26); they were complex pathways and delays to the TWW pathway. Breast had 23 breaches out of 28 patients treated in January.

Urology had a drop in their performance from 57.94% in December to 52.29% in January. It should be noted that this includes the Weston Urology patients, the majority of the breaches in January were from Weston patients transferred in a breach position.

The Urology service treated 54 patients with 26 breaches. The service continues to have delays in the pathway due to oncology capacity prior to decision to treat. Pathway work is ongoing to ensure Weston pathways align to NBT.

What actions are being taken to improve?

A series of Task Force meetings have been established to manage the Cancer pathways and ensure plans for improvement are in place.

Most of the January breaches were caused by the known delays at the front end of the pathway within TWW, and complex pathways.

Progress against the H2 PTL trajectory is being tracked via the H2 Recovery Board with a trajectory to be at 475 by the end of March with 104-Day breaches reduced to a range of 30-60 per month (as per pre-COVID-19 levels).

Safety and Effectiveness

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

NBT - PQSM

	Target	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	TREND
Perinatal Morbidity and Mortality inborn							
Total number of perinatal deaths		3	4	2	2	5	
Number of stillbirths 16 to 23+6 weeks excl. TOP		2	1	1	0	3	
Number of stillbirths (>=24 weeks excl. TOP)		1	1	1	1	0	
Number of neonatal deaths : 0-6 Days		0	1	1	1	0	
Number of neonatal deaths : 7-28 Days		0	1	0	0	2	
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)		1	0	1	0	0	
Maternal Morbidity and Mortality							
Number of maternal deaths (MBRRACE)		0	0	0	0	0	
Number of women who received level 3 care		0.2%	0.2%	0.2%	0.2%	0.0%	
Insight							
Number of datix incidents graded as moderate or above (total)		2	0	2	1	0	
Datix incident moderate harm (not SI, excludes HSIB)		2	0	1	0	0	
Datix incident SI (excludes HSIB)		0	0	0	1	0	
New HSIB SI referrals accepted		0	0	1	0	0	
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0	
Coroner Reg 28 made directly to Trust		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	
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps		1	0.5	2	1	1.3	
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps		1	1	1	1	1	
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)		1	1	1	1	1	
Minimum safe staffing in maternity services: Neonatal Consultants workforce (rota gaps)		1	2	2	2	1	
Minimum safe staffing in maternity services: Neonatal Middle grade workforce (rota gaps)		1	0	0.5	1	0.5	
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled bank shifts).		14%	12%	14%	11%	13%	
Vacancy rate for midwives		2.9%	2.0%	1.9%	1.9%	3.5%	
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained)		42%	42%	42%	40%	42%	
Vacancy rate for NICU nurses		10	10	17.6	14	15	
Datix related to workforce (service provision/staffing)		8	2	5	7	9	
Consultant led MDT ward rounds on CDS (Day and Night)		71%	72%	58%	68%	57%	
One to one care in labour (as a percentage)		98.9%	100%	98%	100%	99%	
Compliance with supernumerary status for the labour ward coordinator	100%	95%	98%	96%	98%	96%	
Number of times maternity unit attempted to divert or on divert		4	2	2	0	2	
Number of consultant non-attendance to 'must attend' clinical situations		0	0	0	0	0	
Involvement							
Service User feedback: Number of Compliments (formal)		66	19	58	44	59	
Service User feedback: Number of Complaints (formal)		5	3	6	9	9	
Staff feedback from frontline champions and walk-abouts (number of themes)		3	2	3	4	4	
Improvement							
Progress in achievement of CNST /10		7	7	6	7	7	
Training compliance in maternity emergencies and multi-professional training (PROMPT)	90%	42%	39%	38%	33%	43%	
Fetal Wellbeing and Surveillance	90%	7%	14%	22%	9%	18%	
training compliance core competency 4. personalised care		DNA	DNA	DNA	DNA		
Continuity of Carer (overall percentage)		16%	15%	16%	17%	16%	
Trust Level Risks		DNA	DNA	DNA	2	4	

Maternity - Perinatal Quality Surveillance Monitoring (PQSM) Tool

Neonatal Morbidity and Mortality: 3 x late fetal losses, no themes identified. 2 x late neonatal deaths will be reviewed as part of the PMRT process.

Maternal Morbidity and Mortality: 0 x maternal admission to the Intensive Care Unit.

Insight: 0 x new incidents; 1 x finalised HSIB report. No safety recommendations identified for trust, however findings up for evaluation and planned actions for improvement and learning within the division.

Workforce: Workforce gaps across all specialities continue to be challenging. The biggest impact on staffing is related to staff absence due to COVID precautions. Impacting on quality improvement work.

Midwifery: Successful recruitment of Band 5 and 6 midwives, anticipated to start from March 2022. Specialist midwifery posts currently in interview phases. Cross city maternal medicine post appointed in Feb. of 2022.

Obstetrics: Review of existing job plans and business case to be completed for further uplift for Consultant PA's, to meet service requirements and successful recruitment of x 2 clinical fellows.

NICU : External funding approved to recruit to BAPM and NCCR standards. Rolling recruitment in place.

Workforce - Diverts: 2 Cossham diverts to centralise staff within the acute maternity unit. Pressures within ambulance services remain and women are informed of expected call out times for cat. 1 and cat. 2 calls.

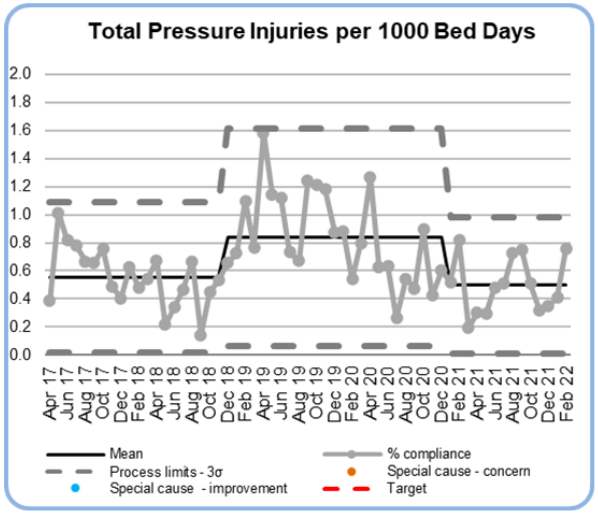
Staff and Service user feedback themes: Staffing across the perinatal service; Estates impacting on capacity; Missing and lack of essential equipment; Civility saves lives service development project commenced.

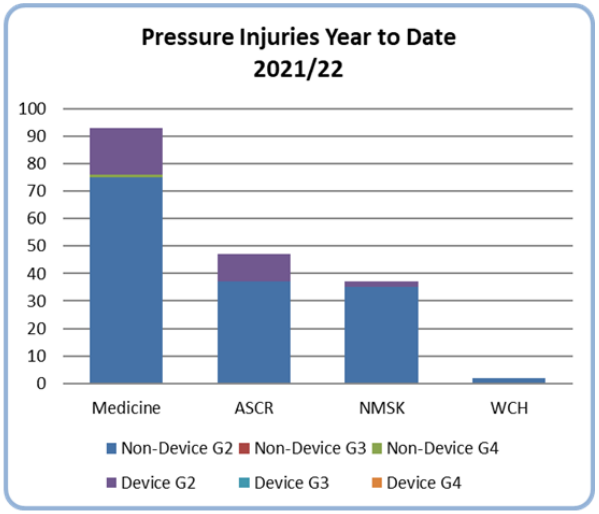
Maternity Incentive Scheme, Year 4: NBT's compliance confidence forecast remains at 7 out 10.
Planned pause for MIS, Year 4 for 3 months due to the pandemic with clear priorities set out by NHSR.
3 areas of concern identified highly likely to impact successful delivery of all 10 Safety Actions:

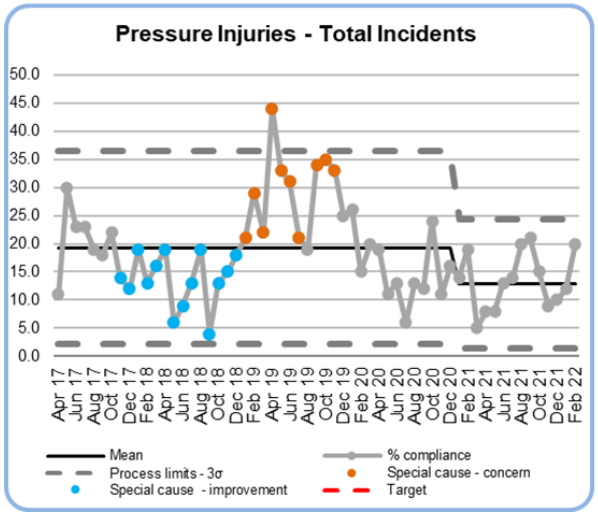
i. ***SA 2 – Maternity Services Data Set*:** Still awaiting update from NHSR regarding clarity of PCSP digital requirements. NBT Community IT connectivity is a major barrier impacting successful delivery. It is highly likely that mitigations to ensure SA2 is achieved will require additional resources. Without the additional personnel resources in place this will almost certainly impact on successful delivery of SA2.
ii. ***SA 7 - Maternity Voices Partnership** (MVP):* Meeting with MVP held on 28/02/2022. Actions agreed
iii. ***SA 6 and 8 – Training*:** No progress has been made towards the compliance with the training - MDT emergency skills training. A meeting has taken place in February 2022. An action plan has being developed to promote training as a divisional priority. Ongoing work regarding data quality of training log.

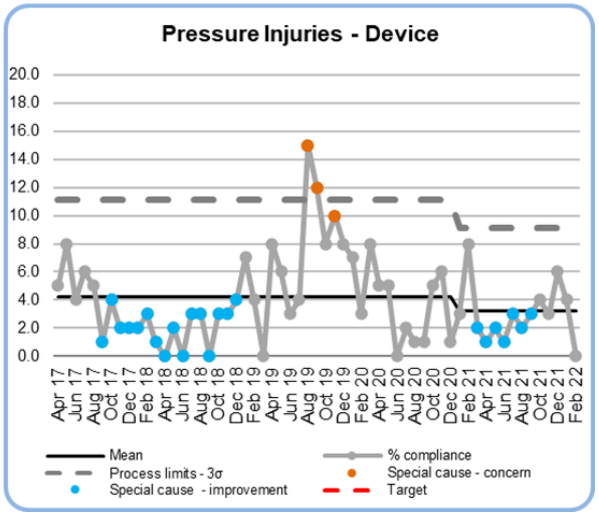
Continuity of Carer: Service strategy developed. Taken to Trust Board; business case to go to April 2022 BCRG; paper ready to go to next LMS Board. LMS midwife now in post and leading on NBT's strategy.

Areas of excellence: Exceptional team working being demonstrated across all areas of perinatal services during these challenging times. Sustained improvement demonstrated with CO recording at booking and 36/40 for MIS Safety Action 6. Agreed workforce funding and Birth Rate plus completion by March end 2022.









Pressure Injuries

What does the data tell us?

In February, there was an increase in the number of Grade 2 pressure injuries but a decrease in medical device related Grade 2 pressure injuries and DTI injuries.
The Trust ambition for 2021/22 is:

- Zero for both Grade 4 and 3 pressure injuries.
- 33% reduction of Grade 2 pressure injuries.
- 30% reduction of device related pressure injuries.

19 Grade 2 pressure injuries were reported of which 0 were related to a medical device and 16 DTI injuries. There were 0 unstageable pressure injuries reported.

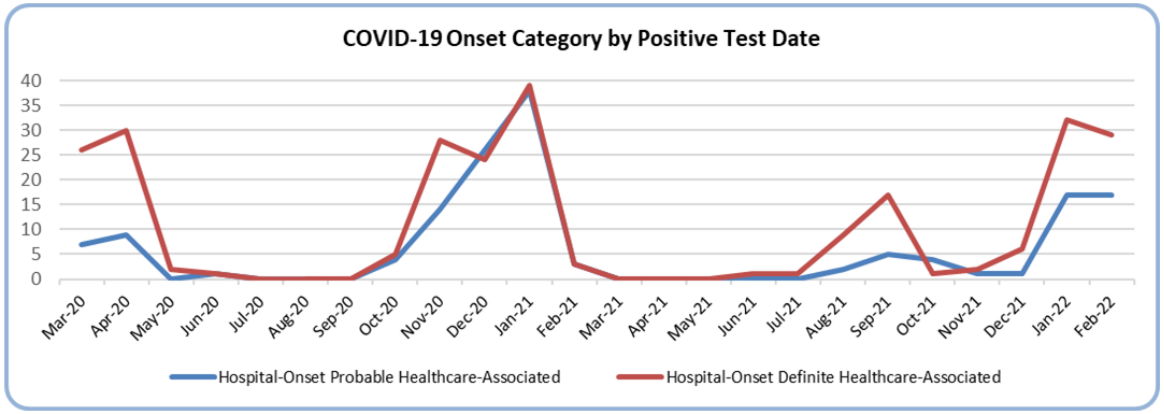
There were no reported Grade 3 injuries, and 1 Grade 4 pressure injury reported in February.

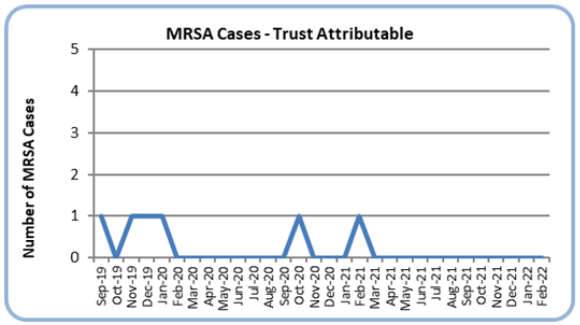
What actions are being taken to improve?

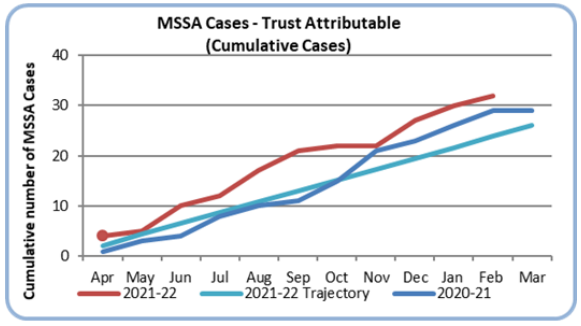
The Tissue Viability (TV) team is continuing to focus on support of clinical areas noted at After Action Reviews and identifying thematic devised solutions around mattress selection.

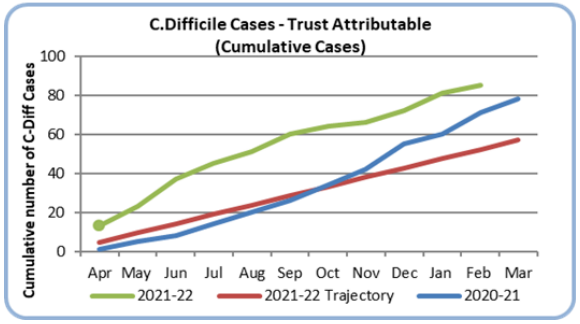
Collaborative work using the RAG rating support system to provide specific and targeted teaching to areas that require support.

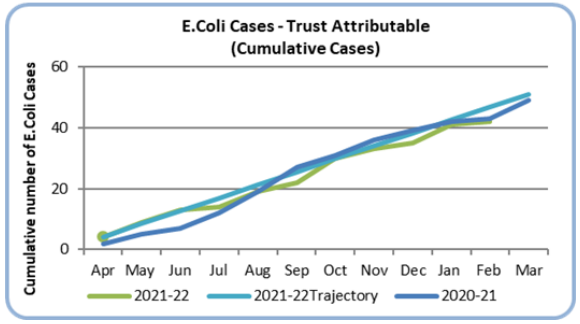
TV Nurses are actively working with the wards to promote suitable mattress selection based on clinical need for patients and have changed their practice. TVNs order a suitable mattress for a ward if the patient is not on the optimal mattress for their clinical need at assessment. To support improvement the TV Team attend and share learning at Divisional Quality huddles.











Infection Prevention and Control

What does the data tell us?

COVID-19 (Coronavirus)
NBT has continued to have Outbreaks in clinical areas and have managed this with outbreak management and hierarchy of controls.
We have seen Outbreaks in NMSK in a number of areas that have required specific input and escalation to DMT due to the nature of the patient group and ward visits from multiple staff.
IPC team have worked with the division to provide bespoke solutions for speciality pts who have contracted COVID .

MRSA
Last bacteraemia was reported in Feb 2021.

C. Difficile
The rate remains higher than trajectory , however we have noted a slower projected growth of cases.

MSSA
MSSA cases continue to be higher than trajectory,

Gram –ve
Trajectory set for a 5% reduction of cases for 21/22 based on 2019/20 figures.
The planned re focus on MRSA , MSSA , C Diff and E- Coli has proved to be a challenge due to the COVID position and Outbreak situation. This will definitely be the focus as we move into Q1 of the 2022/23 financial year.

What actions are being taken to improve?

Support the trust during continued ICI COVID demand This has required decision making to balance the operational risks in Outbreak management .

Continued focus on education and practical support of pandemic response.

Re focus planned in Q1 to address other infections, this will include Link practioners who work in all areas some of whom have recently registered for Florence Nightingale institute IPC training.

COVID-19 SitRep

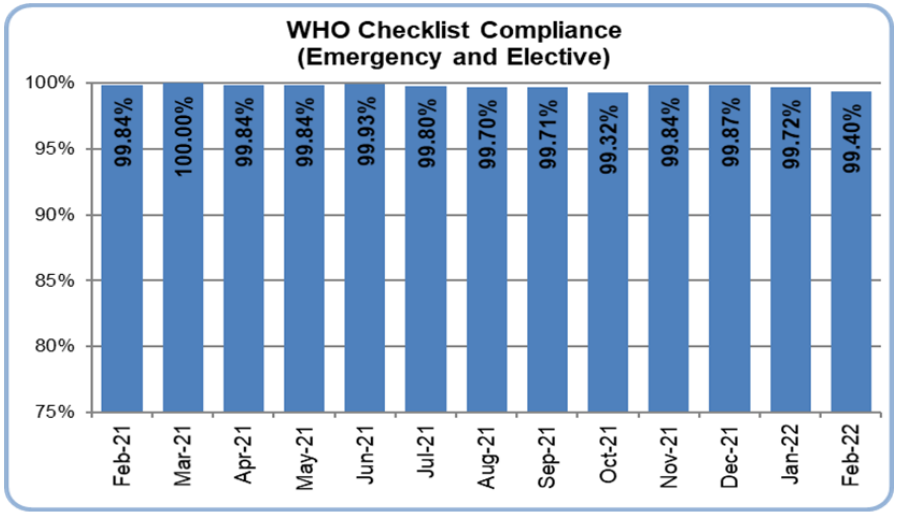
Current COVID Status: Level 2

Metric	17/01/2022	24/01/2022	31/01/2022	07/02/2022	14/02/2022	21/02/2022	28/02/2022	07/03/2022	Trend
New patients last 24 hours – admitted	7	4	5	5	4	4	5	6	
New Patients Diagnosed in last 24 hours	**9**	**5**	**7**	**4**	**6**	**6**	**7**	**6**	
Of these, in-patients diagnosed <48 hours after admission (Community Acquired)	5	4	4	3	4	5	3	4	
Of these, in-patients diagnosed 3-7 days after admission (Indeterminate)	0	0	0	0	0	0	1	1	
Of these, in-patients diagnosed 8-14 days after admission (Hospital Acquired)	1	1	2	0	0	1	1	1	
Of these, in-patients diagnosed 15+ days after admission (Hospital Acquired)	3	0	1	1	1	0	3	0	
Number of confirmed patients admitted from care or nursing home	1	1	1	0	1	0	0	0	
Blue discharges in past 24 hours	10	8	8	8	8	5	8	8	
Number of COVID positive patients as at 08:00	**88**	**46**	**42**	**53**	**44**	**40**	**45**	**50**	
Of these, patients admitted for primary COVID	50	23	25	32	31	33	34	32	
Of these, patients admitted with incidental COVID	38	23	17	21	13	8	11	19	
COVID positive patients in ICU	2	3	1	1	1	2	2	2	
COVID positive patients outside of ICU	86	43	41	52	44	38	43	48	
Query patients	1	1	1	2	2	0	1	4	
Closed and empty beds due to IPC	37	10	6	16	11	7	13	12	
Positive patients outside of blue wards	4	4	2	1	2	3	2	2	
NIV COVID	1	1	0	2	1	2	1	1	
Non COVID NIV (28a & AMU)	1	3	1	1	3	2	6	1	
Deaths	1	1	0	0	1	0	0	1	
Pathology lab positivity rate – rolling 7 day mean	0	0	0	0	0	0	0	0	
Patient Total positivity - detected - number	19	15	16	12	11	10	14	15	
Patient Total positivity - detected - %	0	0	0	0	0	0	0	0	
Staff Total positivity - detected - number	22	22	23	17	12	10	16	17	
Staff Total positivity - detected - %	0	0	0	0	0	0	1	0	

Metric	10/01/2022	17/01/2022	24/01/2022	31/01/2022	07/02/2022	14/02/2022	21/02/2022	28/02/2022	Trend
Bristol cases per 100,000 – 7 days	1189	1068	1190	1130	862	673	487	490	
South Gloucestershire cases per 100,000 – 7 days	1103	1107	1217	1103	852	658	480	501	
North Somerset cases per 100,000 – 7 days	1189	1068	1190	1130	862	673	487	490	

Key:

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

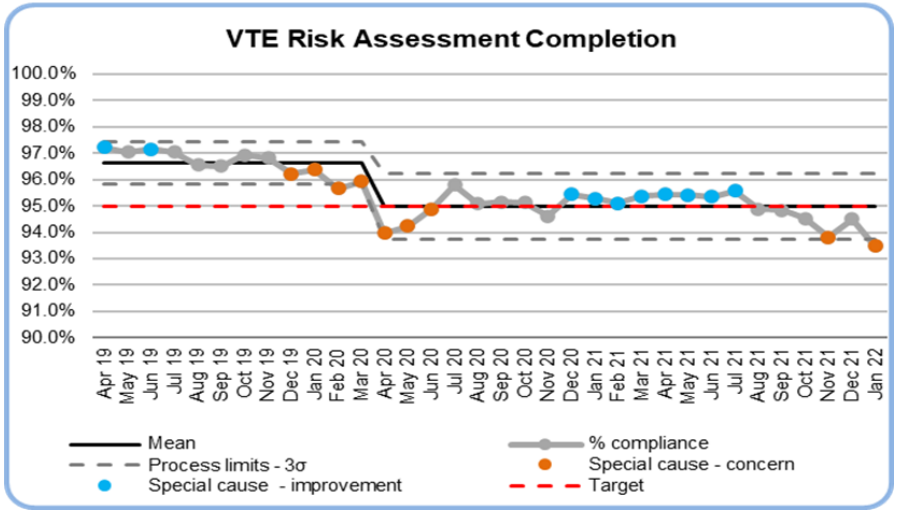


WHO Checklist Compliance

What does the data tell us?

In February, WHO checklist compliance was 99.40%. 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. 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.

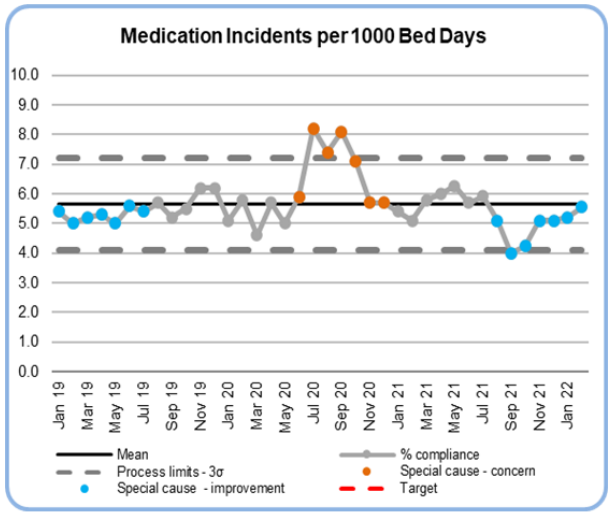


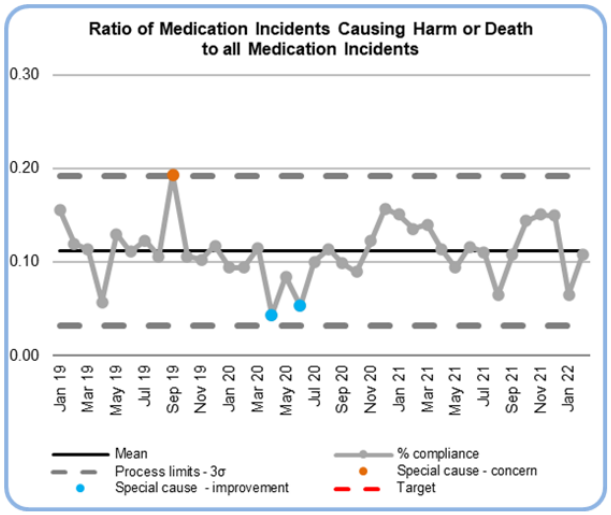
VTE Risk Assessment

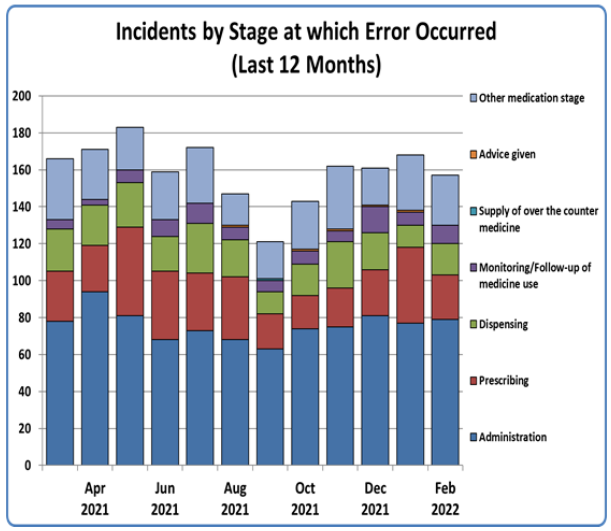
What does the data tell us?

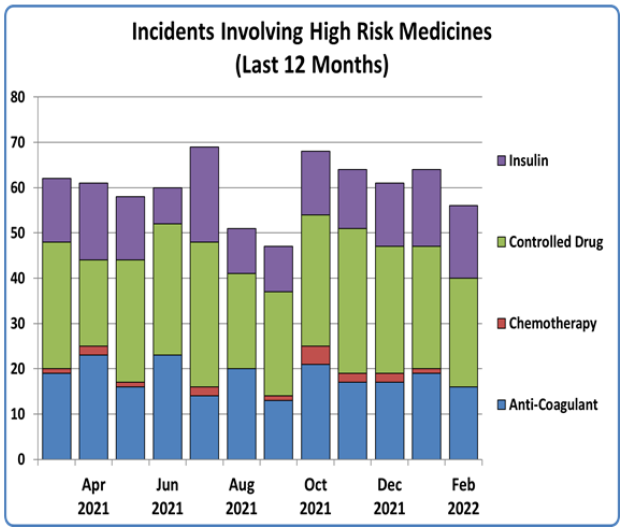
In January, the rate of VTE Risk Assessments performed on admission was 93.47%. VTE risk assessment compliance is targeted at 95% for all hospital admissions.

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









Medicines Management Report

What does the data tell us?
During February 2022, NBT had a rate of 5.6 medication incidents per 1000 bed days. This is the highest rate in the last 6 months.

Ratio of Medication Incidents Reported as Causing Harm or Death to all Medication incidents
During February 2022, c.11% of all medication incidents are reported to have caused a degree of harm (depicted here as a ratio of 0.11). Although higher than January 2022, this is still lower than the mean average over the last 6 months, suggesting a higher rate of reporting of 'no harm' incidents, and an improving reporting and safety culture in the Trust. The actual number of incidents reported as causing any degree of harm is around the mean average for the last 6 months, and is reflective of figures this time last year. 'No harm' incidents accounted for 89% of all NBT reported medication incidents.

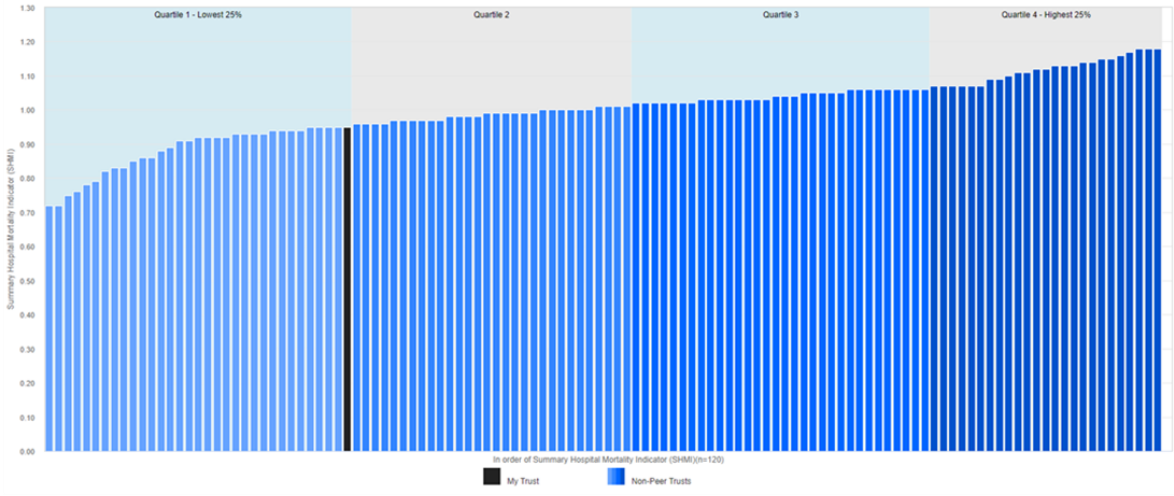
Incidents by Stage
Incidents occurring at the 'administration' stage accounted for c.50% of all medication incidents in February 2022, which is consistent with trends over the last 6 months. The next most frequent stage was 'other', where c.17% of incidents occurred.

High Risk Medicines
During February 2022, c.36% of all medication incidents involved a high risk medicine. This is the lowest proportion since September 2021. The actual number of incidents involving a high risk medicine in February was also the lowest since September 2021. Incidents involving Controlled Drugs made up c.43% of incidents involving high risk medicines, which is consistent with trends over the last 6 months.

What actions are being taken to improve?

The Medicines Governance Team continue to encourage reporting of all incidents to develop and maintain a strong safety culture across the Trust.
Validation of incidents occurring at the administration stage is a priority to ensure learning is being directed to the relevant staff groups, and this insight will form part of the workstreams undertaken in the 'Medicines Academy' project. This project is being delivered using a multi-disciplinary team approach, to include the Patient Safety Team and ward teams.

Summary Hospital Mortality Indicator (SHMI), National Distribution

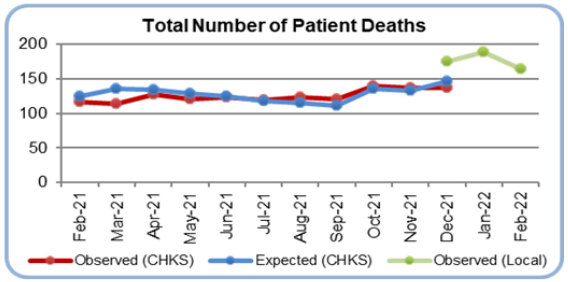


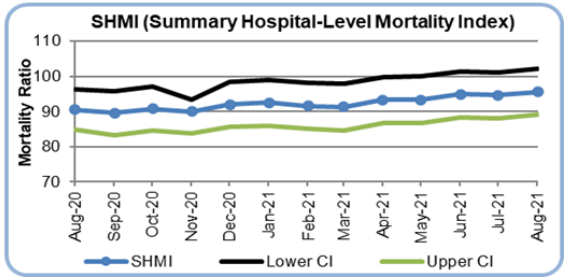
Mortality Review Completion

Jan 21 – Dec 21	Completed	Required	% Complete
Screened and excluded	544		
High priority cases	256		
Other cases reviewed	1107		
Total reviewed cases	1907	2015	95%

Overall Score	1=very poor	2	3	4	5= Excellent
Care received	0	3.8%	29%	38.5%	28.7%

Date of Death	Jan 21 – Dec 21
Scrutinised by Medical Examiner	1472
Referral to Quality Governance team	152





Mortality Outcome Data

What does the data tell us?

Mortality Outcome Data
NBT is in the lowest quartile for SHMI at 0.95 when compared to the national distribution indicating a lower mortality rate than most other Trusts.

Mortality Review Completion
The current data captures completed reviews from Jan 21 – Dec 21 In this time period 95% of all deaths had a completed review, which includes those reviewed through the Medical Examiner system.

Of all "High Priority" cases, 89% completed Mortality Case Reviews (MCR), including 21 of the 23 deceased patients with Learning Disability and 21 of the 26 patients with Serious Mental Illness.

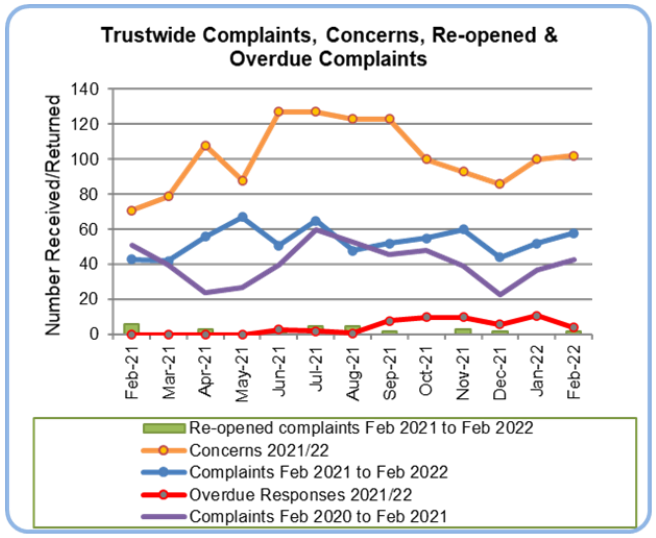
Mortality Review Outcomes
The percentage of cases reviewed by MCR with an Overall Care score of adequate, good or excellent is 96% (score 3-5). There have been 10 mortality reviews with a score of 1 or 2 indicating potentially poor, or very poor care which undergo a learning review through divisional governance processes.

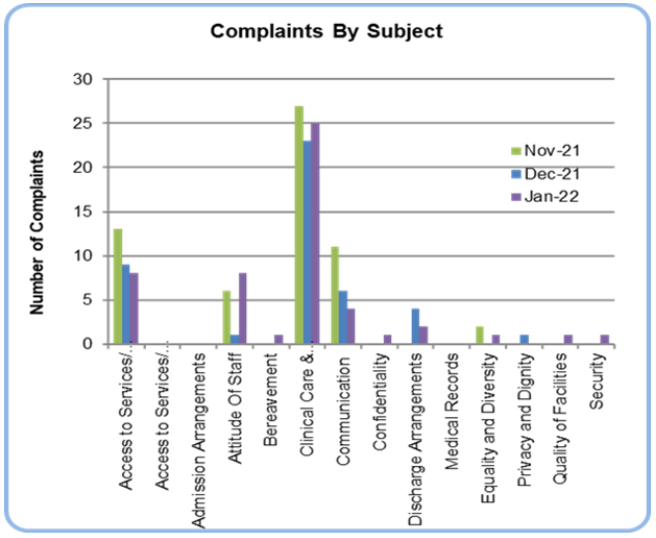
What actions are being taken to improve?

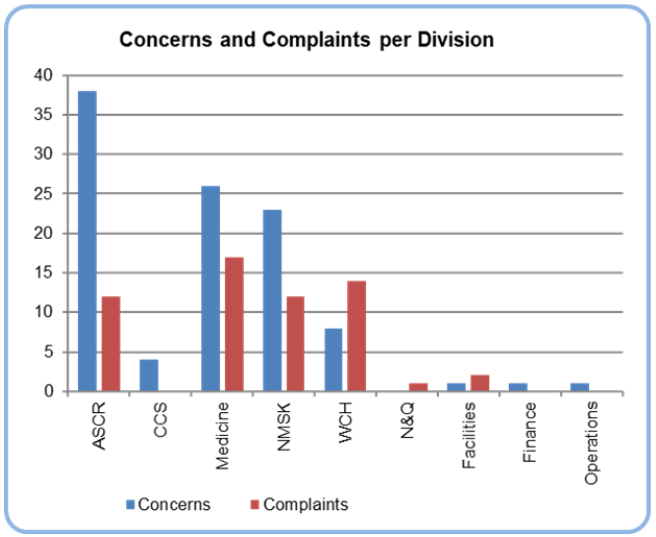
Structured Judgement Reviews into cases of probable and definite hospital associated COVID have begun supporting work undertaken as part of the post-infection reviews. A cohort of reviewers in undertaking this work on cases identified as part of wave 1 and 2, other cases are now being assigned to specialties and a review will be required on all cases moving forward.

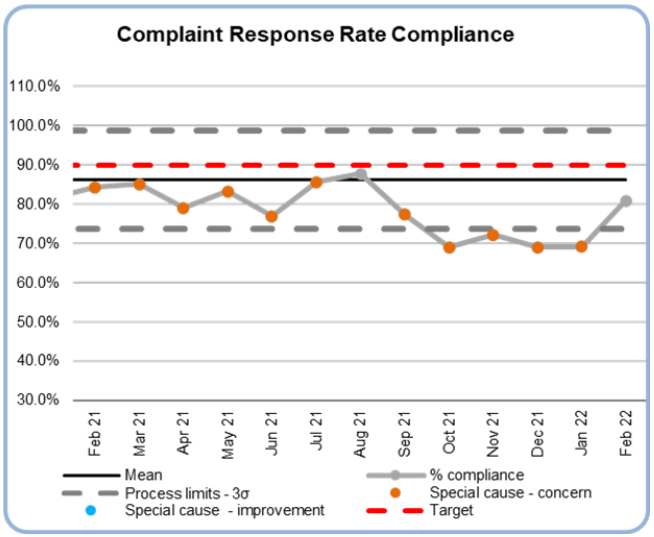
Patient Experience

Board Sponsor: Chief Nursing Officer
Steven Hams









Complaints and Concerns

What does the data tell us?

In February 2022, the Trust received 58 formal complaints, this is an increase on January where 52 complaints were received, and significantly higher than this period last year where 43 were received.

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

There are 2 re-opened complaints in January, both in Medicine.

The 58 formal complaints can be broken down by division: (the previous month total is shown in brackets)

ASCR	12 (15)	CCS	0 (3)
Medicine	17 (18)	NMSK	12 (6)
WCH	14 (6)	Facilities	2 (3)
N&Q	1 (0)		

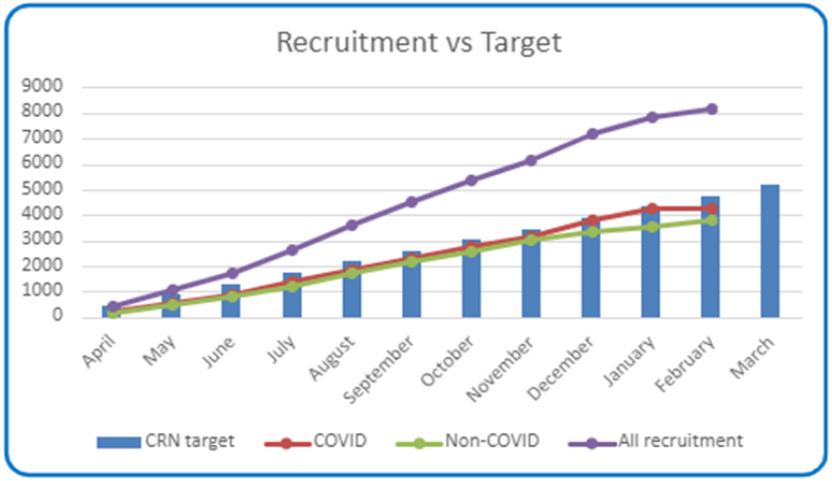
The number of PALS concerns received by the Trust has increased very slightly to 102 in February.

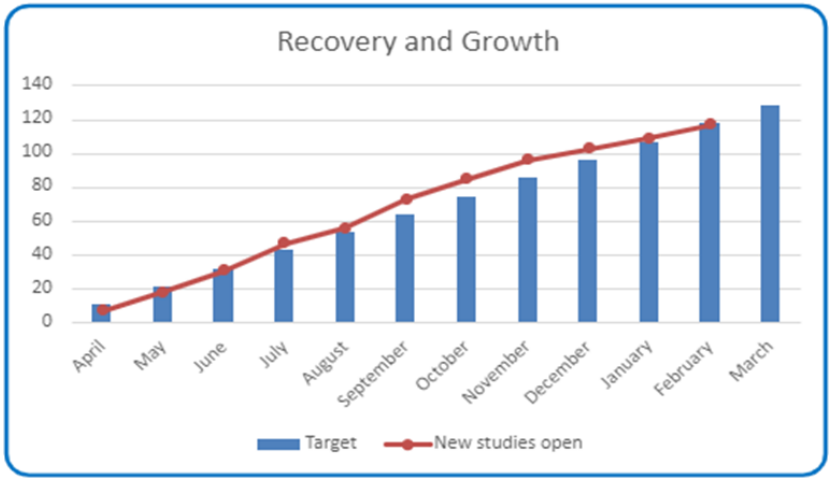
The response rate compliance for complaints has improved from 69% in January to 81% in February. This is a positive improvement and has been particularly notable in ASCR reflecting the recovery plan in place.

The number of overdue complaints has also begun to fall. At the time of reporting there are 4 overdue complaints. 3 are in Medicine and 1 for WaCH.

What actions are being taken to improve?

- Ongoing weekly validation/review of overdue complaints by Patient Experience Manager and/or Complaints Manager.
- Weekly meetings with Medicine Patient Experience Team, PALS Manager and Complaints Manager.
- Recovery plans and a trajectory for improvement agreed with ASCR and Medicine. Impact already evident in ASCR.





Research and Innovation

What does the data tell us?

NBT performance continues to exceed our expectations; recruitment of new patients is currently 176% of our year-to-date target with 8153 participants enrolled in research at NBT so far this year. Our portfolio of research remains strong, and we have opened 117 new studies this year, which is on par with our pre COVID performance.

During the last COVID wave our staff were redeployed to support clinical areas most in need on a voluntary basis, providing that much needed resilience across the trust during periods of increased staff absence.

We continue to support the national efforts to develop effective vaccines to manage current and future COVID variants. In a current study, which we are offering to the regional population, we are leading the way in recruitment performance at a national level.

The NBT Research Strategy for 2022-2027 is currently being drafted after a programme of staff and wider stakeholder engagement, it is our desire that this reflects the needs and aspirations of the trust and our local communities.

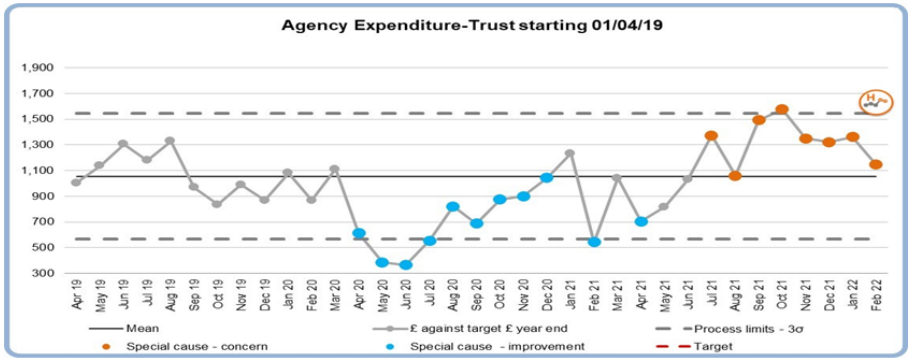
NBT currently leads 60 externally funded research grants, to a total value of £27.9m. This includes 31 prestigious NIHR grants, across a range of specialities, which total £26m. In addition, NBT is a partner on 59 externally-led research grants, to a total value of £10.6m to NBT.

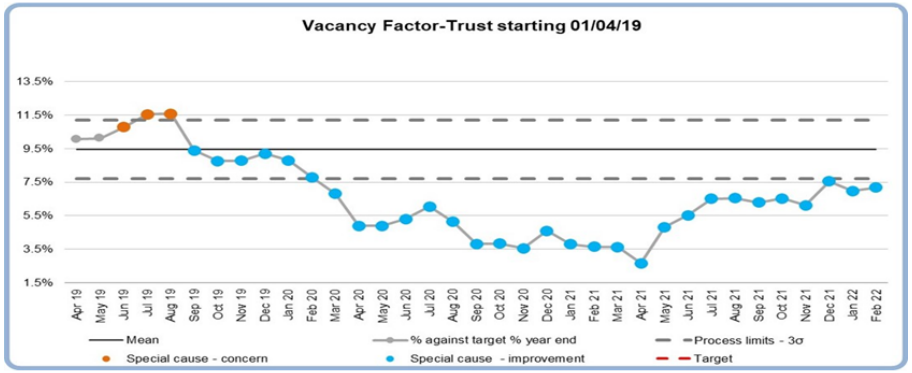
The Southmead Hospital Charity has very kindly agreed to provide additional funding to permit NBT to run two SHC Research Funding calls per annum. The SHC Research Fund welcomes research applications from all NBT staff members to undertake a small pump-priming research project (up to a maximum of £20k) in any subject area. Round 13 is currently at awarding stage and Round 14 will open for new applications in April 2022.

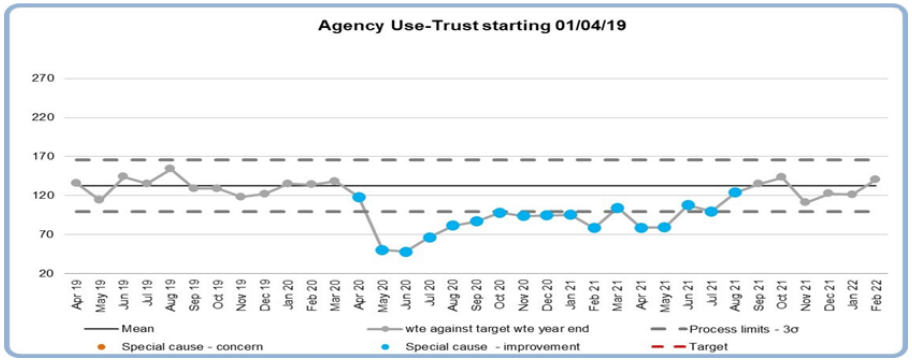
In addition, with support from Southmead Hospital Charity, R&I are piloting a SHC Infrastructure call this year; welcoming applications from across NBT, for research facilitator staff to be embedded within NBT teams, departments, divisions to develop research themes and pipelines of research grants applications (up to £100k). The deadline for applications was 19th January 2022 and R&I received 8 applications, of which 6 have been shortlisted for stage 2: Intensive Care Unit, Neurology and Neurosurgery, Medicine Division, Vascular and Anaesthesia, Neonatology (W&C) and Renal. The awarding panel will meet in mid-April.

Well Led

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







Workforce

What Does the Data Tell Us – Vacancies Nursing and Midwifery

Unregistered Nursing

Band 2 vacancies held steady in February at 95.77 wte. We started 15 HCAs in month and leavers dropped this month to 4.86 wte which is the lowest figure since Sept 2021
Band 3 vacancies dropped to 49 in February There were 9.41 wte starters in Jan and 8.49 wte leavers.

Registered Nursing

Band 5 recruitment continued at a steady pace this month and we made 34 new offers to Band 5 staff. We are finalising our programme of internal and external recruitment events for the rest of the calendar year which will see a return to face to face external recruitment and engagement events. The Band 5 vacancy increased slightly to 165.56 wte this month. February saw 8.83 wte new starters but had 13.15 wte leavers. We also had 9 international nurse arrivals.

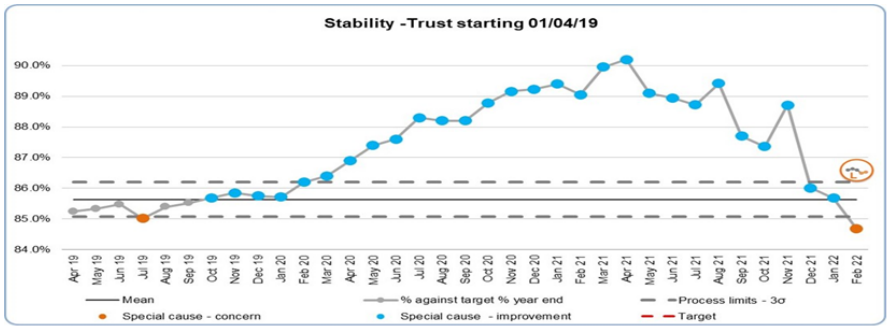
H2

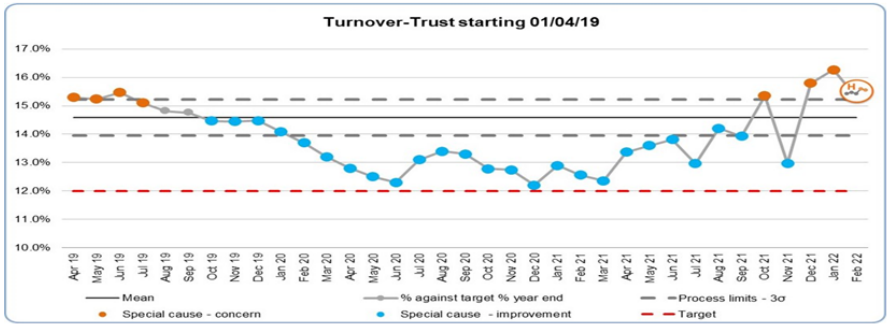
Recruitment for Housekeepers and Administration staff continued throughout February with adverts for both staff groups going out to a wide audience.
We have recruited 15 housekeeping staff, filling all known vacancies.
We have recruited 8 admin staff and have 3 more interviews pending.

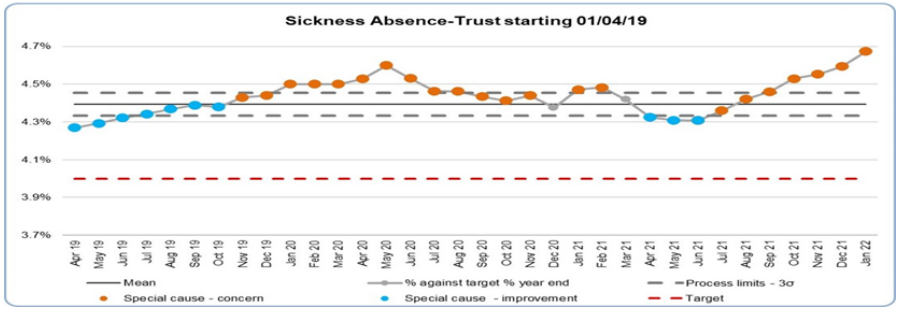
Temporary Staffing

Internal Bank fulfilment remained steady throughout February and Framework Agency fulfilment increased slowly reducing the demand for off framework bookings – which is reflected in the overall spend. Overall unfilled vacancies remained steady at 36% across the month.
Implementation of new BNSSG+B Neutral Vendor for the management of registered Nursing supply commenced with go live 1st April 2022.

Engagement and Wellbeing







What Does the Data Tell Us - Turnover and Stability

While staff turnover reduced slightly in February, it remains high and focussed, targeted work to address this is continuing, as outlined below. While the risk of losing more staff due to the compulsory requirement for COVID vaccination is no longer there, the potential for increased turnover due to staff morale and fatigue remains high.

Actions - Turnover and Stability

Head of People

The Retention Task and Finish has now re-established itself and is meeting again. While we agree upon our areas of focus (staff group and work area) according to what leavers' workforce data tells us, we will be utilising some of the initiatives and interventions referenced in the new NHSEI Retention Toolkit which has just been published.

- Our focus for the next 3 months will be mainly on just one of our key retention priorities: morale: fatigue and resilience of staff.
- We are also very keen to progress career coaching for staff, as feedback from our Itchy Feet calls and leavers' surveys tells us that this is a gap in our current offering and resources to staff. **By end April,** our key, detailed interventions will be defined and will be being implemented in line with the above priorities.

- Focussed work is continuing in the Facilities Division, reviewing their exit and leavers' processes to ensure that staff feel able to give feedback and so that any recurrent themes/trends can be understood **(end April 2022).**

What Does the Data Tell Us - Sickness and Health and Wellbeing

- Short term sickness is increasing, particularly in certain staff groups such as HCSWs and Estates and Ancillary staff. Stress/anxiety/depression/other psychiatric illness, remains the greatest cause of long-term sickness absence. For both clinical and non-clinical staff this type of absence has seen an upward trend throughout the pandemic response period.

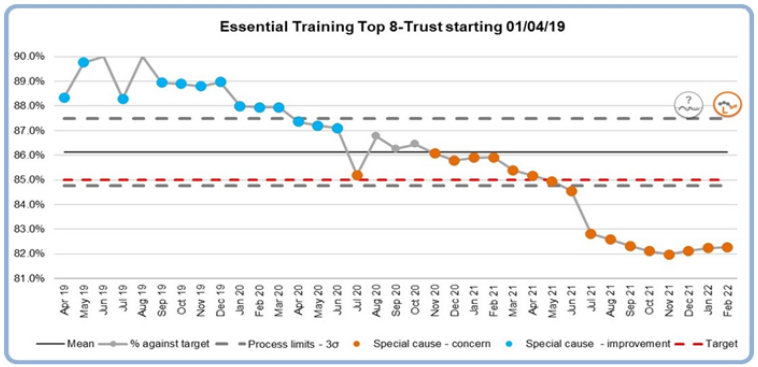
Actions Delivered – Health and Wellbeing – Head of People Strategy

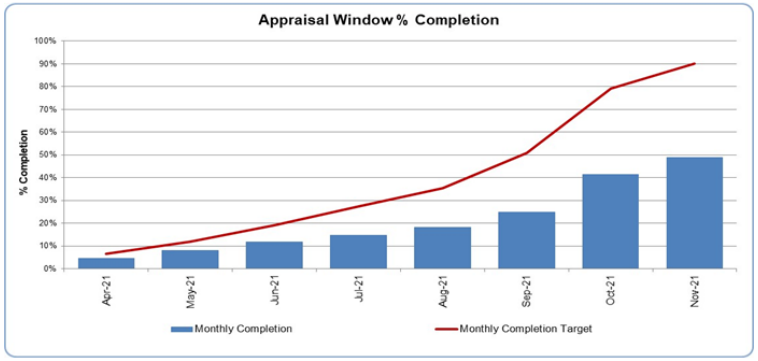
- Targeted wellbeing rounds completed in - Pathology, Pharmacy, Imaging, Wards 33 /9 /27B and Women and Childrens – which was supported by the Divisional Operational Director and People Business Partner. Link established with staff psychology and freedom to speak up for hot spot areas to be appropriately supported through signposting and wellbeing drop ins. Clinical directors informed of areas being supported for overview.

Actions in Progress - Sickness and Health and Wellbeing

Head of People and Head of People Strategy

- Our new sickness policy (more supportive, simpler in style and more practical in application); has been discussed and agreed at JUC. The Implementation plan scheduled for **Jan-22 – Mar-22 is now almost complete and the new policy will be fully operationalised from Apr-22**
- Focus on World Sleep Day 18/3/22 with an NBT Twitter Campaign #NBTSupersleep and Noticeboard competition **– March-22**
- **Wellbeing committee** Paper developed for execs to agree proposed trust level targeted interventions supporting Morale, Tailored team support, Engagement and empowerment, and recognition.





Training Topic	Variance	Jan-22	Feb-22
Child Protection	0.2%	82.0%	82.2%
Adult Protection	0.1%	83.7%	83.8%
Equality & Diversity	0.0%	85.1%	85.1%
Fire Safety	-0.3%	80.8%	80.5%
Health &Safety	0.3%	84.2%	84.5%
Infection Control	-3.0%	92.3%	89.2%
Information Governance	1.0%	75.9%	76.9%
Manual Handling	1.8%	74.0%	75.8%
Waste	-0.1%	82.9%	82.8%
Total	**0.0%**	**82.23%**	**82.27%**

What Does the Data Tell Us - Essential Training

Throughout the pandemic, essential training compliance has shown a downward trend across the Trust and has been below the minimum threshold of 85% since March-21. This is a trend being seen by other NHS Trusts although we are now starting to see small month on month improvements in the compliance data.

Actions – Essential Training

Head of Learning and Organisational Development

- In March, we continue to explore different mechanisms to help improve Stat Man compliance. These include:
  - ➢ Promoting completion of StatMan through Operational Communication channels and agenda items on Executive Management meetings
  - ➢ Piloting a process that allows new joiners the chance to complete their StatMan e-learning as part of their onboarding journey (completely at the discretion of the individual)
  - ➢ Working with our technical teams to look at deployment of Single Sign On (SSO) for our Learning Management System which will take away the barrier of forgotten user ids and passwords
  - ➢ Final project activities are underway to complete the migration of our learning management platform across to Kallidus LEARN which will provide a much-improved user experience (working towards 11th April launch)

Other Wider Actions

Leadership & Management Learning

- Following a planned pause in learning (Jan & Feb) all leadership and management learning options resume including the One NBT Management Modules and ILM Awards in Leadership & Team Skills and Effective Coaching

Apprenticeships

- Whilst some non-essential learning activities have been postponed, the Trust has maintained the delivery of its Apprenticeship programmes. This will ensure Apprentices are able to receive development core to their role, allowing them to progress to the next pay band level within the agreed timelines. This progression also allows Apprentices (eg. HCSW) to apply their skills to a wider variety of tasks in the workplace.
- A delay in processing of invoices at UWE means we are unable to share our monthly levy utilisation but this has been tracking at c 75%

Feb-22	Day shift		Night Shift	
	RN/RM	CA Fill	RN/RM	CA Fill
Southmead	91.6%	77.7%	96.7%	87.7%

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

The safe staffing report now requires the wards to identify Nursing Associates including Trainees and AHP staff employed in an inpatient area. There are however ongoing issues with the reporting and this has been escalated to Allocate the roster provider. We will be back reporting as soon as it is possible.

Staff absence related to COVID self-isolation impact experienced during February as can be seen below. There is an organisational focus on recruiting to Care Staff (HCSW) vacancies

Wards below 80% fill rate for Registered Staff:

for all areas safe staffing maintained through daily staffing monitoring and supplementing with unregistered staff as required

- 27b (63.4% Day / 60.6% Night) staffing supplemented with redeployed RNs and HCSW
- 32b (79.9% Day) staffing supplemented with redeployed RNs and HCSW.
- Medirooms (79.6% Day) Registered staff vacancies and absence, staffing deployed as required to meet patient needs across the service
- 7b (67.4% Day) staffing supplemented with redeployed RNs and HCSW
- Cotswold (50.8% Day / 79.7% Night) Registered staff vacancies, reduced occupancy staffing deployed as required to meet patient needs across the service
- Cossham Birth Centre (79.5% Night) Registered staff vacancies and absence, staffing deployed as required to meet patient needs across the service
- Percy Phillips (70% Day) Registered staff vacancies and absence, staffing deployed as required to meet patient needs across the service
- Mendip (70.6% Day) Registered staff vacancies and absence, staffing deployed as required to meet patient needs across the service

Wards below 80% fill rate for Care Staff:

for all areas safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required

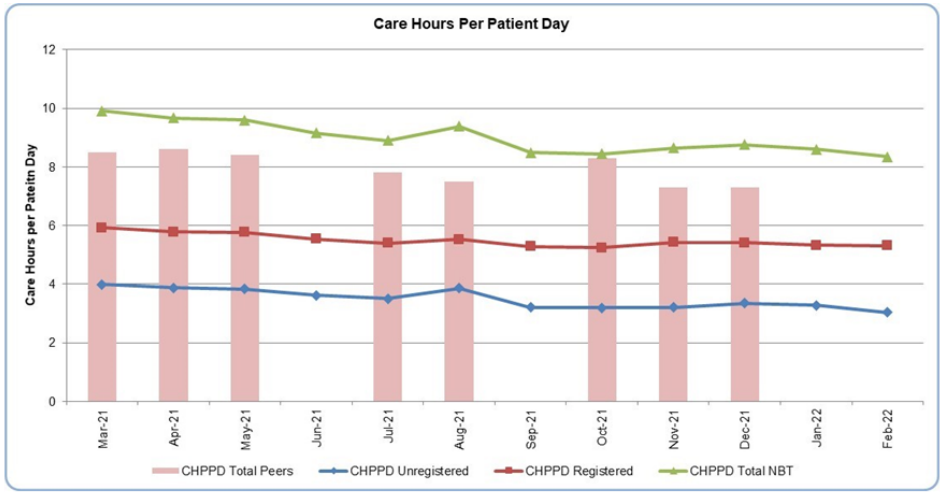
- 9a (76.2% Day) Unregistered staff vacancies and absence
- 32a (76.7% Day) Unregistered staff vacancies and absence
- EEU (61.1% Day) Unregistered staff vacancies and absence
- 9b (66.1% Day) Unregistered staff vacancies and absence
- AMU (79.7% Day / 57.1% Night) Unregistered staff vacancies and absence
- 8a (79.9% Day) Unregistered staff vacancies and absence
- 28b (78.7% Day) staffing supplemented with redeployed RNs
- 34b (61.7% Day / 70.4% Night) Unregistered staff vacancies
- Medirooms (58.7% Day / 71.9% Night) Unregistered staff vacancies
- 8b (58.7 Day / 68.9% Night) Unregistered staff vacancies
- 26a (76.6% Day) Unregistered staff vacancies and absence
- 26b (71.9% Day) Unregistered staff vacancies and absence
- 7a (67.5% Day / 72.2% Night) Unregistered staff vacancies and absence
- NICU (35.5% Day / 41.9% Night) Unregistered staff vacancies, safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required.
- Quantock (55% Day / 74.5% Night) vacancies, staffing deployed as required to meet patient needs across the service.
- Cotswold (68.8% Day / 79.7 Night) Unregistered staff vacancies staffing deployed as required to meet patient needs across the service

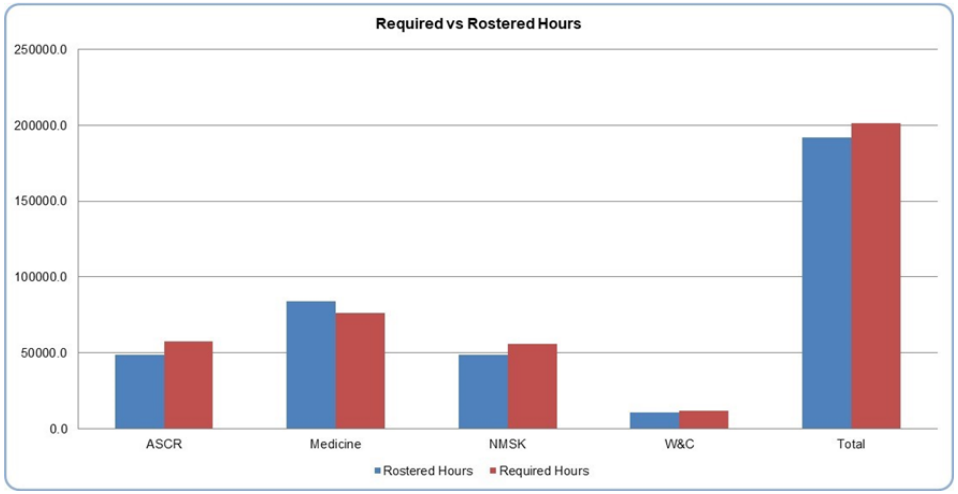
Wards over 150% fill rate for Registered Staff:

None

Wards over 150% fill rate for Care Staff:

- 33a (200.2% Night) patients requiring enhanced care support
- 25a (152.2% Night) patients requiring enhanced care support





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

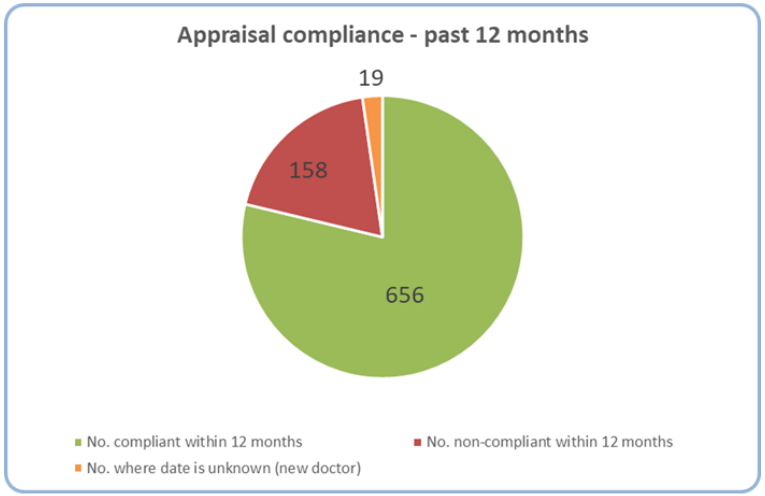
The chart shows care hours per patient day for NBT total and is split by registered and unregistered nursing. The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital).

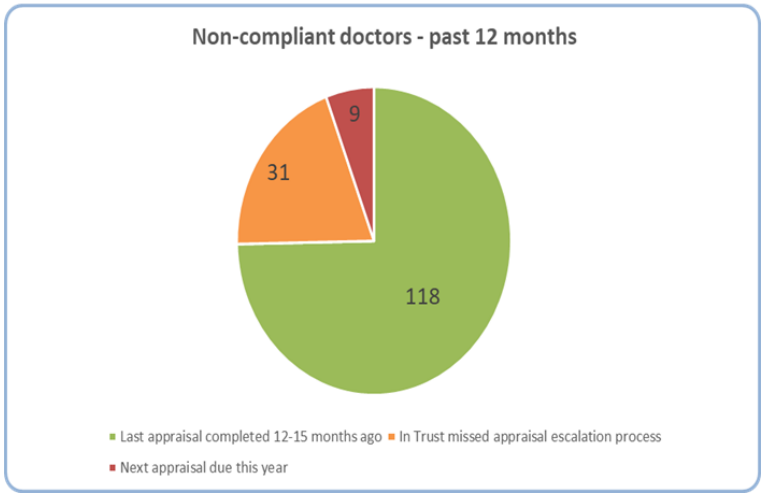
CHPPD are consistent with last month, rostered hours overall are above the required hours due to the decreased patient census and reduced lists.

Safe Care Live (Electronic Acuity Tool)

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

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





Medical Appraisal

What does the data tell us?

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).

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.

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. Due to these automatic deferrals, the number of revalidations due in 2021/22 has now risen.

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 2021/22.

Finance

Board Sponsor: Chief Financial Officer
Glyn Howells

Statement of Comprehensive Income at 28 February 2022

	Month 11			Year To Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Contract Income	56.9	56.4	(0.5)	619.4	620.0	0.6
Other Income	6.5	6.5	0.1	66.7	80.8	14.1
Pay	(39.0)	(39.0)	0.0	(421.8)	(416.9)	4.9
Non-Pay	(24.4)	(23.9)	0.4	(264.2)	(283.8)	(19.6)
Surplus/(Deficit)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Assurances

The year to date financial position to the end of February 2022 shows a breakeven position which is in line with plan.

Pay expenditure year to date is £4.9m favourable to plan due to unfilled vacancies across all clinical divisions.

Non-pay spend year to date is £19.6m adverse driven by underperformance on savings, actual and estimated accelerator costs, and the costs of the Nightingale Facility on site.

The Trust has made no changes to its forecast outturn of a breakeven position for the year and is formally reviewing the position on a monthly basis.

Statement of Financial Position at 28 February 2022

	20/21 M12 £m	21/22 M10 £m	21/22 M11 £m	In-Month Change £m	YTD Change £m
Non Current Assets					
Property, Plant and Equipment	579.3	571.2	571.7	0.5	(7.6)
Intangible Assets	14.7	12.0	11.8	(0.2)	(2.9)
Non-current receivables	1.7	1.7	1.7	0.0	0.0
Total non-current assets	**595.8**	**585.0**	**585.3**	**0.3**	**(10.5)**
Current Assets					
Inventories	8.5	8.8	8.8	(0.0)	0.3
Trade and other receivables NHS	10.2	23.1	19.0	(4.1)	8.8
Trade and other receivables Non-NHS	26.3	23.1	21.1	(2.0)	(5.2)
Cash and Cash equivalents	121.5	116.1	125.9	9.8	4.4
Total current assets	**166.5**	**171.1**	**174.7**	**3.6**	**8.3**
Current Liabilities (< 1 Year)					
Trade and Other payables - NHS	26.9	6.1	8.1	2.0	(18.8)
Trade and Other payables - Non-NHS	98.7	106.9	106.0	(0.9)	7.3
Deferred income	8.5	19.6	23.5	3.8	15.0
PFI liability	12.3	15.2	15.2	0.0	3.0
Finance lease liabilities	2.8	2.2	2.2	(0.1)	(0.6)
Total current liabilities	**149.2**	**150.1**	**155.0**	**4.9**	**5.8**
Trade payables and deferred income	7.8	8.2	8.1	(0.1)	0.3
PFI liability	368.7	360.8	360.1	(0.8)	(8.6)
Finance lease liabilities	3.9	2.3	2.2	(0.1)	(1.8)
Total Net Assets	**232.6**	**234.6**	**234.6**	**0.0**	**2.0**
Capital and Reserves					
Public Dividend Capital	448.7	448.7	448.7	0.0	(0.0)
Income and expenditure reserve	(381.6)	(378.1)	(378.1)	0.0	3.5
Income and expenditure account - current year	3.5	0.4	0.5	0.0	(3.0)
Revaluation reserve	162.0	163.5	163.5	0.0	1.5
Total Capital and Reserves	**232.6**	**234.6**	**234.6**	**0.0**	**2.0**

Assurances and Key Risks

Capital – Plan Year to date £19.9m, with actual spend of £17.9m. Plans are in place to ensure that capital funding is fully utilised by year end.

Receivables - Of the £8.8m year to date increase in NHS receivables, £10.0m relates to accrued Mass Vaccination Service income.

Payables - Year to date NHS payables have reduced by £18.8m, of which £14.0m is a result of the monies paid in advance by NHS England relating to 2020/21, along with the settlement of a £7.9m credit note that was due to BNSSG CCG at 31 March 2021 plus £3.1m of net other increases.

Cash – Cash at 28 February amounts to £125.9m, an in-month increase of £9.8m due to £4.5m of NHS England receipts in respect of mass vaccinations, £3.4m of cash from Health Education England, and £1.4m lower payments in-month.

The cash balance has increased by £4.4m in-year.

Forecast Outturn Position

The Forecast Outturn Position for the end of the financial year is still expected to be breakeven as per table below.

	H1	H2	2021/22	2021/22
	Actual	Financial Plan	Forecast	Budget
	£m	£m	£m	£m
Contract Income	337.5	338.1	675.7	662.3
Other Income	39.0	38.4	87.4	71.6
Pay	(223.7)	(233.1)	(456.8)	(442.2)
Non-Pay	(152.8)	(143.4)	(303.8)	(291.7)
Total	**0**	**0**	**2.5**	**0**

Risk and Mitigations

Each month an assessment of the Risks and Mitigations is completed and included in the monthly Finance Report.

The Trust is developing schemes that will contribute to improving performance and / or investing in schemes that will deliver financial benefits in the 2022/23 financial year.

An increase in non-recurrent income in Half 2 to support recovery actions will be managed through Recovery Boards to support workstreams.

Regulatory

Board Sponsor: Chief Executive
Maria Kane

Monitor Provider Licence Compliance Statements at March 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, 28 February 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 2021/22

QP1 Ensure quality and safety of services is sustained whilst recovering from the impact of the COVID-19 pandemic; including:

- Maintaining excellence in infection prevention and control
- Ensuring the appropriate clinical priorities for recovery work
- Keeping people waiting for planned care safe
- Maintaining safety and excellent outcomes from emergency care

QP2 Being outstanding for Safety– a national leader in implementing the NHS Patient Safety Strategy within a "just" safety culture

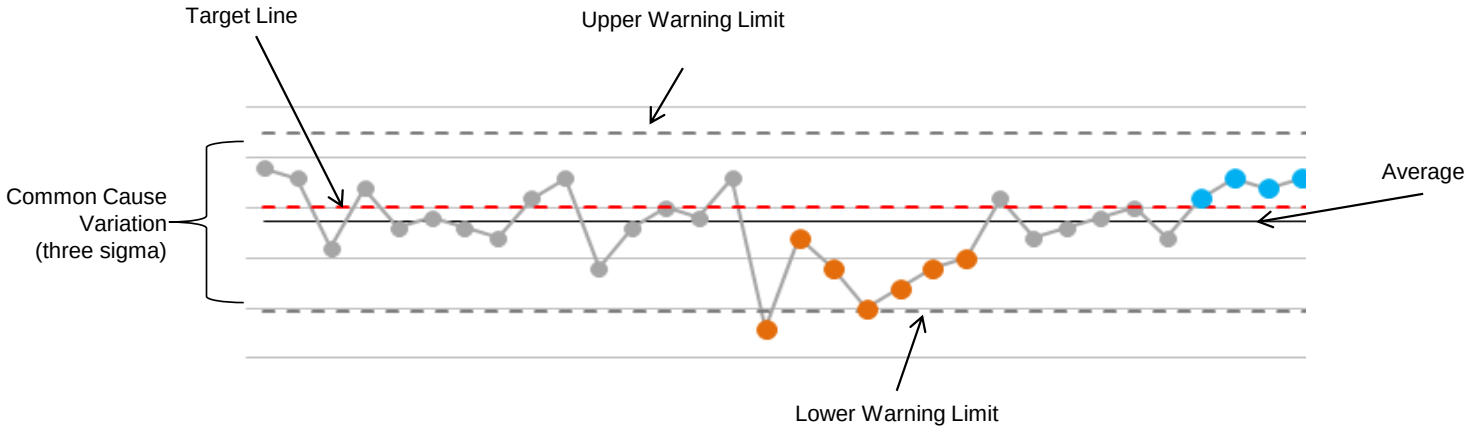
QP3 Ensuring excellence in our maternity services, delivering safe and supportive maternity care.

QP4 Meeting the identified needs of patient with learning difficulties, autism or both.

Abbreviation Glossary

AMTC	Adult Major Trauma Centre
ASCR	Anaesthetics, Surgery, Critical Care and Renal
ASI	Appointment Slot Issue
C2R	Criteria to Reside
CCS	Core Clinical Services
CEO	Chief Executive
Clin Gov	Clinical Governance
CT	Computerised Tomography
D2A	Discharge to assess
DDoN	Deputy Director of Nursing
DTOC	Delayed Transfer of Care
ERS	E-Referral System
GRR	Governance Risk Rating
HoN	Head of Nursing
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
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
WCH	Women and Children's Health
WTE	Whole Time Equivalent

Appendix 2: Statistical Process Charts (SPC) Guidance



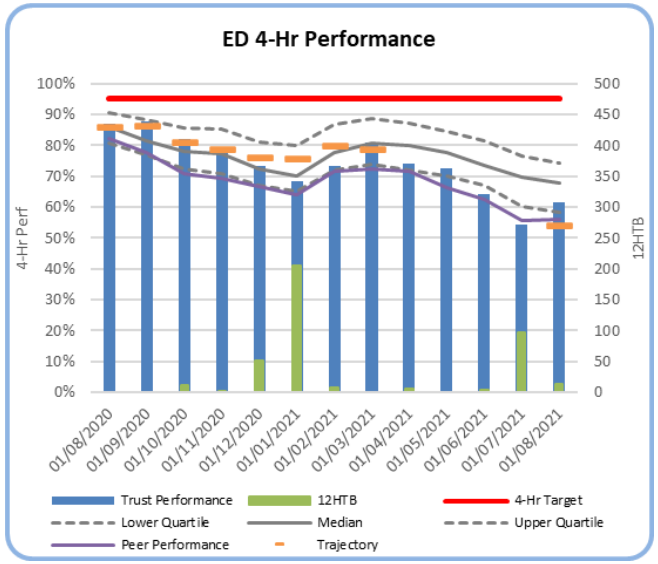
Orange dots signify a statistical cause for concern. A data point will highlight orange if it:
A) Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.
B) Runs for 7 consecutive points below 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

Appendix 3: Benchmarking Chart Guidance



Month	Quartile
Aug-20	2nd
Sep-20	2nd
Oct-20	2nd
Nov-20	2nd
Dec-20	2nd
Jan-21	3rd
Feb-21	3rd
Mar-21	2nd
Apr-21	3rd
May-21	3rd
Jun-21	4th
Jul-21	4th
Aug-21	3rd

Grey lines reflect the monthly quartile positions based on the Trusts positioning in comparison to other Trusts. If higher performance is better, then Trust performance beneath the lower dotted line would reflect being in the lower quartile (4th), among the worst performing Trusts. If low performance is good then this would reflect being in the upper quartile (1st), among the best performing Trusts. The table to the right of the chart lists the quartile positions for each month based on the Trust Performance placement within the graph for guidance.

Purple lines reflect combined peer performance. Urgent Care metrics use Adult Major Trauma centres to compare against whilst planned care metrics use those identified by Model Hospital as similar to NBT.

Quartiles are calculated using main NHS Trusts only.

NHS
North Bristol
NHS Trust

No Right to Reside

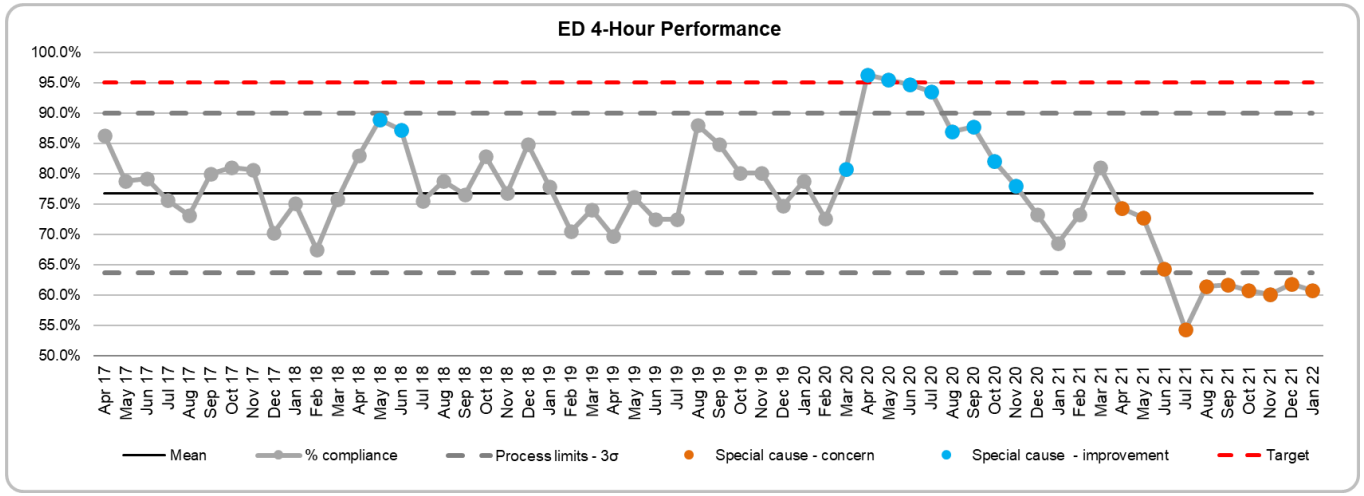
Impact on Acute Bed Base and UEC Performance

22 March 2022

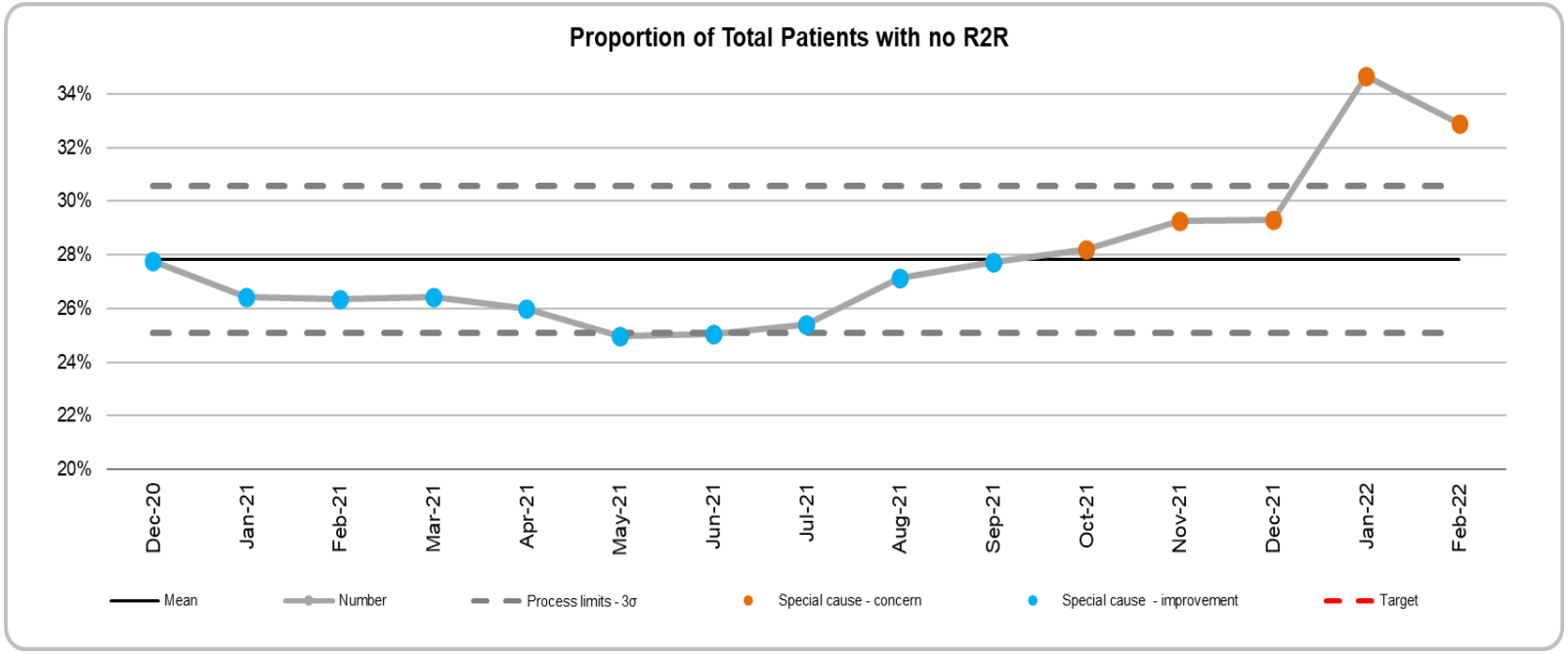
COO 31/03/2022

Exceptional healthcare, personally delivered

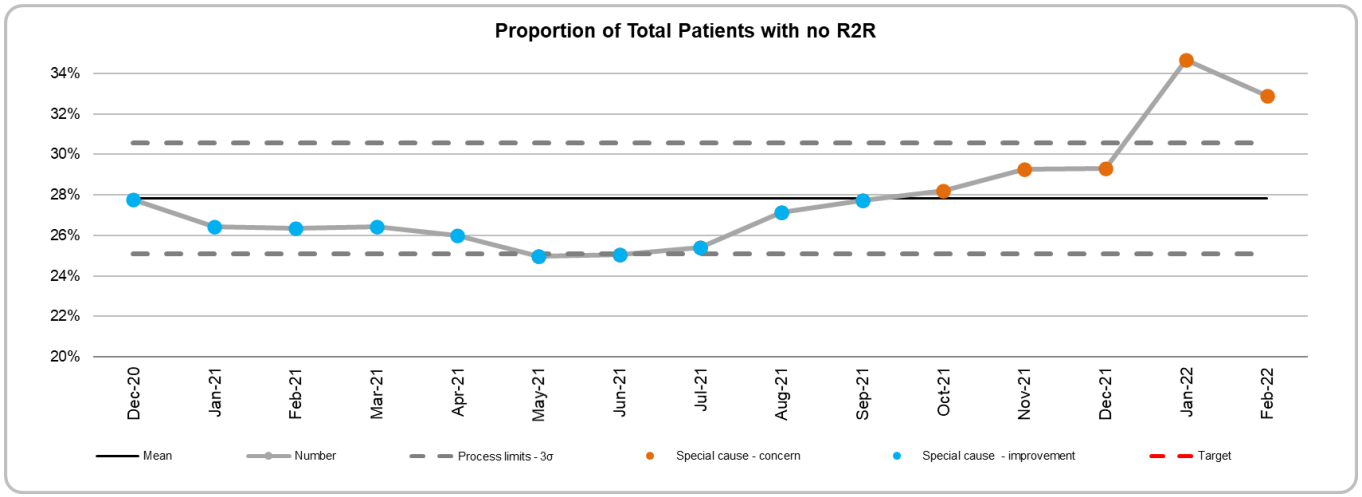
Understanding the UEC position

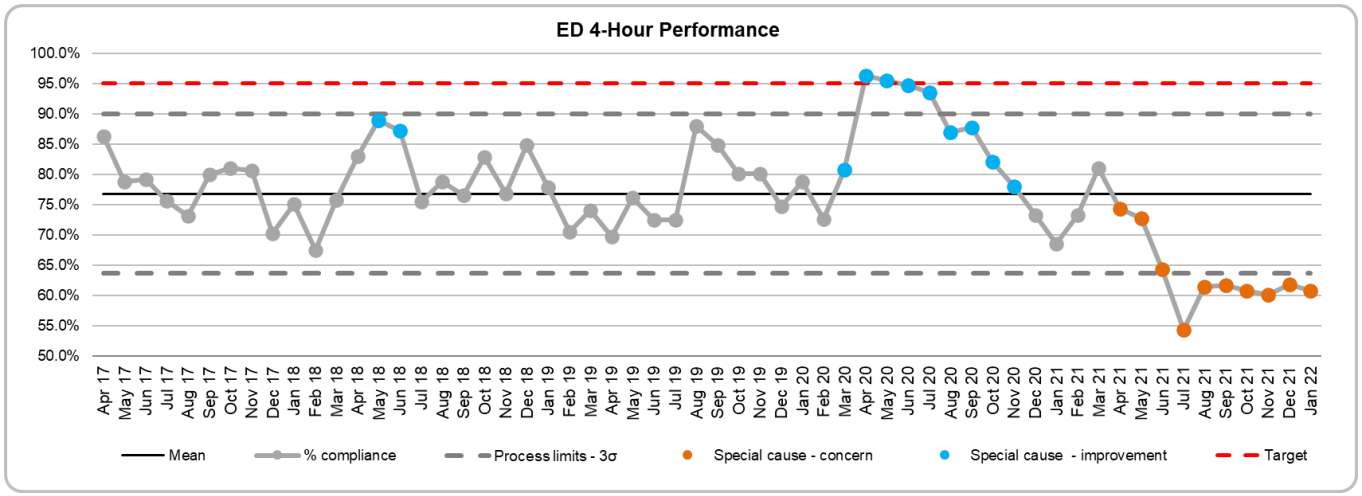


Understanding the UEC Position



R2R | Monthly Trends





R2R | Weekly Reporting – Breakdown of Non-R2R Reasons

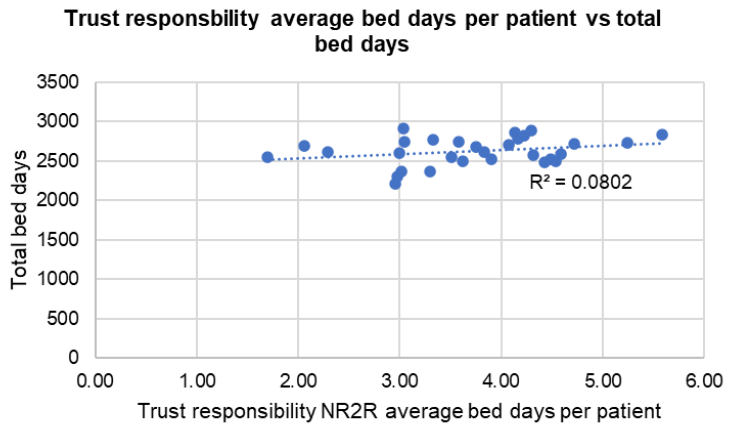
North Bristol NHS Trust

Mon/Fri R2R Report	Fri 18/03/2022			Mon 21/03/2022		
Metric	Patients	Current bed days	Trend	Patients	Current bed days	Trend
Total patients	900		↑	885		↓
Meet Criteria to Reside	528		↑	490		↓
Unknown (status not recorded)	86		↓	138		↑
Repats	23	145	↓	15	98	↓
Trust Non-R2R Responsibility						
P0	6	18	↓	6	29	↑
Therapy	1	0	←	1	3	↑
Medical	1	1	↑	0	0	↓
To avoid spread of (non-Covid19) infectious disease	17	75	↑	5	36	↓
Diagnostic test	1	10	↑	1	13	↑
Waiting Covid test	0	0	←	0	0	←
Family not agreeing	1	16	↑	1	19	↑
Safeguard concern	0	0	←	0	0	←
Awaiting ref to Community SPA	14	48	↓	16	73	↑
AM ward round declared no R2R, then meeting criteria to reside later	0	0	←	0	0	←
Awaiting Medicines	0	0	←	2	0	←
Awaiting Transport	0	0	←	0	0	←
Not Recorded	2	0	←	1	0	←
Total	**43**	**168**	↓	**33**	**173**	↑
Community Non-R2R Responsibility						
P1	82	675	↑	77	847	↑
P2	54	619	↑	57	647	↑
P3	64	998	↓	62	1002	↑
Homeless/no right of recourse to public funds/no place to discharge to	1	11	↑	1	14	↑
Awaiting confirm from Community SPA	19	51	↓	11	50	↓
Equipment and adaptions	0	0	↓	1	2	↑
Total	**220**	**2354**	↑	**209**	**2562**	↑
Grand Total	**263**	**2522**	↑	**242**	**2735**	↑

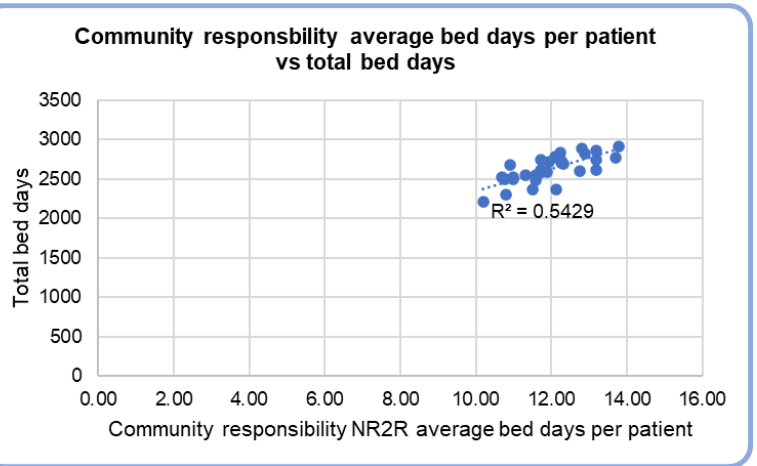
R2R | Original Statistical Analysis

North Bristol NHS Trust

Graph 1



Graph 2



The graphs are based on data from 08/02/2022 to 22/03/2022 working days, which equates to 30 data points.

For the comparison the average number of bed days per patient, per day was calculated for the internal and external reasons.

Graph 1 – shows that Trust responsibility average bed days per patient explains 08.20% of the variation in total average non-R2R bed days per patient.
Graph 2 – shows that Community responsibility average bed days per patient explains 54.29% of the variation in total average non-R2R bed days per patient.

	Patients	Bed days	Patients	Bed days	Patients	Bed days
13-December 2021 (baseline)	45	283	188	2015	233	2298
Proportion of total	**19.31%**	**12.32%**	**80.69%**	**87.68%**		
Daily average (08/02/2022-22/03/2022)	44.87	164.37	206.10	2463.00	250.41	2656.00
Proportion of total	**17.88%**	**6.26%**	**82.12%**	**93.74%**		
Reduce trust by 50%	22.43	82.18	206.10	2463.00	228.53	2545.18
	9.82%	**3.23%**				
Reduce community by 50%	45.23	154.86	103.05	1231.50	148.28	1386.36
			69.50%	**88.83%**		
Percentage point reduction		**3.03%**		**4.91%**		

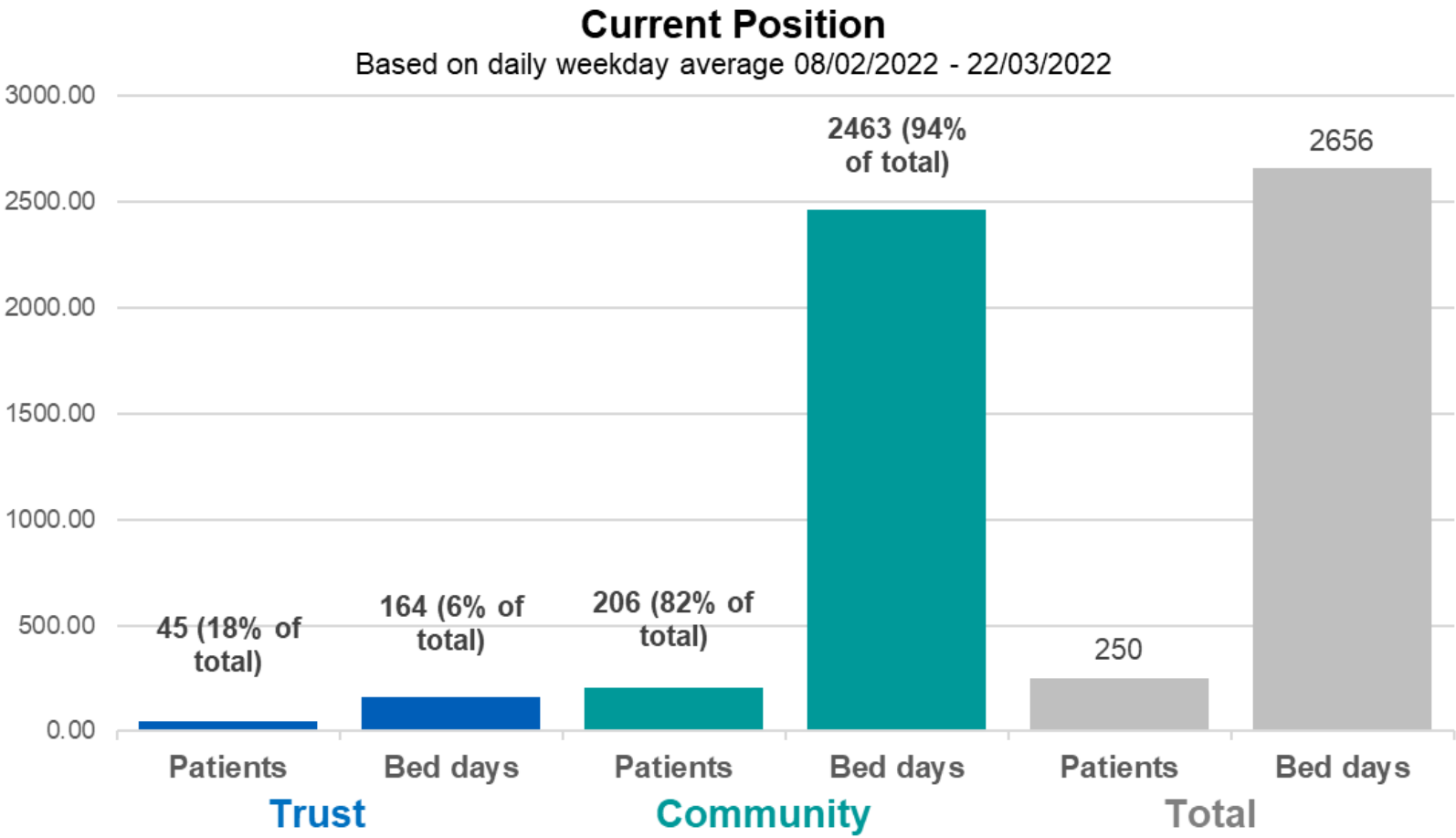
The table above shows that Trust responsibility patients, which on average make up 17.88% of total non-R2R patients, account for just 6.26% of the average total number of bed days. Whereas Community responsibility patients, which make up on average 82.12% of total non-R2R patients, account for 93.74% of the average total number of bed days.

When compared with the December 2021 baseline, the proportion of Trust responsibility patients that account for the total number of bed days has decreased.

If the number of Trust non-R2R patients was reduced by 50%, the proportion of bed days of the total would reduce by only 3.03 percentage points. However if the number of Community non-R2R patients was reduced by 50% the proportion of bed days would reduce by 4.91 percentage points.

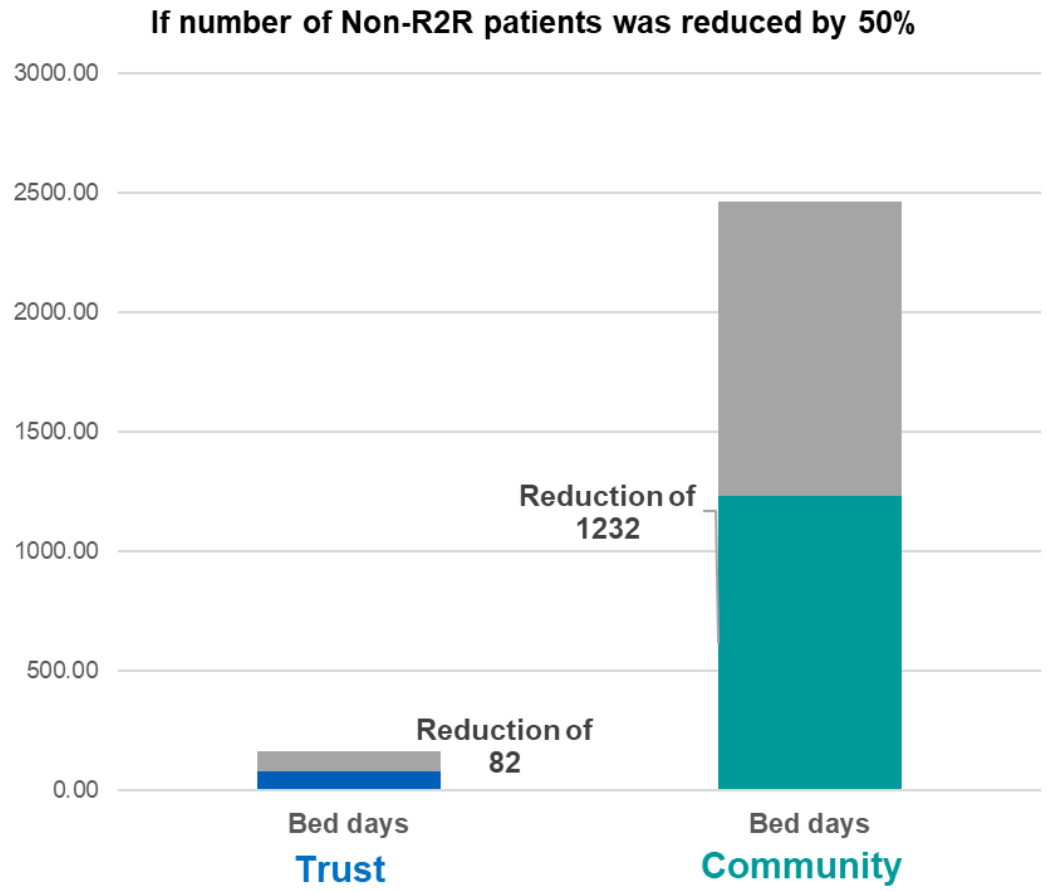
To summarise, based on the data set community responsibility patients account for more bed days than the same number of Trust responsibility patients, and reducing the community responsibility patients by 50% would have a greater relative impact on the total number of bed days than compared to a 50% reduction in Trust responsibility patients.

R2R | Trust vs Community Responsibility



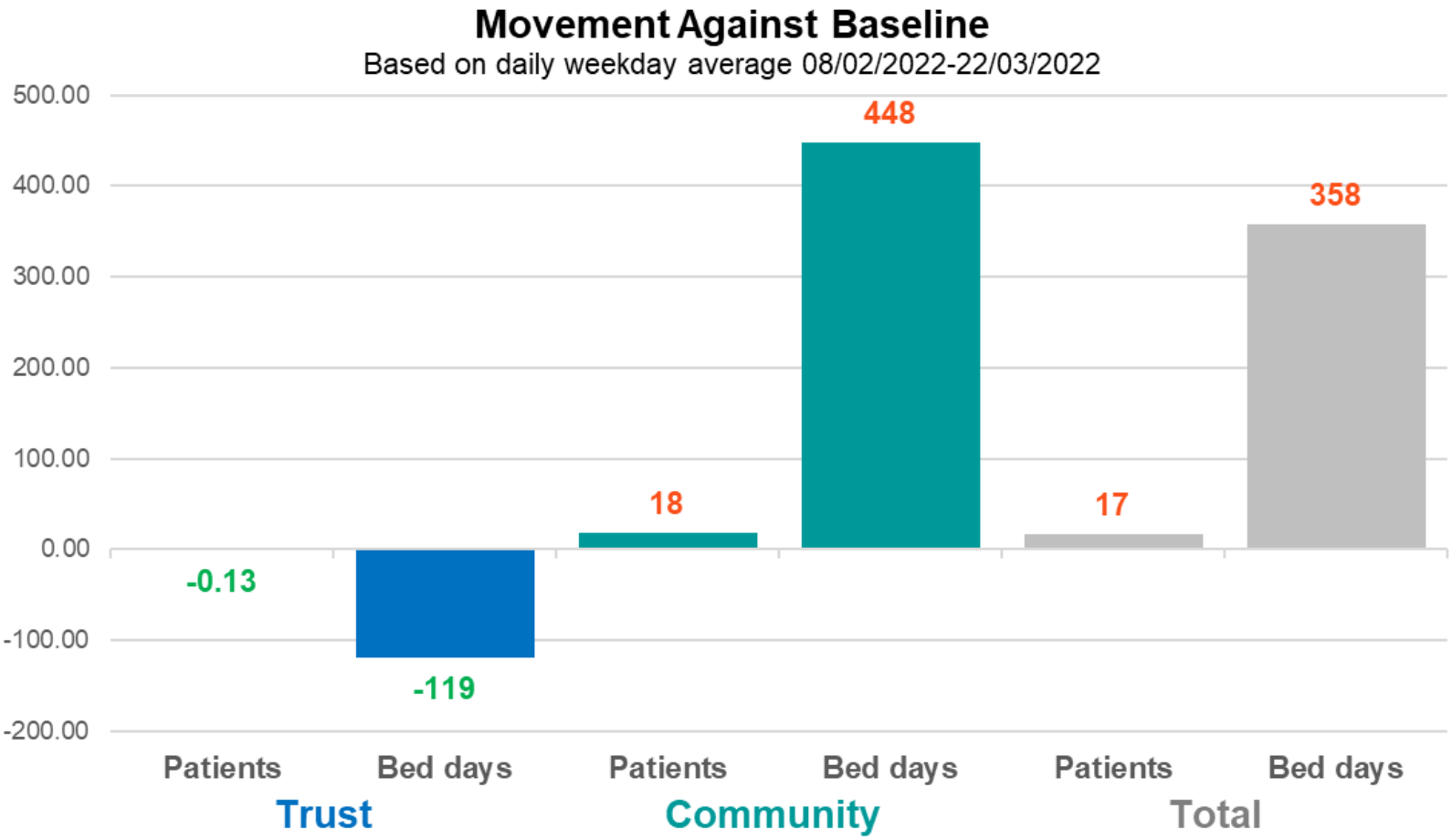
Figures rounded to nearest whole number

R2R | Trust vs Community Responsibility – 50% Reduction



Figures rounded to nearest whole number

R2R | Trust vs Community Responsibility



Against 13/12/2021 baseline. Figures rounded to nearest whole number

R2R | Trust vs Community Responsibility

Based on daily weekday average 08/02/2022 - 22/03/2022

NHS North Bristol NHS Trust

Trust

x1 =

an acute hospital bed occupied for 3.66 days without R2R

Community

x1 =

an acute hospital bed occupied for 11.95 days without R2R

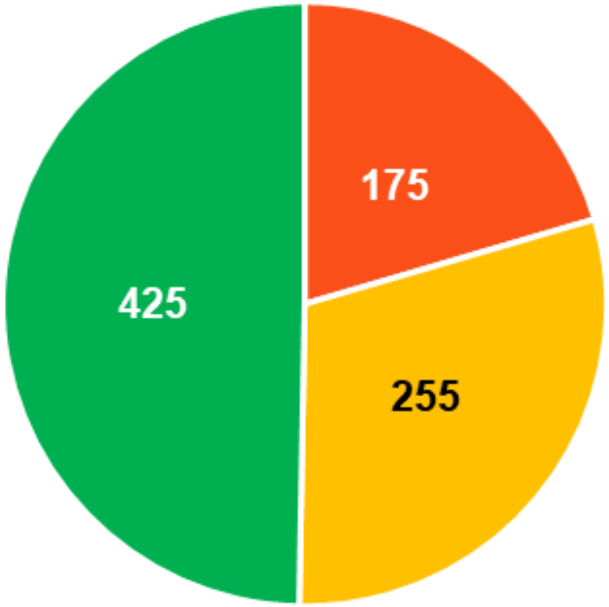
R2R | Functional Flow Capacity

North Bristol NHS Trust

Bed Base Breakdown

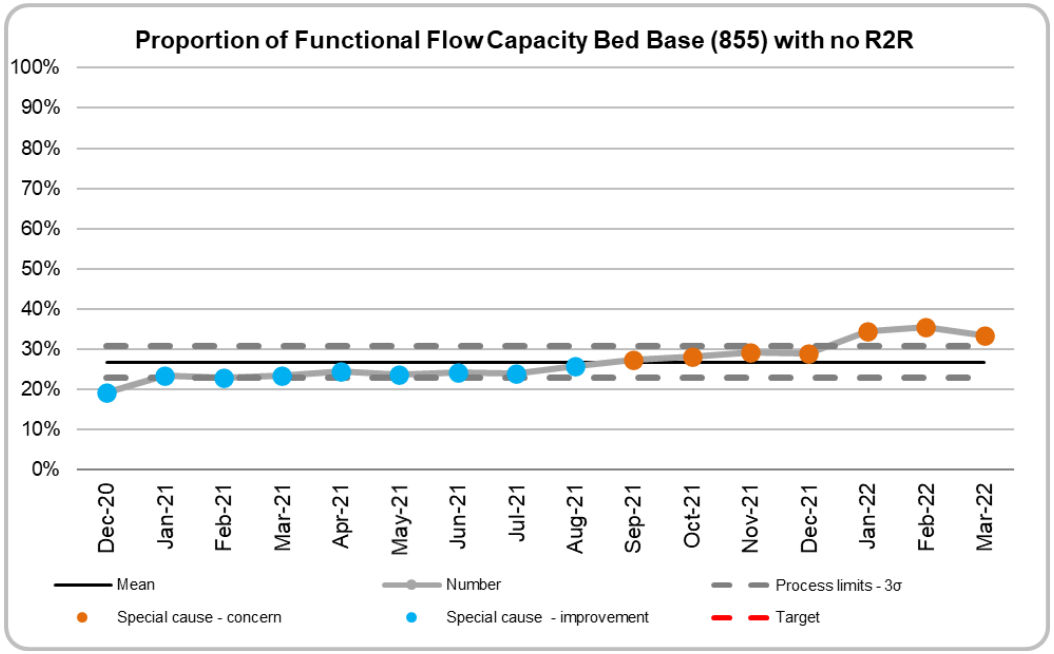
395 if at 93% occupancy

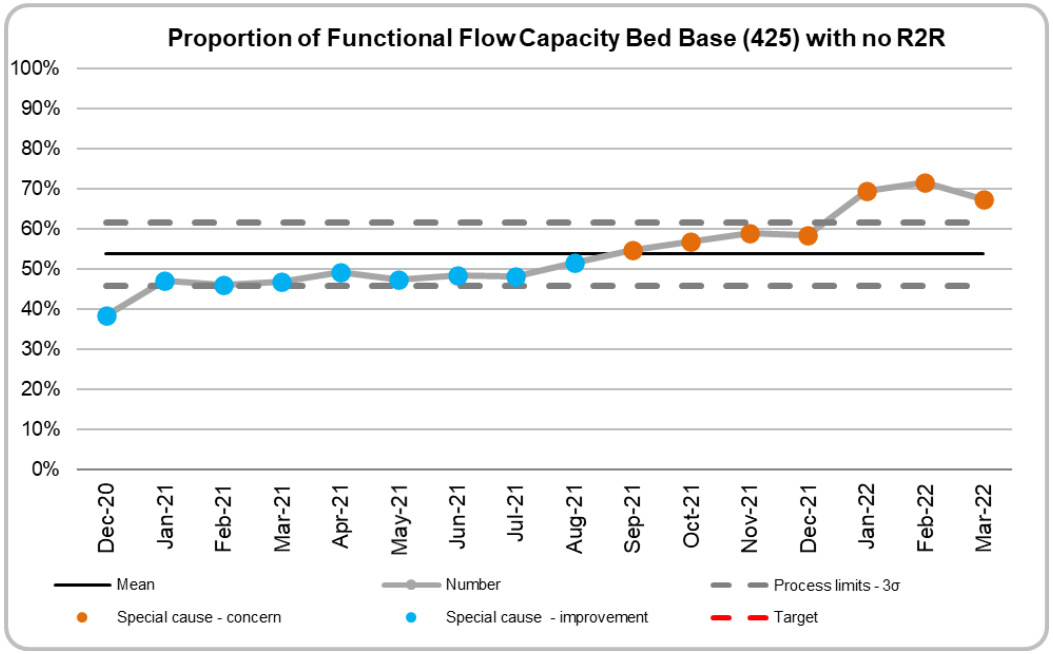
361 if at 85% nationally recommended occupancy



- No go - for defined use only (e.g. Covid, burns, AEC)
- Restricted - some flexibility but limitations in use
- Functional flow capacity

R2R | Functional Flow Capacity – R2R Trend

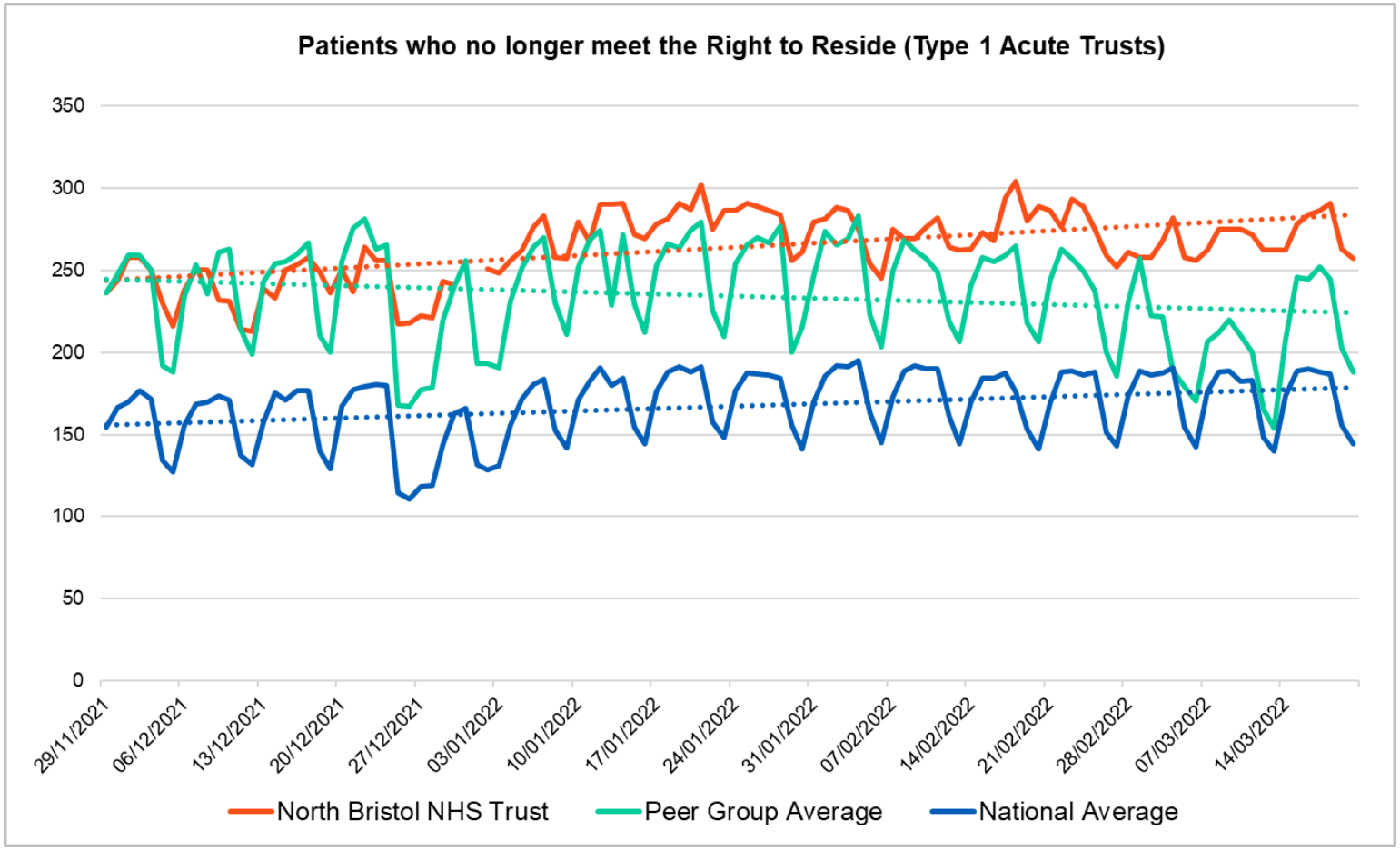




These graphs give a broad illustration of how non-R2R patients impact each bed base, assuming all non-R2R patients occupy functional flow capacity beds. In reality there will be non-R2R patients that aren't part of the functional flow capacity bed base, and in fact occupy a restricted bed e.g. Covid.

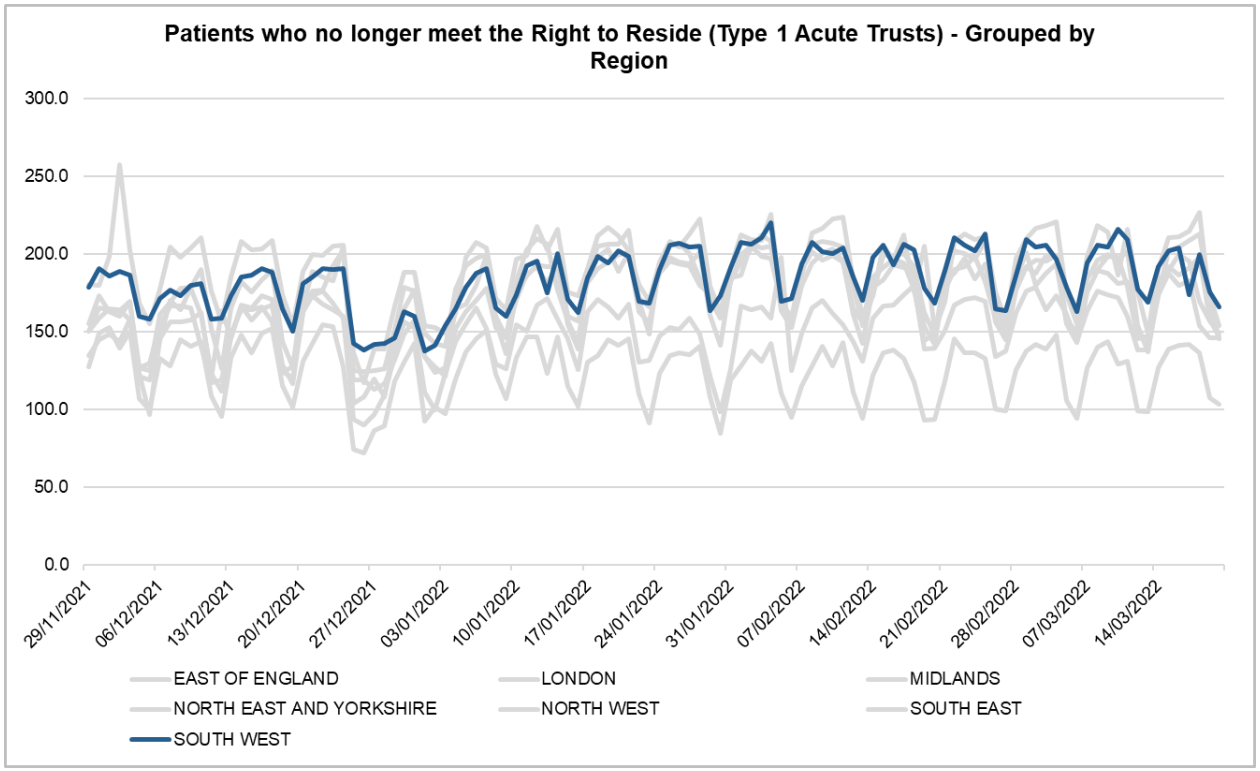
R2R | National Data

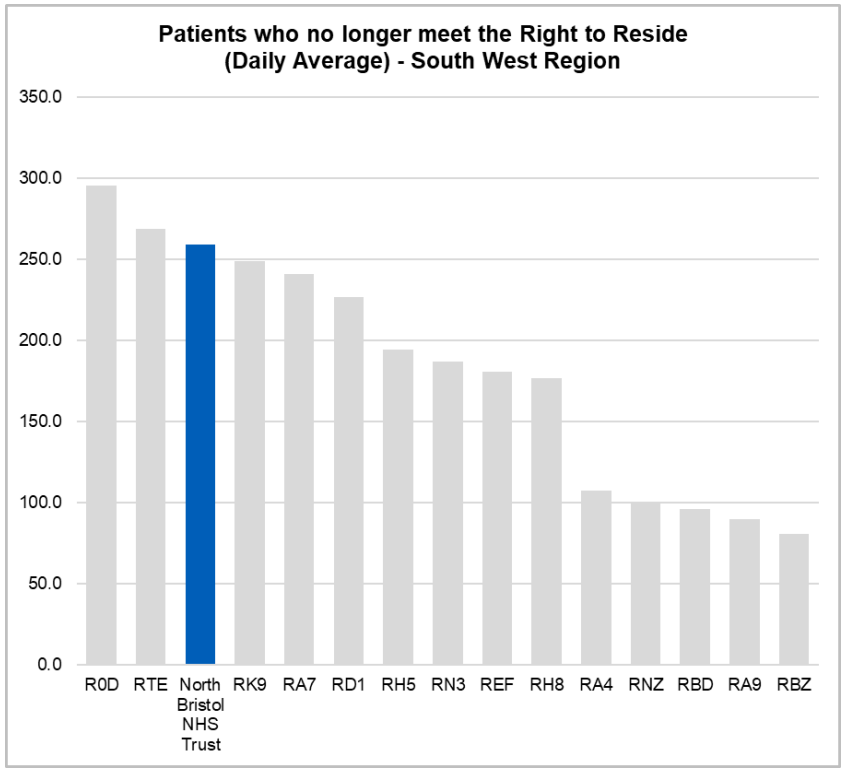
Data range: 29/11/2021 – 20/03/2022



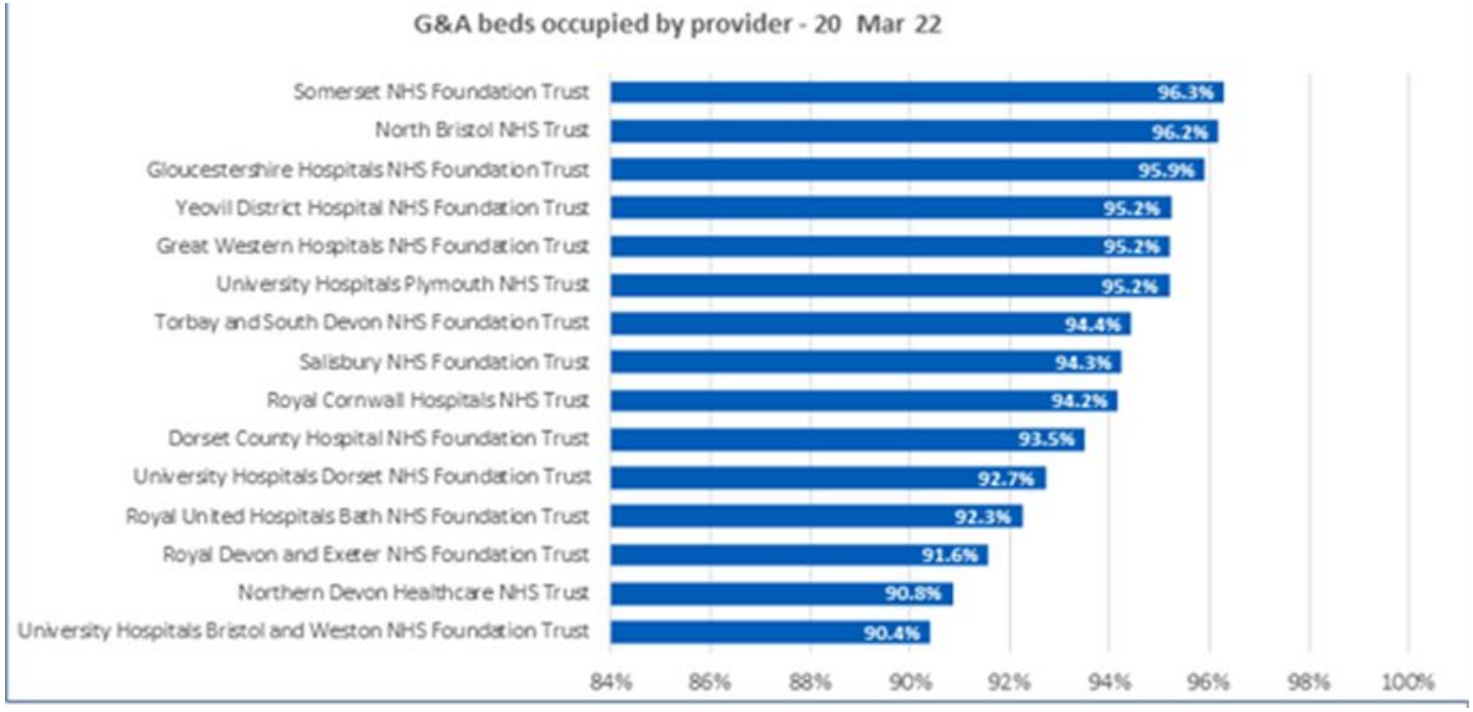
Data source: NHS England | Daily Discharge Sitrep

R2R | Regional Data





NHS
North Bristol
NHS Trust



NHS North Bristol NHS Trust

Key Messages

- Worsening NR2R position 32% - 70% bed availability reduction.
- Greatest opportunity and bed day impact is in community NR2R waits
- Internal actions remain a priority but not sufficient to resolve issue.
- Hospital Exit Block is the overwhelming driver for the current risk and performance in UEC.

- How do we position ourselves as a Trust – to influence an effective system response to this primary system driver.

Report To:	Trust Board - Public		
Date of Meeting:	31 March 2022		
Report Title:	Finance & Performance Committee Upward Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance Isobel Clements, Senior Corporate Governance Officer & Policy Manager		
Executive/Non-executive Sponsor (presenting)	Tim Gregory, Non-Executive Director		
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. • Note the Month 11 Finance Report • Support a discussion regarding the Digital Maternity programme at the next Acute Provider Collaborative Board		
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 February 2021 private Board meeting.		
Next Steps:	The next report to Trust Board will be to the April 2022 private 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 24 March 2022 F&PC.

Strategic Theme/Corporate Objective Links	**Provider of high-quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services c. A Centre of Excellence for specialist healthcare d. A powerhouse for pathology & imaging **Developing Healthcare for the future** e. Training, educating and developing out workforce

	f. Increase our capability to deliver research g. Support development & adoption of innovations h. Invest in digital technology
Board Assurance Framework/Trust Risk Register Links	Reports received at the meeting support the mitigation of various BAF risks.
Other Standards Reference	Links to key lines of enquiry within the CQC regulatory framework.
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.
Other Resource Implications	No other resource implications associated with this report.
Legal Implications	None identified.
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	Appendix 1: Finance & CIP Update Month 11 Report

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 the 24 March 2022.

2. Background

2.1 The Finance and Performance Committee is a sub-committee of the Trust Board. It meets monthly (bar August and December) 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 the NBT Performance Report which provided an update on the latest Trust performance position against a range of key national metrics. Data was broken down into unscheduled and planned care, the latter split between cancer, diagnostics and Referral To Treatment (RTT).

The Committee discussed the performance report, focusing on:

- The continued high levels of patients in the hospital who do not meet the criteria to reside, but remain in hospital due to various blocks to discharge (including limited capacity in community settings), and the associated actions across the system

- The good progress in pursuing the Trust's targets to reduce the longest waiting patients on the RTT backlog
- The fact that the operating environment remains challenging, with Covid-19 levels increasing again, although Covid-19 patient acuity and length of stay is less than earlier in the year
- The balancing of risk between managing the elective programme and the pressures in the Emergency Department

The Committee was also advised that a deep-dive into planned care will be shared with Trust Board in the coming week.

3.2. Finance Report (Month 11)

The Committee received the Month 11 finance report which confirmed that: the financial performance for the year-to-date 2021/22 remains breakeven against the agreed 2021/22 budget; and it would deliver the planned £2m overspend on capital that had been agreed with the System and regulators subject to the approval of the business case being discussed later in Private Board.

The Committee's discussion focused on:

- CIP delivery, noting that CIP delivery was below target for 2021/22, driven largely by Covid-19 and operational pressures over the year. The Committee sought further assurance around future CIP plans, given the CIP requirements for 2022/23
- The difficulty and risk in managing the short turn-around times associated with some national funding streams was noted, which required spending plans to be developed at pace.

The full finance report is attached at Appendix 1.

3.3. Digital Change Programme Delivery

The Committee received an update on the Digital Change Programme including implementation of the new EPR, Office 356, ICU Clinical Information System, Digital Patient, Digital Maternity, ICNet, and Procurement systems.

The Committee discussed some of the risks around the projects in particular the changes of funding source for some investments from capital to revenue.

The Committee felt that some of the programmes, particularly the Digital Maternity and Digital Patient programmes needed to be raised via the Acute Provider Collaborative to ensure an aligned approach/prioritisation across BNSSG, and that issues were being dealt with at an appropriate level.

The update on the EPR implementation focused on the risks and issues being worked through ahead of go-live and ensuring buy-in from all areas of the organisation, and appropriate clinical and operational involvement in decision-making.

3.4. Data Quality Position Statement (Including Annual Data Quality Internal Audit for 2021/22)

The Committee received the Data Quality Position Statement, which identified that overall, the Trust's data quality position has improved from "Good" in 2020/21 to "Excellent" in 2021/22. This included improvements in process and procedure reflected in an excellent 2021/22 Data Quality Internal Audit outcome, maintaining the rating of 'Significant Assurance with Minor Improvements', but with a notably reduced number of recommendations compared to previous years.

3.5. Finance & Performance Trust Level Risks and Board Assurance Framework

The Committee received the F&PC risk reports and noted that the Committee had discussed most of the key risks earlier on the agenda. The Committee was content that key risks were reflected and receiving appropriate attention.

3.6. Other

- F&PC Forward work plan 2022/23: Noted Committee oversight of Transformation going forward (including Patient First) required consideration.

4. Summary and Recommendations

The Committee recommends that Trust Board:

- Receive the report for assurance and note its content.
- Note the Month 11 Finance Report
- Support a discussion regarding the Digital Maternity programme at the next Acute Provider Collaborative Board

Report To:	Finance & Performance Committee (F&PC)		
Date of Meeting:	24 March 2022		
Report Title:	Finance Report for February 2022		
Report Author & Job Title	Elizabeth Poskitt, Director of Operational Finance		
Executive/Non-executive Sponsor (presenting)	Glyn Howells, Chief Financial Officer		
Purpose:	**Approval/Decision**	**Review**	**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 to date • the associated assumptions, opportunities, risks, and mitigations • the forecast outturn for both revenue and capital • the spend on Mass Vaccinations and Covid-19 expenditure areas • the delivery of Cost Improvement Plan savings and how they compare with divisional targets • the Cash position and Capital spend levels to date and forecast		
Report History:	N/A		
Next Steps:	N/A		

Executive Summary
The financial framework for 2021/22 requires the Trust to deliver core operations within an agreed financial envelope and, manage costs incurred in dealing with the Covid-19 pandemic in line with Covid-19 funding provided. The financial performance for the year to date 2021/22 remains breakeven as set out in the Board approved budget paper. A phased plan was developed and submitted to NHS England & Improvement (NHSEI) in Month 2, with a further Half 2 update submitted in Month 8. The actual result for Month 11 (February) is a breakeven position. Bristol, North Somerset, and South Gloucestershire (BNSSG) system are indicating a surplus forecast for the end of the year is £10m, within this NBT are forecasting a £2.5m surplus. This

has been driven by the non-recurrent funding received in year and underspends within pay as a result of vacancies. There continue to be upside risks which will be monitored throughout March. The capital plan is forecast to be overspent by £2m which is making use of a System capital underspend.

Where non-recurrent income has been received in year, there is a risk that we will not be able to deliver recovery actions fully, which could lead to a larger underspend, this will be managed through Half 2 Recovery Board to support the workstreams, system-wide discussions, and a review of actions to mitigate. Whilst the Trust is forecasting a small surplus position, the management of this is dependent upon the ability to maximise opportunities for non-recurrent delivery in 2021/22 which will allow for recurrent benefits in 2022/23.

The Trust continues to deliver a breakeven position as per the plan and a small (<0.5%) forecast surplus despite under delivery of CIP targets, which is offset by the delay in the implementation of recurrent and non-recurrent service developments.

Cash at 28 February amounts to £125.9m, an in-month increase of £9.8m due to receipt of funding from NHS England of £4.5m in respect of mass vaccinations and £3.4m from Health Education England in line with payment schedules.

Total capital spend to date is £17.9m compared to a plan of £19.9m for the first eleven months of the year. £13.5m has been delivered against the core plan of £19.9m, which is offset by an additional £4.4m of capital expenditure on the Accelerator capital programme not planned at the start of the year.

The income reported in Month 11 is based on notified allocations from Bristol, North Somerset, and South Gloucestershire (BNSSG) system for both normal operation and covid pandemic response.

Strategic Theme/Corporate Objective Links	Change how we deliver services to generate affordable capacity to meet the demands of the future
Board Assurance Framework/Trust Risk Register Links	
Other Standard Reference	N/A
Financial implications	N/A
Other Resource Implications	N/A
Legal Implications including Equality, Diversity, and Inclusion Assessment	Delivery of Trust statutory financial responsibilities and Obligations

1. Purpose

This report is to inform and give an update to F&PC on the financial position and performance for Month 11 and the year to date position.

2. Summary

The financial framework for 2021/22 requires the Trust to deliver core operations within an agreed financial envelope and, manage costs incurred in dealing with the Covid-19 pandemic in line with Covid-19 funding provided.

The financial performance for the year to date 2021/22 remains breakeven as set out in the Board approved budget paper. A phased plan was developed and submitted to NHS England & Improvement (NHSEI) in Month 2, with a further Half 2 update submitted in Month 8. The actual result for Month 11 (February) is a breakeven position.

Bristol, North Somerset, and South Gloucestershire (BNSSG) system are indicating a surplus forecast for the end of the year is £10m, within this NBT are forecasting a £2.5m surplus. This has been driven by the non-recurrent funding received in year and underspends within pay as a result of vacancies. There continue to be upside risks which will be monitored throughout March. The capital plan is forecast to be overspent by £2m which will allow the Trust to utilise some of the BNSSG System capital underspend which would otherwise be lost to the system.

Where non-recurrent income has been received in year, there is a risk that we will not be able to deliver recovery actions fully, which could lead to an increased underspend, this will be managed through Half 2 Recovery Board to support the workstreams, system-wide discussions, and a review of actions to mitigate. Whilst the Trust is forecasting a breakeven position, the management of this is dependent upon the ability to maximise opportunities for non-recurrent delivery in 2021/22 which will allow for recurrent benefits in 2022/23.

The Trust continues to deliver a breakeven position as per the plan and the updated forecast underspend of £2.5m despite under delivery of CIP targets, which is offset by the delay in the implementation of recurrent and non-recurrent service developments.

Cash at 28 February amounts to £125.9m, an in-month increase of £9.8m due to receipt of funding from NHS England of £4.5m in respect of mass vaccinations and £3.4m from Health Education England in line with payment schedules.

Total capital spend to date is £17.9m compared to a plan of £19.9m for the first eleven months of the year. £13.5m has been delivered against the core plan of £19.9m, which is offset by an additional £4.4m of capital expenditure on the Accelerator capital programme not planned at the start of the year.

The income reported in Month 11 is based on notified allocations from Bristol, North Somerset, and South Gloucestershire (BNSSG) system for both normal operation and covid pandemic response.

3. Financial Performance

3.1. Total Trust

Overall, the Trust delivered a breakeven position for the year to date.

The tables and commentary in section 3 below provide the financial performance in month and year to date across North Bristol NHS Trust for the Core Trust, Covid-19, Mass Vaccination programme and Nightingale Hub.

The table below summarises the Trust financial performance for Month 11 and year to date.

	Month 11			Year To Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Contract Income	56.9	56.4	(0.5)	619.4	620.0	0.6
Other Income	6.5	6.5	0.1	66.7	80.8	14.1
Pay	(39.0)	(39.0)	0.0	(421.8)	(416.9)	4.9
Non-Pay	(24.4)	(23.9)	0.4	(264.2)	(283.8)	(19.6)
Surplus/(Deficit)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

For Month 11 the Trust has delivered a breakeven position in line with plan. While the Trust continues to meet the overall financial target, there are issues in under performance against CIP targets and delivery of recurrent and non-recurrent service developments.

The Trust has improved its forecast outturn to a small underspend of £2.5m (<0.5%) for the year. A full review of the forecast has been undertaken in advance of Month 11, in addition to a System-wide review, to ensure alignment of approach and understanding.

3.2 Core Trust

The table below summarises the Core Trust including Accelerator activity (excluding Covid-19, Mass Vaccination and Nightingale Hub) financial performance for Month 11 and year to date.

	Month 11			Year To Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Contract Income	55.9	55.4	(0.5)	608.4	609.0	0.6
Other Income	6.5	5.7	(0.7)	66.7	65.2	(1.5)
Total Income	**62.4**	**61.1**	**(1.3)**	**675.0**	**674.2**	**(0.8)**
AHP's and STT's	(5.8)	(5.3)	0.5	(61.8)	(57.4)	4.3
Medical	(11.0)	(11.1)	(0.1)	(119.4)	(119.2)	0.2
Nursing	(13.0)	(13.7)	(0.6)	(141.5)	(143.1)	(1.7)
Other Non Clinical Pay	(8.2)	(8.2)	(0.0)	(88.2)	(84.2)	4.0
Total Pay	**(38.0)**	**(38.3)**	**(0.3)**	**(410.8)**	**(403.9)**	**6.9**
Drugs	(4.0)	(3.5)	0.5	(42.8)	(45.3)	(2.5)
Clinical Supplies (Incl Blood)	(7.3)	(8.2)	(1.0)	(79.6)	(77.6)	2.0
Supplies & Services	(2.8)	(2.6)	0.1	(30.2)	(30.6)	(0.5)
Premises Costs	(2.9)	(3.2)	(0.4)	(30.6)	(33.4)	(2.8)
Other Non-Pay	(7.5)	(5.4)	2.1	(81.1)	(87.6)	(6.5)
Total Non-Pay Costs	**(24.4)**	**(23.0)**	**1.4**	**(264.2)**	**(274.5)**	**(10.3)**
Surplus/(Deficit)	**0.0**	**(0.1)**	**(0.1)**	**0.0**	**(4.2)**	**(4.2)**

The core Trust position in month is £0.1m adverse, and £4.2m adverse year-to-date. This highlights that non-recurrent Covid-19 funding is being utilised to provide the breakeven position.

3.2.1 Core In Month

The contract income variance is £0.5m adverse, driven by additional funding for non-recurrent service developments (such as Target Investment Funding), offset by a year-to-date adjustment of funding for genetics services.

Other Income is £0.7m adverse to plan mostly drive by year-to-date adjustments to education and research income as final agreements are made with our partners in preparation for financial year-end.

Pay expenditure is £0.3m adverse due to the impact of enhanced bank rates paid in February, unbudgeted Accelerator spend and underdelivery of CIPs, offset by the inability to fill vacancies at all levels across all divisions in the hospital.

Non-pay spend is £1.4m favourable which is driven underspend on capital charges, such as deprecation, due to delays in Capital Programme delivery and underspend on drugs, offset by non-recurrent investments in clinical equipment and premises, and underdelivery of CIPs.

3.2.2 Core Year to Date

The year-to-date position is £4.2m adverse.

Pay expenditure is £6.9m favourable to plan due to vacancies across all clinical divisions and unclaimed reserves, which both represent delays in delivery of recurrent and non-recurrent service developments. This is partially adversely offset by unbudgeted Accelerator costs, particularly enhanced bank rates, increased spend on mental health agency nurses in Medicine and underdelivery of CIPs.

Non-pay spend is £10.3m adverse driven by underperformance on CIPs, actual and estimated Accelerator costs, and a central accrual for service restoration, which corresponds with year-to-date increase in payables.

3.3 Covid-19 Trust

The table below summarises the Covid-19 financial performance for Month 11 and year to date.

	Month 11			Year to Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Contract Income	1.0	1.0	0.0	11.0	11.0	0.0
Other Income	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**1.0**	**1.0**	**0.0**	**11.0**	**11.0**	**0.0**
AHP's and STT's	0.0	0.0	0.0	0.0	(0.1)	(0.1)
Medical	0.0	(0.3)	(0.3)	0.0	(0.7)	(0.7)
Nursing	(0.0)	(0.3)	(0.3)	0.0	(3.6)	(3.6)
Other Non Clinical Pay	(1.0)	0.0	1.0	(11.0)	(0.9)	10.1
Total Pay	**(1.0)**	**(0.7)**	**0.3**	**(11.0)**	**(5.4)**	**5.7**
Drugs	0.0	0.0	0.0	0.0	0.0	0.0
Clinical Supplies (Incl Blood)	0.0	0.0	0.0	0.0	0.0	0.0
Supplies & Services	0.0	0.0	0.0	0.0	(0.5)	(0.5)
Premises Costs	0.0	(0.2)	(0.2)	0.0	(0.8)	(0.8)
Other Non-Pay	0.0	0.0	0.0	0.0	(0.1)	(0.1)
Total Non-Pay Costs	**0.0**	**(0.2)**	**(0.2)**	**0.0**	**(1.4)**	**(1.4)**
Surplus/(Deficit)	**0.0**	**0.1**	**0.2**	**0.0**	**4.2**	**4.2**

3.3.1 Covid-19 In month

In Month 11, the position is £0.2m favourable to plan.

The Trust has seen £0.7m spent in month on pay; £0.2m to cover additional sickness and Covid-19 related absences along with an additional £0.4m of pay costs related to ward reconfiguration, additional cleaning, and additional pre-op assessments. The non-pay costs (cleaning, security costs and social distancing measures) are £0.2m in month.

3.3.2 Covid-19 Year to Date

The overall year-to-date position is £4.2m favourable to plan.

The pay position is £5.7m favourable which includes £2.8m to cover additional sickness and Covid-19 related absences and £2.6m of pays costs relating to ward reconfigurations, additional pre-op assessments and additional cleaning.

Non-pay is £1.4m adverse (as all covid costs were budgeted as pay) and includes the additional premises costs linked with cleaning, security, and social distancing measures as well as additional clinical and non-clinical consumables (such as PPE).

3.4 Nightingale Hub

The hospital has been designated as one of the sites for a Nightingale Hub and work started in January 2022 on this project. The facility is now being decommissioned in line with NHSE instructions and will be removed from site by the end of the financial year. The table below summarises Nightingale Hub income and expenditure for Month 11 and year to date.

	Month 11			Year to Date		
	Budget £m	Actual £m	Variance £m	Budget £m	Actuals £m	Variance £m
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0
Other Income	0.0	0.5	0.5	0.0	5.1	5.1
Total Income	**0.0**	**0.5**	**0.5**	**0.0**	**5.1**	**5.1**
AHP's and STT's	0.0	0.0	0.0	0.0	0.0	0.0
Medical	0.0	0.0	0.0	0.0	0.0	0.0
Nursing	0.0	0.0	0.0	0.0	0.0	0.0
Other Non Clinical Pay	0.0	0.0	0.0	0.0	0.0	0.0
Total Pay	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Drugs	0.0	0.0	0.0	0.0	0.0	0.0
Clinical Supplies (Incl Blood)	0.0	0.0	0.0	0.0	0.0	0.0
Supplies & Services	0.0	0.0	0.0	0.0	0.0	(0.0
Premises Costs	0.0	(0.5)	(0.5)	0.0	(5.0)	(5.0)
Other Non-Pay	0.0	0.0	0.0	0.0	0.0	0.0
Total Non-Pay Costs	**0.0**	**(0.5)**	**(0.5)**	**0.0**	**(5.1)**	**(5.1)**
Surplus/(Deficit)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

The costs year to date are mostly linked with construction and setup costs. Income in line with expenditure was recorded and a breakeven position for Month 11 and year to date is reported. All the figures in the table are in line with the current forecast. The Trust will be reimbursed for all costs by NHSEI.

3.5 Mass Vaccination

The table below summarises the Mass Vaccination Programme income and expenditure for Month 11 and year to date.

	Month 11			Year to Date		
	Budget	Actual	Variance	Budget	Actuals	Variance
	£m	£m	£m	£m	£m	£m
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0
Other Income	0.0	0.3	0.3	0.0	10.5	10.5
Total Income	**0.0**	**0.3**	**0.3**	**0.0**	**10.5**	**10.5**
AHP's and STT's	0.0	(0.1)	(0.1)	0.0	(0.6)	(0.6)
Medical	0.0	0.0	0.0	0.0	(0.2)	(0.2)
Nursing	0.0	0.2	0.2	0.0	(4.4)	(4.4)
Other Non Clinical Pay	0.0	(0.1)	(0.1)	0.0	(2.4)	(2.4)
Total Pay	**0.0**	**0.0**	**0.0**	**0.0**	**(7.7)**	**(7.7)**
Drugs	0.0	0.0	0.0	0.0	0.0	0.0
Clinical Supplies (Incl Blood)	0.0	0.0	0.0	0.0	0.0	0.0
Supplies & Services	0.0	0.0	0.0	0.0	0.0	0.0
Premises Costs	0.0	(0.1)	(0.1)	0.0	(2.2)	(2.2)
Other Non-Pay	0.0	(0.2)	(0.2)	0.0	(0.6)	(0.6)
Total Non-Pay Costs	**0.0**	**(0.3)**	**(0.3)**	**0.0**	**(2.8)**	**(2.8)**
Surplus/(Deficit)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

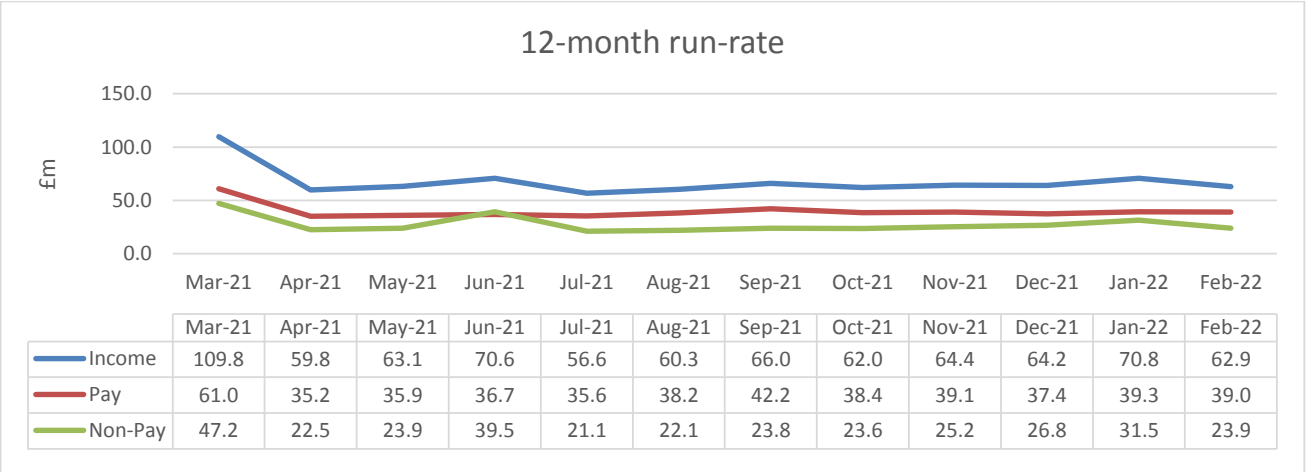
During Month 11 the Trust has continued delivery of Covid-19 Mass Vaccination programme, which resulted no additional Pay Costs and additional non-pay costs of £0.3m. There are variances across individual lines of pay driven by slightly different mix of actuals against accruals. These are offset by the income the Trust receives for this service.

Income in line with expenditure was recorded and a breakeven position for Month 11 and year to date is reported. All the figures in the table are in line with the current forecast. Most costs incurred are staff related, as consumables, such as drugs costs, are being met with nationally supplied stock.

3.6 Trust Trends

The chart below sets out the income, pay and non-pay trends for the Trust over the last 12 months.

The March 2021 position shows the impact of the annual leave accrual, the impact of the employer's contribution to pensions, PPE costs and the income to offset these.



	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Income	109.8	59.8	63.1	70.6	56.6	60.3	66.0	62.0	64.4	64.2	70.8	62.9
Pay	61.0	35.2	35.9	36.7	35.6	38.2	42.2	38.4	39.1	37.4	39.3	39.0
Non-Pay	47.2	22.5	23.9	39.5	21.1	22.1	23.8	23.6	25.2	26.8	31.5	23.9

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

	20/21 M12 £m	21/22 M10 £m	21/22 M11 £m	In-Month Change £m	YTD Change £m
Non Current Assets					
Property, Plant and Equipment	579.3	571.2	571.7	0.5	(7.6)
Intangible Assets	14.7	12.0	11.8	(0.2)	(2.9)
Non-current receivables	1.7	1.7	1.7	0.0	0.0
Total non-current assets	**595.8**	**585.0**	**585.3**	**0.3**	**(10.5)**
Current Assets					
Inventories	8.5	8.8	8.8	(0.0)	0.3
Trade and other receivables NHS	10.2	23.1	19.0	(4.1)	8.8
Trade and other receivables Non-NHS	26.3	23.1	21.1	(2.0)	(5.2)
Cash and Cash equivalents	121.5	116.1	125.9	9.8	4.4
Total current assets	**166.5**	**171.1**	**174.7**	**3.6**	**8.3**
Current Liabilities (< 1 Year)					
Trade and Other payables - NHS	26.9	6.1	8.1	2.0	(18.8)
Trade and Other payables - Non-NHS	98.7	106.9	106.0	(0.9)	7.3
Deferred income	8.5	19.6	23.5	3.8	15.0
PFI liability	12.3	15.2	15.2	0.0	3.0
Finance lease liabilities	2.8	2.2	2.2	(0.1)	(0.6)
Total current liabilities	**149.2**	**150.1**	**155.0**	**4.9**	**5.8**
Trade payables and deferred income	7.8	8.2	8.1	(0.1)	0.3
PFI liability	368.7	360.8	360.1	(0.8)	(8.6)
Finance lease liabilities	3.9	2.3	2.2	(0.1)	(1.8)
Total Net Assets	**232.6**	**234.6**	**234.6**	**0.0**	**2.0**
Capital and Reserves					
Public Dividend Capital	448.7	448.7	448.7	0.0	(0.0)
Income and expenditure reserve	(381.6)	(378.1)	(378.1)	0.0	3.5
Income and expenditure account - current year	3.5	0.4	0.5	0.0	(3.0)
Revaluation reserve	162.0	163.5	163.5	0.0	1.5
Total Capital and Reserves	**232.6**	**234.6**	**234.6**	**0.0**	**2.0**

4.1 Receivables

Of the £8.8m year to date increase in NHS receivables, £6.2m relates to accrued Mass Vaccination Service income. NHS invoiced debt has decreased by £0.5m in year, however, there have been increases of £3.1m accrued income across Divisions.

The £4.1m in-month decrease in NHS receivables was largely due to a £3.8m decrease in Mass Vaccination Service income as a result of cash receipts from NHS England.

Non-NHS receivables reduced by £2.0m in-month, mainly due to the £1.6m unwinding of the prepaid CNST premium to NHS Resolution.

The value of invoiced debt is £20.1m, of this £7.5m relates to non-NHS individuals and organisations and is over 365 days old. £3.8m of the non-NHS debt older than 365 days relates to private and overseas patients and has been fully provided for. The Financial Services team have implemented

new credit control pathways to reduce the level of aged non-NHS debt. They are also currently reviewing all debt >365 days with a view to reducing the balance at year end through a combination of further debt collection and have identified uncollectable debt which will be written off in March 2022. The total Month 11 provision for invoiced doubtful debt is £9.4m.

	Outstanding invoiced debtors, £m	Total	Up to 30 days	30-60 days	60-90 days	90-180 days	180-365 days	365 + days
Feb-22	NHS	6.6	2.4	1.9	0.0	1.0	0.5	0.8
	Non-NHS	13.5	2.2	0.9	0.2	1.4	1.3	7.5
	Total	**20.1**	**4.5**	**2.8**	**0.3**	**2.3**	**1.8**	**8.3**
Mar-21 (excluding £7.9m credit note to BNSSG CCG)	NHS	6.8	3.9	0.1	(0.0)	0.3	0.4	2.0
	Non-NHS	11.2	2.5	0.6	0.3	0.8	2.0	5.1
	Total	**18.0**	**6.4**	**0.7**	**0.2**	**1.1**	**2.5**	**7.1**
Change	NHS	(0.2)	(1.5)	1.8	0.0	0.6	0.1	(1.2)
	Non-NHS	2.2	(0.3)	0.3	(0.0)	0.6	(0.7)	2.4
	Total	**2.1**	**(1.9)**	**2.1**	**0.0**	**1.2**	**(0.7)**	**1.2**

4.2 Payables

Year to date NHS payables have reduced by £18.8m, of which £14.0m is a result of the monies paid in advance by NHS England relating to 2020/21, along with the settlement of a £7.9m credit note that was due to BNSSG CCG as of 31 March 2021, plus £3.1m of net other increases across Divisions.

Non-NHS payables have increased by £7.3m for the year to date, of which £5.5m relates to central accruals and £1.9m relates to covid contingency.

4.3 Deferred Income

Within the year-to-date increase of £15.0m, £6.0m relates to the income received in advance in a commercial arrangement against costs to be incurred in future years, £3.5m relates to deferral of a rates rebate which will be released in Month 12, with the remaining £5.5m relating to the deferral of education, training, and grant monies across Divisions.

Of the £3.8m increase in-month, £1.9m relates to the deferral of cash received from Health Education England during February and £0.5m relates to deferral of a rebate received from NHS Resolution in respect of the NHS CNST maternity incentive scheme.

4.4 Cash

The cash balance increased by £9.8m in-month due to £4.5m of NHS England receipts in respect of mass vaccinations, £3.4m of cash from Health Education England, and £1.4m lower payments in-month.

The cash balance has increased by £4.4m in year.

A high-level cash flow forecast has been developed which shows that the Trust is able to manage its affairs without any external support for the 2021/22 financial year.

	Mar-22 (Forecast) £m
Cash brought forward	**125.9**
Total in-month cash movement	**9.2**
Cumulative cash balance	**135.1**

The cash balance of £125.9m continues to remain high, there is no significant reduction in cash resulting from the known 2021/22 financial framework and the cash forecast assumes a breakeven I&E position at year end.

4.5 Capital

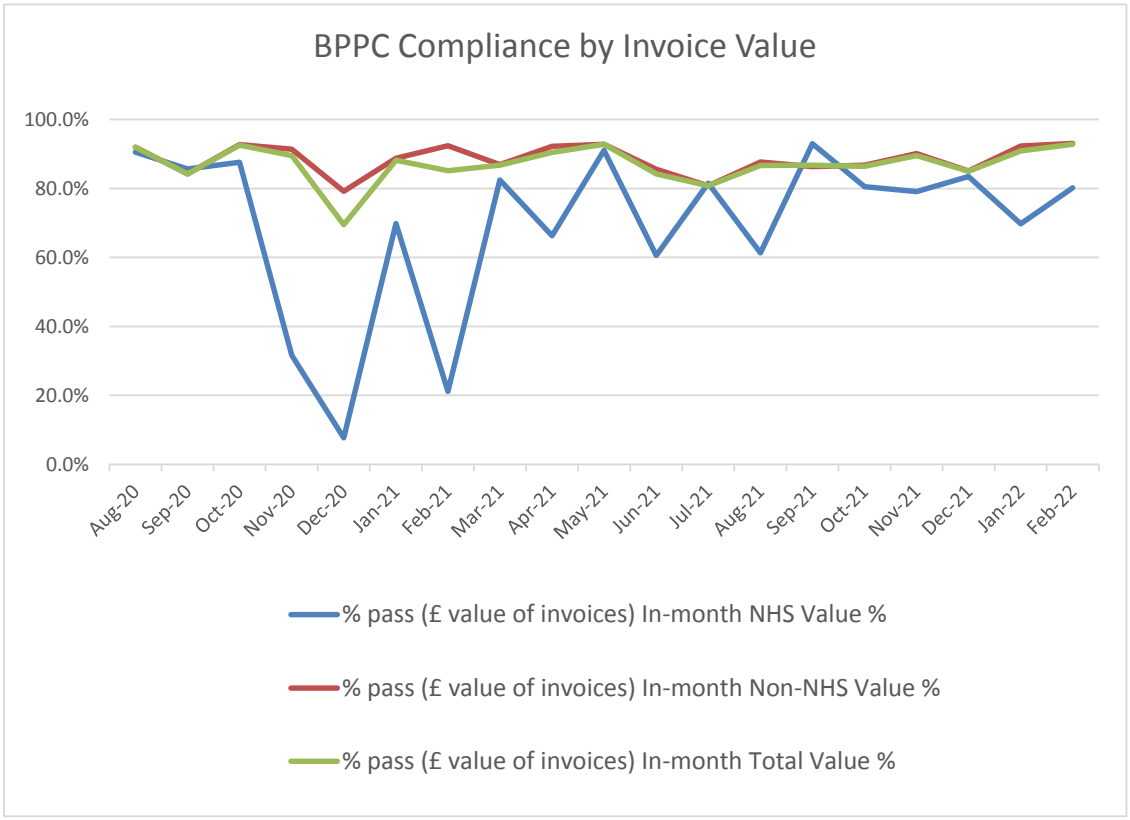
Total capital spend to date is £17.9m, compared to a plan of £19.9m for the first 11 months of the year. Expenditure to date on the core plan is £6.4m below plan but this is offset by an additional £4.4m of capital expenditure on the accelerator capital programme not planned at the start of the year.

The Capital Planning Group reviewed the forecast outturn position at Months 9 and 10 to assess whether further activity is required to ensure delivery and identified a number of additional schemes to mitigate the underspend. Actions are underway to ensure full delivery of the revised plan by the end of March 2022 which will see the Trust delivering an overspend of £2m against the original plan. This overspend has been agreed with the BNSSG System and NHSEI and allows the Trust to utilise some BNSSG system capital underspend.

2021/22 Capital Expenditure	2021/22 plan £m	Forecast £m	Year to date Plan £m	Year to date Actual £m	Year to date Variance from plan £m
Divisional Schemes	3.5	1.4	3.2	0.6	(2.6)
CRISP	6.0	6.2	5.7	3.3	(2.4)
Medical equipment	5.5	7.9	4.9	2.8	(2.1)
IM&T	5.5	8.4	5.0	5.8	0.8
Charity and grant funded	0.6	0.5	0.6	0.4	(0.2)
PFI lifecycle	0.6	0.6	0.5	0.6	0.1
Total Core Plan	21.7	25.0	19.9	13.5	(6.4)
Accelerator programme	0.0	5.9	0.0	4.4	4.4
Additional PDC schemes		1.9	0.0	0.0	0.0
Total	21.7	32.8	19.9	17.9	(2.0)

4.6 BPPC

The Better Payment Practice Code (BPPC) achievement of invoices paid within 30 days, by value, is 87.7% for the year to date in 2021/22, compared to 86.6% for 2020/21. BPPC achievement by volume of invoices has fallen from 86.4% in 2020/21 to 83.8% for the year to date. Supplier terms changes have occurred to ensure coherence with NHS standard 30-day terms. Additionally, the Financial Services team have implemented some opportunities, and this has resulted in an improvement and bringing the monthly achievement level by BPPC value to 92%.



5.Cost Improvement Programme

The CIP plan for 2021/22 was targeting savings of £10m, however delivery in year has fallen short, with less than half forecast to be delivered by year end. The budget reduction targets set for each division and the amounts delivered to date are as below.

Summary Division	FYE Target	Completed	To be Completed by year end	Total FYE	Variance FYE
ASCR	2.2	0.2	0.6	1.0	(1.2)
CCS	2.0	0.7	0.3	1.0	(1.0)
CORP	0.8	0.5	0.1	0.7	(0.1)
FAC	1.0	1.0	0.0	1.0	0.0
MED	1.6	0.3	0.3	0.6	(1.0)
NMSK	1.7	0.1	0.4	0.5	(1.2)
WCH	0.7	0.1	0.0	0.1	(0.6)
Total	**10.0**	**3.1**	**1.8**	**4.9**	**(5.1)**

The current identified CIP position is £4.9m, of which £4.7m are Cash Releasing and £0.2m are through Productivity. Within this number completed schemes amount to £3.1m. The schemes in implementation are £0.8m and schemes in planning are £1.0m.

There remain £1.8m of schemes to be completed by year end, however divisions are working towards delivery.

Departments are working on strategies to develop and provide an outline plan for 2022/23 CIP savings.

6. Assumptions, opportunities, and risks

The Trust has assumed that any surplus Covid-19 cost funding from the System can be retained.

There is a risk that non-recurrent funding is currently being used to cover recurrent costs as block contracts are being rolled over based on 2019/20 costs whilst inflation and other cost pressures are increasing the recurrent cost base of the Trust.

Increased pressure on the hospital over the Winter risks a reduction in elective activity resulting in further underspends against clinical non-pay items.

7. Forecast

Bristol, North Somerset, and South Gloucestershire (BNSSG) system are indicating a surplus forecast for the end of the year is £10m, within this NBT are at £2.5m surplus. This has been driven by the non-recurrent funding received in year and underspends within pay as a result of vacancies. There continue to be upside risks which will be monitored throughout March.

The table below shows the Half 1 actual delivery, the plan for Half 2 and what the resultant forecast is against the originally approved budget.

	H1 Actual £m	H2 Financial Plan £m	2021/22 Forecast £m	2021/22 Budget £m
Contract Income	337.5	338.1	675.7	662.3
Other Income	39.0	38.4	87.4	71.6
Pay	(223.7)	(233.1)	(456.8)	(442.2)
Non-Pay	(152.8)	(143.4)	(303.8)	(291.7)
Total	**0**	**0**	**2.5**	**0**

Risk and Mitigations as of 28 February are set out below. The table shows a surplus position as the most likely year end forecast.

	£m	Commentary
Risks		
Other Risks		
Non delivery of efficiency benefits	(0.5)	
Increase in agency and locum costs, including Registered Mental Health Nurses	(1.0)	Increasing costs in line with year to date run rates
Total	**(1.5)**	
Opportunities		
Mitigating Actions		
Delays in recruitment	1.0	
Delays in recovery actions	1.5	
Depreciation / PDC benefit from delays in investment	1.5	Lower capital charges due to delays in capital expenditure programmes
Total	**4.0**	
Most likely outturn	**2.5**	

Where non-recurrent income has been received in year, there is a risk that we will not be able deliver recovery actions fully, which could lead to an underspend, this has been managed through the Recovery Boards to support the workstreams, system-wide discussions and review of actions to mitigate through Balance Sheet flexibility. The management of this is dependent upon the ability to maximise opportunities for non-recurrent delivery in 2021/22 which will allow for recurrent benefits in 2022/23.

A full review of the forecast has been undertaken in advance of Month 11, in addition to a System-wide review to ensure alignment of approach and understanding.

Following discussion with NHSEI regional colleagues, the NBT forecast position for consolidation into NHSE is shown as a breakeven position with an unmitigated risk of a £2.5m upside.

8. Recommendation

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
- the associated assumptions, opportunities, risks, and mitigations
- the forecast outturn for both revenue and capital
- the spend on Mass Vaccinations and Covid-19 expenditure area
- the delivery of Cost Improvement Plan savings and how they compare with divisional targets
- the Cash position and Capital spend levels to date and forecast

NHS North Bristol NHS Trust

Report To:	Public Trust Board Meeting			
Date of Meeting:	31 March 2022			
Report Title:	Audit & Risk Committee Report			
Report Author & Job Title	Xavier Bell, Director of Corporate Governance Aimee Jordan, Corporate Governance Officer			
Executive/Non-executive Sponsor (presenting)	Richard Gaunt, Non-Executive Director (Committee Chair)			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
			X	
Recommendation:	The Trust Board is recommended to receive the report for assurance and approve the revised Standing Orders and SFIs.			
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 May 2022.			

Executive Summary	
The report provides assurances received, issues escalated to the Trust Board and any new risks identified from the Audit Committee Meeting held on 1 March 2022.	
Strategic Theme/Corporate Objective Links	**1. Provider of high-quality patient care** **2. Developing Healthcare for the future** **3. Employer of choice** **4. An anchor in our community**
Board Assurance Framework/Trust Risk Register Links	The Committee is now the Audit & Risk Committee, with oversight of the Trust's overall risk management systems and processes.
Other Standard Reference	Links to the CQC Well Led domain and key lines of enquiry.
Financial implications	None within this report.
Other Resource Implications	No other resource implications associated with this report.
Legal Implications including Equality, Diversity, and Inclusion Assessment	None identified.
Appendices:	Amended Standing Orders & SFIs.

1. Purpose

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 1 March 2022.

2. 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.

3. Meeting of 1 March 2022

3.1. External Audit Plan 2021-22
The Committee received the External Audit Plan for 2021-22 which included; the approach to discharge responsibilities for 2021/22, the significant risks and value for money review.

It was agreed that the annual audit account review and sign off meeting would be moved from May to June to align with the timeline for the audit process. The Committee were advised that Grant Thornton would be exiting from charity auditing and so the 2021/22 audit for the Trust Charity would be the last one provided by Grant Thornton. It was confirmed that the Charity audit would go out for tender next year.

3.2. External Audit Planning Inquiries
The Committee received the External Audit Planning Inquiries report, noted the contents, and did not raise any concerns regarding the approach.

3.3. Internal Audit Progress Report Including Tracker
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. The recommendation tracker showed the Trust's performance against implementing recommendations.

The Committee were advised that recommendations from the recent Health & Safety review would be actioned by the new Health and Safety manager and the outstanding responses would be sent to KPMG and disseminated to Committee members once agreed.

The Draft 2022-23 plan was discussed at length with particular focus on the capacity to achieve the plan given the current hospital pressures, however the Committee were reassured that the plan could be stood down and changed if required. The Committee endorsed the Draft 2022-23 plan (subject to capacity concerns) and requested regular progress updates.

The Committee noted the positive Draft Head of Internal Audit Opinion and acknowledged the efforts undertaken by the Financial team to tighten controls and processes.

The Internal Audit report on Accessible information Standards was rated as 'partial assurance with improvements required'. It was noted that this was helpful as it would act as a catalyst to undertake improvements and to drive change.

The Committee were assured that the following reports were positive and rated 'significant assurance with minor improvement opportunities': Theatre Bluespier, Financial Systems, and Data Quality and requested that the relevant Board Committees were sighted on the reports.

3.4. Counter Fraud Report:

The Committee received an update from the Local Counter Fraud Specialist. This included the completion of the Patient Expenses and the Conflict-of-Interest reviews and provided an overview of the work undertaken with the Trust communications team to publicise fraud through training sessions with Freedom to Speak Up, Finance, Procurement and Payroll teams.

The Committee also received a counter fraud audit report on the Private Patient Ambulance Review, and KPMG confirmed that the recommendations from the report are being tracked through the internal audit recommendation tracker.

3.5. Counter Fraud 2022/23 Draft Plan

The Committee received the Counter Fraud 2022/23 Draft Plan which included the high-risk area of bank and agency staffing, sickness absence fraud and the ongoing national fraud exercise to analyse matches against sickness and public sector bodies.

The benefits of informing staff of the approach to counter-balance fraud were discussed and the Committee were advised that that the information was being shared through newsletters, fraud reporting and training.

3.6. Risk Report

The Committee received the Trust Level Risk Report and noted that of the 37 risks on the register, 15 of them were new. The Committee were advised the register showed active management of each of the risks, but work was ongoing to improve the process, address the gaps and better understand the target risk scores.

The Committee requested a summary be provided of which risks were dealt with by which committee. A detailed discussion was held regarding the definition of risk and the likelihood scores. and the Committee were advised that there would be a change to how Health and Safety risks were recorded and managed.

The Committee were advised that the Covid-19 BAF risk would be reviewed as the risk of infectious diseases was reducing, but the risks around planned care backlogs still remained.

3.7. External Agency Visits Report

The Committee received the External Agency Visits Report which detailed the register of reviews and visits and ensured visibility of high-risk agency visits and provided assurance that actions and issues were appropriately tracked.

3.8. Cyber Security Assurance Paper

The Committee examined the Cyber Security Assurance Paper and noted the detailed and comprehensive level of review included in the paper.

It was noted that the full results of the compliancy of the Data Security and Protection Toolkit (DSPT) audit would be presented at the next Committee meeting, but early indications were showing a favourable outcome.

The Committee discussed the benefits of having the right cyber security system in place, staff vulnerability and the need to keep communication and awareness high to mitigate the risks. The Committee supported the approach detailed in the paper and noted that a detailed presentation was planned for March Trust Board.

3.9. Updated Standing Orders and SFI

The Committee reviewed the updated Standing Orders & SFIs and endorsed the changes which are as follows:

From December 2024 the role of **Director of Estates & Facilities** ceased to exist. The Estates and Facilities directorate now reports to the Chief Finance Officer. The SO/SFI document has therefore been updated to move all responsibilities of the previous Director of Estates & Facilities to the Chief Finance Officer, the Operational Director of Estates & Facilities (reporting to the Chief Finance Officer), or another deputy/individual as nominated by the Chief Finance Officer.

The other key change presented for approval is a revision of the Single Tender Action (STA) Exception report Authorisation Financial Values (see pages 78-79 of the SO/SFI document). The proposed changes update from the position below:

STA & Exception report Authorisation Financial Values

Up to £25k
Director of Procurement

£25k to £100K
Director of Finance

£100K to £1m
Chief Executive

£1m+
Trust Board

Recommendation Report - Authorisation Levels

up to £100K
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Corporate Director

£100K to £1m
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Corporate Director **and**
Director of Finance

£1m+
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Corporate Director **and**
Director of Finance **and**
Trust Board

To the following:

STA & Exception 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 Director
£100k to £1m
Director of Procurement and
Finance Business Partner/Divisional Finance and
Divisional Operations Director or relevant Corporate Director and
Chief Financial Officer
£1m+
Director of Procurement and
Finance Business Partner/Divisional Finance and
Divisional Operations Director or relevant Corporate Director and
Chief Financial Officer and
Trust Board

This is intended to align more with the revised business case and contract approval levels agreed in November 2021. This document is attached for Trust Board approval.

3.10. Biannual Policies Update Report
The Committee received the Biannual Policies Update Report which highlighted progress had been made in IM&T but due to the cyclical nature of policies there were still more to be reviewed.

The Committee were reassured that the Quality Committee would have sight of the report to review the process and governance so assurance could be provided that the approach was robust and appropriate.

The Committee requested that a forward-looking plan be developed and included all areas to set dates that policies needed to be reviewed by.

3.11. Single Tender Actions
The Committee received a report on Single Tender Actions (STA) for the period October 2021-December 2021.

The Committee were reassured that the new procurement system would be in place mid-March and the full details of the project implementation would be shared at the next Committee meeting in particular to address the non-PO spend, which is some 33% of total.

3.12. Losses And Salary Overpayments
The Committee received an update as part of its standing agenda items and noted the inclusion of the process of paying out and doing adjustments in future reports.

4. New risks or items for escalation

4.1. No specific risks were identified for Trust Board attention; however, the Board is asked to note the Committee's support of the approach detailed in the Cyber Security Assurance Paper and the review to the Covid-19 BAF risk.

5. Recommendations

The Trust Board is recommended to receive the Audit & Risk Committee Upward report for assurance and approve the revised Standing Orders and SFIs.

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 Committee Trust Board
Ratifying Committee:	Trust Board
Executive Lead:	Xavier Bell, Director of Corporate Governance/Trust Secretary
Date of Approval:	~~25 November 2021~~
Next Review Due:	~~November 2023~~ – or earlier if required by legislation or regulatory change
Version:	8.~~2~~3

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).

Trust Standing Orders

Contents

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.

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
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. They are ***excluded*** from the term "Director" for the purposes of this document, unless specifically stated otherwise.
- **Directors** are the Non-Executive Directors and the Executive Directors
- ~~**Director of Facilities** is the Director of Estates Facilities and Capital Planning~~
- **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

Commented [KD1]: Placeholder to consider whether a shortened form of Director of Operational Estates and Facilities is required to be added here and used throughout document.

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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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North Bristol NHS Trust

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

2.3.4. Director of Nursing, or equivalent

2.3.5. Chief Operating Officer

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

3. *Appointment of the Chair and directors*

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

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

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

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

4. *Vice-Chair*

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

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

4.3. When the Chair is unable to perform 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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North Bristol NHS
NHS Trust

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.

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22.7. This Standing Order shall not prohibit a director from taking part in the consideration or discussion of the contract or other matter, or from voting on any question with respect to it, if:

22.7.1. 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 should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
- **Objectivity:** In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
- **Accountability:** Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
- **Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
- **Leadership:** Holders of public office should promote and support these principles by leadership and example.

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

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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.

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).

25.3. The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration, to meetings of any committee or sub-committee.

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25.4. The Trust Board shall approve the terms of reference of each such committee. Each committee shall approve the terms of reference of each sub-committee reporting to it. The terms of reference shall include details of the powers vested and conditions, including reporting back to the committee, or Trust Board. Such terms of reference shall have effect as if incorporated into the Standing Orders and be subject to review every two years, at least, by that committee; and adoption by the Trust Board.

25.5. Committees may not delegate their powers to a sub-committee unless expressly authorised by the Trust Board.

25.6. The Board shall approve the appointments to each of the committees and sub-committees that it has formally constituted. Where the Board determines that a committee shall include members who are neither directors nor officers, the Board shall determine the terms of such appointment. The payment of travelling and other allowances shall be in accordance with the rates as may be determined by the Secretary of State for Health, with the approval of the Treasury (see Part 11, paragraph 233 of the 2006 Act).

25.7. Minutes, or a representative summary of the issues considered and decisions taken, of any committee appointed under this Standing Order are to be formally recorded and submitted for inclusion onto the agenda of the next possible Trust Board meeting. Minutes, or a representative summary of the issues considered and decisions taken of any sub-committee shall be submitted for inclusion onto the agenda of the next committee meeting to which it reports.

25.8. The committees to be established by the Trust will consist of statutory and mandatory; and non-mandatory committees.

Statutory and Mandatory Committees

Role of Audit Committee

25.9. The Trust Board shall appoint a committee to undertake the role of an audit committee. This role shall include providing the Trust Board with a means of independent and objective review of the financial systems and of general control systems that ensure that the Trust achieves its objectives, the reliability of the financial information used by the Trust and of compliance with law, regulations, guidance and codes of conduct. This Committee will pay due regard to good practice guidance, including, in particular, the NHS Audit Committee Handbook.

25.10. The terms of reference of the Audit Committee shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

Role of Auditor Panel

25.11. The Trust Board shall nominate its Audit Committee to act as its Auditor Panel in line with schedule 4, paragraph 1 of the Local Audit and Accountability Act 2014.

25.12. The Auditor panel shall advise the Trust Board on the selection and appointment of the external auditor.

25.13. The terms of reference of the Auditor Panel shall have effect as if incorporated into these Standing Orders and their approval shall be recorded in the appropriate minutes of the Trust Board and may be varied from time to time by resolution of the Trust Board.

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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):

- Quality Committee
- Finance and Performance Committee
- People Committee
- Patient and Carer Experience Committee
- Acute Provider Collaborative Board (A committee-in-common with University Hospitals Bristol & Weston NHS Foundation Trust)

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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.

30. Sealing of documents

30.1. The Seal of the Trust shall only be attached to documents where the sealing has first been approved by the Trust Board, or the Chair, or the Chief Executive, or their designated acting replacement, in accordance with the Scheme of Delegated Authorities.

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30.2. The seal shall be affixed in the presence of the signatories.

31. Bearing witness to the affixing of the Seal

31.1. A recommended wording for the witnessing of the use of the Seal is "The Common Seal of the North Bristol National Health Service Trust was hereunto affixed in the presence of…."

32. Register of sealing

32.1. An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose. The entry shall be signed by the persons who approved and authorised the sealing of the document; and who attested the seal.

32.2. A report of all sealing shall be made to the Trust Board, or a committee delegated to oversee the register at periods of its discretion. The report shall contain details of the seal number, the description of the document and date of sealing.

Part V – Appointment of directors and officers of the Trust

33. Canvassing of, and recommendations by, directors

33.1. Canvassing of any director of the Trust or member of a committee of the Trust directly or indirectly for any appointment under the Trust, shall disqualify the candidate from such appointment. Where the Chair or any such director or committee member is so canvassed, 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.

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34.3. Where the relationship to the director or senior officer of the Trust is disclosed, Standing Order 21 (Interest of directors in contracts and other matters) shall apply.

34.4. This Standing Order applies to circumstances where a candidate or candidate's partner or spouse is an immediate family relation or dependent of the director or senior officer of the Trust, or their partner or spouse.

Part VI – Tendering and contracting procedures

35. General

35.1. The Trust 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. Directives of the Council of the European Union (EU) for awarding all forms of contracts shall take precedence over all other procedural requirements and guidance and shall have effect as if incorporated in these Standing Orders. The EU Procurement Rules apply to public authorities under the, Public Contracts Regulations 2015 for England, Wales and Northern Ireland. The regulations cover fully regulated procurements and 'light touch regime'. The rules set out detailed procedures for contracts where the value equals or exceeds specific thresholds. These thresholds are exclusive of VAT and relate to the full life of the contract. The Chief Executive shall be responsible for ensuring the best value for money can be demonstrated for all services provided under contract or in-house. The Trust Board may also determine from time to time those in-house services should be market tested by competitive tendering.

35.5. Contract procedures shall take account of the Trust's 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. The application of the provisions of this part of the Standing Orders to contracts and purchases may be varied by resolution of the Trust Board from time to time.

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36. Delegated authority to enter into contracts

36.1. The Trust Board shall have power to accept tenders and to authorise the conclusion of contracts. It may delegate such authority subject to financial limits set in accordance with Standing Order 36.2 to:

- 36.1.1. a committee appointed under sections 24 and 25 of these Standing Orders
- 36.1.2. the Chief Executive
- 36.1.3. to the Chief Executive jointly with the Chair
- 36.1.4. the directors or nominated officers
- 36.1.5. officers of the Trust's procurement service supplier, in accordance with that organisation's standard operating procedures.

36.2. The financial limits determining whether quotations (competitive or otherwise) or sealed bid tenders must be obtained shall be set in accordance with the procedure in the Standing Financial Instructions the current thresholds being set out in the Trust Scheme of Delegated Authorities (Appendix 3).

37. Competition in purchasing or disposals – procedures

37.1. The Trust Board shall from time to time adopt procedures which shall be regarded as being incorporated into these Standing Orders and which shall take account of Standing Financial Instructions, the Trust's Procurement rules and regulations including implementing EC Directives on Public Procurement and which shall deal with:

- 37.1.1. Tender process selection
- 37.1.2. methods for inviting tenders
- 37.1.3. the manner in which tenders are to be submitted
- 37.1.4. the receipt and safe custody of tenders
- 37.1.5. the opening of tenders
- 37.1.6. evaluation
- 37.1.7. re-tendering
- 37.1.8. such other matters in connection with tendering as the Board considers appropriate

38. Disposals of land and buildings

38.1. Land and buildings that are owned by the Trust, or are otherwise recorded as being part of the estate of the Trust, shall be disposed of in accordance with the most recent rules and guidance issued by the Department of Health. Disposal will require the approval of the Trust Board.

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North Bristol NHS
NHS Trust

Part VII – Miscellaneous

39. Suspension of Standing Orders

39.1. Except where this would contravene any statutory provision or any direction made by the Secretary of State for Health, any one or more of the Standing Orders, except for Standing Order 40 which may not be suspended, may be suspended at any meeting, provided that at least two-thirds of the directors of the Trust are present and the majority of those present vote in favour of suspension.

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

39.3. A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the directors.

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

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

40. Variation of Standing Orders

40.1. These Standing Orders shall be varied only if:

40.1.1. A notice of motion under Standing Order 17 has been given **and**

40.1.2. no fewer than half of the appointed Non-Executive Directors vote in favour of such variation **and**

40.1.3. at least two-thirds of the directors who are eligible to vote are present **and**

40.1.4. the variation proposed does not contravene a statutory provision or direction made by the Secretary of State for Health.

40.2. Standing Order 40 (this Standing Order) may not be varied.

40.3. Any financial limits in these Standing Orders and the Schedule of Decisions Reserved for the Trust Board and the Scheme of Delegated Authorities may be varied by resolution of the Trust Board at any time.

40.4. Where financial limits are varied the 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 directors shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

43. Standing Financial Instructions

43.1. Standing Financial Instructions adopted by the Trust shall have effect as if incorporated in these Standing Orders.

44. Review of Standing Orders

44.1. Standing Orders shall be reviewed annually, or earlier, if developments within or external to the Trust indicate the need for a significant revision to the Standing Orders. The requirement to review extends to all documents having the effect as if incorporated in Standing Orders.

44.2. Any change will be reviewed by the Audit Committee before a recommendation is made to the Trust Board for adoption.

ENDS

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North Bristol NHS Trust Board

Appendix 1 – Schedule of decisions reserved to the Trust Board

Introduction

Standing Order 1 provides that "the Trust has resolved that certain powers and decisions may only be exercised or made by the Trust Board in formal session." These powers and decisions are set out in this Schedule.

1. Structure and governance of the Trust, including regulation, control and approval of Standing Orders and documents incorporated into the Standing Orders

1.1. Approve, including variations to:

- 1.1.1. Standing Orders for the regulation of its proceedings and business (SO40).
- 1.1.2. this Schedule of matters reserved to the Trust Board (SO 24).
- 1.1.3. Standing Financial Instructions (SO 44, SFI 2)
- 1.1.4. Scheme of Delegated Authorities, including financial limits in delegations, from the Trust Board to officers of the Trust (SO 24, SO 40).
- 1.1.5. suspension of Standing Orders (SO 39)

1.2. Determine the frequency and function of Trust Board meetings (SO 8), including:

- 1.2.1. administration of public and private agendas of Board meetings (SO 8)
- 1.2.2. calling extra-ordinary meetings of the Board (SO 9)

1.3. Ratify the exercise of emergency powers by the Chair and Chief Executive (SO 24)

1.4. Establish Board committees including those which the Trust is required to establish by the Secretary of State for Health or other regulation (SO 25); and:

- 1.4.1. delegate functions from the Board to the committees (SO 24)
- 1.4.2. delegate functions from the Board to a director or officer of the Trust (SO 24)
- 1.4.3. approve the appointment of members of any committee of the Trust Board or the appointment of representatives on outside bodies (SO 25)
- 1.4.4. receive reports from Board committees and take appropriate action in response to those reports (SO 25)
- 1.4.5. confirm the recommendations of the committees which do not have executive decision making powers (SO 25)

1.4.6. approve terms of reference and reporting arrangements of committees (SO 25).

1.4.7. approve delegation of powers from Board committees to sub-committees (SO 25)

1.5. Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust; and modifications thereto.

1.5.1. Appoint the Chief Executive (SO 3)

1.5.2. Appoint the Executive Directors (SO 3)

1.6. Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests (SO 21).

1.7. Agree and oversee the approach to disciplining directors who are in breach of statutory requirements or the Trust's Standing Orders.

1.8. Approve the disciplinary procedure for officers of the Trust.

1.9. Approve arrangements for dealing with and responding to complaints.

1.10. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on Trust (SO 25)

1.11. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2. Determination of strategy and policy

2.1. Approve those Trust policies that require consideration by the Trust Board. These will be determined by the individual directors responsible for adopting and maintaining the policies.

2.2. Approve the Trust's strategic direction:

2.2.1. annual budget, strategy and business plans

2.2.2. definition of the strategic aims and objectives of the Trust.

2.2.3. clinical and service development strategy

2.2.4. overall, programmes of investment to guide the letting of contracts for the supply of clinical services.

2.3. Approve and monitor the Trust's policies and procedures for the management of governance and risk.

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3. *Direct operational decisions*

3.1. Approve capital investment plans:

- 3.1.1. the annual capital programme
- 3.1.2. all variations to approved capital plans over £1 million (SoDA 13f)
- 3.1.3. to acquire, dispose of, or change of use of land and/or buildings (SO 38,)
- 3.1.4. capital investment over £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)
- 3.1.5. contracts for building works, which exceed the pre-tender estimate by over 10% (minimum £100k). (SoDA 10j)

3.2. Introduce or discontinue any significant activity or operation which is regarded as significant (if it has a gross annual income or expenditure, before any set off, in excess of £1 million.

3.3. Approve individual contracts and commitments to pay, other than Commissioning Contracts, of a revenue nature amounting to, or likely to amount to over £2.5 million:

- 3.3.1. Tenders and quotations over the lifetime of the contract (SoDA 8a)
- 3.3.2. Revenue funded service developments, in line with the approval guidance issued by the NHS England & Improvement (SoDA 8f)
- 3.3.3. Orders processed through approved supply arrangements (SoDA 10c)
- 3.3.4. Orders processed through non-approved supply arrangements (SoDA 10d)
- 3.3.5. Receipt of loans and trials equipment and materials (SoDA 10e)
- 3.3.6. Prepayment agreements for services received (SoDA 10g)

3.4. Decide the need to subject services to market testing (SO 35)

4. *Quality, financial and performance reporting*

4.1. Appraise continuously the affairs of the Trust through receipt of reports, as it sees fit, from directors, committees and officers of the Trust.

4.2. Monitor returns required by external agencies; and significant performance reviews carried out by, including, but not exclusively limited to:

- 4.2.1. The Care Quality Commission
- 4.2.2. NHS Improvement

4.3. Consider and approve of the Trust's Annual Report including the annual accounts.

4.4. Approve the Annual report(s) and accounts for funds held on trust.

4.5. Approve the Quality Account

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5. *Audit arrangements*

5.1. Approve audit arrangements recommended by the Audit Committee (including arrangements for the separate audit of funds held on trust).

5.2. Receive reports of the Audit Committee meetings and take appropriate action.

5.3. Receive and approve the annual audit reports from the external auditor in respect of the Financial Accounts and the Quality Account.

5.4. Receive the annual management letter from the external auditor and agree action on recommendations of the Audit Committee, where appropriate.

5.5. Endorse the Annual Governance Statement for inclusion in the Annual Report

ENDS

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 (appendix 1) and the Scheme of Delegated Authorities (appendix 3) which both also form part of the Trust's Standing Orders.

2.4. Detailed procedural advice, which shows how the SFIs should be applied, is maintained in departmental and financial procedure notes.

2.5. These SFIs do not refer to all legislation or regulations and advice issued by the Department of Health applicable to the Trust. Any uncertainty regarding the application of these SFIs should be discussed with the 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 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 (appendix 1). All other powers have been delegated to the Board's appointed committees; and the directors and officers of the Trust.

2.12. **The Chief Executive** is the Accountable Officer of the Trust and:

2.12.1. is legally accountable to Parliament for all of the actions of the Trust

2.12.2. is accountable to the Trust Board for ensuring that the Board of Directors meets its obligation to perform the Trust's functions within the available financial resources

2.12.3. holds overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that its financial obligations and targets are met

2.12.4. is responsible overall for the maintenance of the Trust's systems of internal control

2.12.5. is responsible for ensuring that all members and staff of the Trust are aware of and understand their responsibilities within these SFIs

2.13. Save for the decisions and actions reserved to the Trust Board, the Chief Executive has full operational authority to approve the financial transactions of the Trust and to delegate such powers to post-holders within the Trust management. The Chief Executive will, as far as possible, delegate detailed responsibilities, as described in these SFIs and, in more detail in the Scheme of Delegated Authorities (appendix 3).

2.14. **The 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 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 ~~**Director of Facilities**~~**Chief Finance Officer**, advised by the Director of 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 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 regarding public procurement

8.3. The Trust shall comply with all European Union and Government directives regarding public sector purchasing and the procedures set out for awarding all forms of contracts.

8.4. Contracts above specified thresholds for supply and service contracts (awarded by central government bodies subject to the World Trade Organisation Government Procurement Agreement) shall be advertised and awarded in accordance with EU and other directives and relevant equivalent UK government legislation. Works contracts above separate specified thresholds shall also be awarded in accordance with EU and other directives and relevant UK government legislation.

8.5. The Trust shall comply as far as is practicable with all guidance and advice issued by the Department of Health and the NHS Trust Development Authority in respect of procurement, capital investment, estate and property transactions and management consultancy contracts.

Competitive tendering and quotations

8.6. The **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. 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. the supply of goods, materials and manufactured articles

8.7.2. services, including management consultancy services from non-NHS organisations

8.7.3. design, construction and maintenance of building and engineering works, including construction and maintenance of grounds and gardens

8.8. The **Trust Board** shall allow for exceptions to the requirement for formal tendering procedures where:

8.8.1. 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. the supply is proposed under special arrangements negotiated by the DH, in which event the special arrangements must be complied with

8.8.3. It is a government directive that tenders over the value of £25,000 must be advertised in 'Contracts Finder'

8.8.4. the supply requirement 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.

8.8.5. 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 trust.

8.9. The **Trust Board** shall allow for the requirement for formal tendering procedures to be waived where:

- the **Chief Executive** decides that formal tendering procedures would not be practicable
- available timescales genuinely mean that competitive tendering is not a realistic option. Failure to plan the work properly should not be regarded as a justification for waiving tendering procedures
- specialist expertise, goods and services are required and available from only one source. Evidence of the unique status will be required to support any exemption.
- the task is essential to complete the project, and arises as a consequence of an existing or recently completed assignment; and engaging different suppliers for the new task would be counter-productive
- there is a clear benefit to be gained from maintaining continuity with an earlier supply. In such cases, the benefits of such continuity must outweigh any potential advantage to be gained from competitive tendering

Note that section 8.4 takes precedence over the above list of waived exemptions to competitive tendering. The Trust should take the advice of BWPC when enacting any of the aforementioned exemptions. Approval of any exemptions should be carried out with reference to SoDa (Single Tender Actions)

8.10. The **Chief Executive** shall provide formal approval, which may be retrospective where time constraints apply, in each instance where competitive tendering requirements are waived. These instances will be reported to each meeting of the Audit Committee.

8.11. The **Chief Finance Officer** shall ensure that:

8.11.1. any fees paid to an organisation to administer the competitive tendering exercise are reasonable and within commonly accepted rates for such work

8.11.2. waivers to competitive tendering procedures are not used to avoid competition, for administrative convenience, or to award further work to a supplier originally appointed through a competitive procedure.

8.11.3. contracts that were initially expected to be below the value limits set in this SFI; and for which formal tendering procedures were not used, which subsequently prove to have a value above such limits shall be reported to the Audit Committee and be recorded in an appropriate Trust record

8.12. The Trust's Procurement Service provider shall ensure that, for contracts under the EU threshold, it maintains a record of competitive tenders and subsequent contract awards. The Procurement Service provider shall take advice from technical experts, as required and assess the suitability of suppliers to be included in that record. The assessment of potential suppliers shall include reviews of technical and financial competence; as well as the specific skills and assurances required in the scope of the goods and/or services to be supplied through the tendered contract.

8.13. The Estates & Facilities ~~Directorate~~ division in agreement with the Trust's provider, shall refer to the Government Register of Contractors in considering suppliers suitable to be invited to provide tenders or quotations for their requirements.

8.14. All suppliers invited to submit quotations or tenders shall be informed that they are expected to comply with the Human Rights Act, 1998; the Equality Act, 2010; the Health and Safety at Work Act, 1974; procurement sustainability, fair and equitable trade policy and all other legislation concerning employment and the health, safety and welfare of workers and other persons.

8.15. The Chief Finance Officer shall, through the Trust's Procurement Service provider (BWPC), ensure that:

8.15.1. invitations to tender are sent to a sufficient number of suppliers to promote fair and adequate competition in accordance with Appendix 3, SoDa BWPC will ensure sufficient market research has taken place to ensure the right suppliers are engaged in competition via market development and engagement exercises.

8.15.2. the suppliers invited to tender, or requested to provide a quote, are suitably pre-qualified by BWPC . BWPC must fully assess the viability and suitability of any framework agreement before any procurement exercises are conducted through a mini-competition or directly awarded via a framework

8.15.3. Invitation to tenders comply with Government requirements to evaluate suppliers on the grounds of:

- Their Carbon reduction plan
- Their Social Value contribution
- Their management of Modern Slavery within their supply chain

8.15.4. the tender process and rules are in accordance with up-to-date and relevant specialist guidance, which is recognised, or recommended by the DH

Tendering procedure

8.16. The **Chief Finance Officer** shall ensure that procedural guidance from the Procurement Service provider is kept up to date. The guidance will include the rules, requirements and records to be maintained for each key stage of the tendering process. Separate procedural guidance and rules shall be maintained for:

8.16.1. contracts awarded through the Procurement Service's electronic tendering evaluation and contract award system, which will be subject to the controls built into the system regarding the receipt, storage of records and provision of audit trail for all relevant procurements.

8.17. These procedures shall include, but not be limited to, requirements for:

8.17.1. record of issue of invitations to tender

8.17.2. submission, storage and audit trail for receipt of tenders

8.17.3. process and record of opening tenders

8.17.4. evaluation of tenders (inc. completeness, accuracy, compliance with

prescribed format etc)

8.17.5. admissibility of tenders, including treatment of tenders received after the deadline, but prior to other bids being "opened"

8.17.6. reasons behind decision to award the contract

Quotations: competitive and non-competitive

8.18. The **Trust Board** shall approve the value range whereby formal tendering procedures are not adopted, but quotations will be required. This range is currently for intended expenditure that is reasonably expected to exceed £25,000.

8.19. The **Chief Finance Officer** shall determine the procedures to be followed in respect of competitive and non-competitive quotations. These will include:

8.19.1. types of service or supply to be sought through quotations

8.19.2. minimum number of competitive quotes to seek, currently set at three

8.19.3. requirement for written quotations

8.19.4. retention of records

8.19.5. treating all records of the process as confidential

8.19.6. recording the decision to go to contract

Temporary suspension of procedures in exceptional circumstances

8.20. The **Trust Board** shall allow the SFIs to be suspended temporarily in exceptional circumstances, where the circumstance is:

8.20.1. a Trust wide problem, rather than a directorate specific issue.

8.20.2. of sufficient scale that failure to act quickly and decisively would put the Trust at significant financial and reputational risk

8.20.3. unforeseen and rapidly developing

8.20.4. such that following normal procedures would hinder the recovery of the situation

8.21. 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 Procurement Directives and other statutory provisions

9.1.3. any relevant directions issued, or recognised by the DH

9.1.4. such of the NHS standard contract conditions as are applicable

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.

9.2. In all contracts made by the Trust, the Trust Board shall:

9.2.1. seek to obtain best value for money

9.2.2. for contracts subjected to tendering, or quotation, ensure that the contracts contain the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.3. The **Chief Executive** and **Executive Directors** shall nominate managers to oversee and manage each contract on behalf of the Trust

9.4. The Procurement Service shall maintain a record of the details of all requisitions and orders placed. No requisition or order shall be placed for items for which there is no provision in an authorised budget.

Longer term commitments

9.5. All contracts, leases, tenancy agreements and other commitments, which might result in a long-term liability, must be notified to; and authorised, in accordance with the limits set out in the Scheme of Delegated Authorities, in advance of any commitment being made.

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 DH.

In-house services

9.7. The **Trust Board** shall determine which in-house services should be market tested by competitive tendering; and the frequency with which this should be done. In instances where competitive tendering is required, the Board shall nominate suitably qualified staff to administer the process and ensure that EU procurement and competition laws, legislation and DHSC guidance are applied correctly, including:

9.7.1. setting clearly defined specifications for the service

9.7.2. clear separation between the in-house service provider tender team and the Trust's commissioning team

9.7.3. independent evaluation process

9.8. The **Chief Executive** shall ensure that best value for money can be demonstrated for all services provided on an in-house basis and shall nominate officers to oversee and manage the contract on behalf of the Trust, separate from those that are providing the service.

10. Non-pay expenditure

10.1. Requisitions and orders are subject to the delegations and limits set out in SFI 8 and SFI 9.

10.2. The **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

10.3. These delegation limits are maintained in the Scheme of Delegated Authorities.

Requisitioning and ordering goods and services

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)

10.5. **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.

10.6. Employees shall use the Trust's approved supply arrangements.

10.7. Where the service is provided by or maintained by the Shared Business Service, the arrangements shall be set out in the SLA.

Receipt of goods and services and system of payment and payment verification

10.8. The **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).

10.9. Such requirements will be specified in any SLA with the Shared Business Service provider.

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

10.11. 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 rates, rentals, service and maintenance contracts, insurance, utilities standing charges)

10.12. The **budget holder** shall confirm that the goods and services due under a prepayment arrangement are received satisfactorily and in accordance with the contractual arrangements.

Payments to contractors by instalments

10.13. The **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 after the Trust's nominated contract manager has certified the accuracy and completeness of the value of the final account submitted by the contractor; and has confirmed that the procedure set out in the contract terms has been followed properly.

10.15. Overruns to contracts shall be reported in accordance with the Scheme of Delegated Authorities.

10.16. With reference to Appendix 3 (SoDA 8x), all planned (including Capital funded) procurements with a projected value of over £100k* must have a signed off Options Appraisal and/or Business Case report for the Procurement which is produced in conjunction with BWPC. This should be noted only applies to planned procurements with exceptions only via the Single Tender Action process.

10.17. All Options Appraisals, and ultimately procurement Business Case's must include Whole Life Costs estimates as well as identification of projected savings.

10.18. The above process also applies to Extensions and Variations with a projected value which exceeds £100k

*A genuine pre-estimate of contract value must be ascertained and should not automatically be based on previous years expenditure, but also based on an estimate of future demand, and any additional value gained by the supplier.

Variations and extensions to contracts

10.19. Contracts may be designed to allow for variations to the sum agreed, or the goods and services to be delivered. These variations shall be clearly identified and subject to specific limits; and shall be approved as part of the contract process. Further, or new variations shall be subject to the authorisation process in place for new contracts. Variations shall be authorised in advance of commencement.

10.20. Where variations are needed in emergency, approval should be sought from a relevant

authorising officer; and shall be confirmed and authorised, using the relevant contract procedure, on the next working day.

10.21. Extensions to contracts shall be confirmed in writing and authorised in accordance with the Scheme of Delegated Authorities. Contract Extensions should not exceed the maximum term permitted under the terms of the contract defined when the contract was let.

Joint finance arrangements with local authorities and voluntary bodies

10.22. Payments to local authorities and voluntary organisations shall comply with 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 DH.

Other employees

11.4. The Trust Board shall consider and approve proposals presented by the **Director of People & Transformation** for the setting of remuneration and conditions of service for those employees not covered by the Remuneration and Nominations Committee.

Funded establishment and staff appointments

11.5. The staff establishment plans incorporated within the annual plans approved by the Trust Board shall be regarded as the funded establishment. The funded establishment of any department should reflect the Trust's approved workforce plans, which form part of the Trust's budget plans submitted to the NHS TDA.

11.6. The **Director of People and Transformation** shall ensure adherence to the Agenda for Change rules and approved policies and procedures and terms and conditions for employees paid on alternative contractual arrangements, including the consultant contract. These procedures shall address:

- 11.6.1. setting starting pay rates and conditions of service, for employees
- 11.6.2. approving plans to engage, re-engage employees, either on a permanent or temporary nature, or hire agency staff
- 11.6.3. agreeing to changes in any aspect of remuneration, including re-grading, within the Agenda for Change allowed rules.
- 11.6.4. ensuring that all employees are issued with a contract of employment in a form which complies with employment legislation

11.7. The **Budget Holder** shall ensure that the cost of the appointment, or change in conditions can be met within the limit of their approved budget and funded establishment.

Processing payroll

11.8. The **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 the NTDA for a risk assessment and decision to approve the borrowing

13.11. Any PFI proposal shall be specifically agreed by the **Trust Board**.

13.12. Where a capital scheme is funded using the PFI, any variations to the contract will be dealt with under procedures for variations in capital contracts and shall be authorised by the Trust Board.

Instructions specific to the Southmead Hospital PFI

13.13. The **Trust Board** shall approve and authorise the schedule of payments payable by the Trust to the PFI Project Co (Hospital Company (Southmead) Limited), as documented in the Project Agreement made between the Trust and the PFI Project Co dated 25 February 2014 ("Project Agreement").

13.14. The Schedule of Service Payments (Project Agreement, Schedule 18, Appendix I) shall be fixed for the duration of the Project Term save in respect of

13.14.1. inflationary adjustments

13.14.2. procurement of additional works (i.e. Small Works etc.)

13.14.3. variations in accordance with Schedule 22 of the Project Agreement.

13.15. Inflationary adjustments shall be calculated annually and presented to the Trust Board for approval. Arrangements for the procurement of additional works and variations shall be dealt with in accordance with the procedures for variations in capital contracts and shall be authorised by the Trust Board.

13.16. During the Operational Term, the ~~**Director of Facilities**~~**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 ~~Director of Facilities~~ **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 ~~**Director of Facilities**~~**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 Facilities~~Director of Operational Estates & Facilities and, where appropriate, the Chief Finance Officer.

13.20. The ~~**Director of Facilities**~~**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

13.23. The **Chief Finance Officer** shall maintain procedures for controlling the disposal of assets and updating of asset registers and financial records to reflect the event. These procedures will include the requirement for the authorisation and validation of the de-commissioning and disposal of the asset.

13.24. 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

13.25. The **Chief Executive** shall maintain procedures for controlling the security of assets, including fixed assets, cash, cheques and negotiable instruments. The procedures will include:

13.25.1. recording managerial responsibility for each asset

13.25.2. identification of additions and disposals

13.25.3. identification of all repairs and maintenance expenses

13.25.4. physical security of assets

13.25.5. periodic verification of the existence of, condition of, and title to, assets recorded

13.25.6. identification and reporting of all costs associated with the retention of an asset

13.25.7. reporting, recording and safekeeping of cash, cheques, and negotiable instruments

13.26. **All employees** are responsible for the security of property of the Trust and for following such routine security practices in relation to NHS property as may be

determined by the Board. Any breach of agreed security practices, or damage and losses to Trust property shall be reported in accordance with agreed procedures.

13.27. Where practical, assets should be marked as Trust property.

Disposals and condemnations

13.28. The **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

13.29. 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 ~~Director of Facilities~~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:

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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**

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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 ~~**Director of Facilities**~~**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

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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

	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 service level agreements, in accordance with NHS standard contract		SFI 7.6
	i. under £1 million	i. Chief Finance Officer, or nominated deputy	
	ii. over £1million	ii. Chief Executive and Chief Finance Officer	
	Subject to any required approvals being obtained, execute Agreements/Contracts (including Service Level Agreements and Deeds of Variation[2]) with NHS and non-NHS bodies for the purchase or provision of goods and/or services ii. under £1 million iii. over £1million	i. Chief Finance Officer ii. 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
	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, Chief Executive	
	Overseas visitors i. set pricing policy and price structure ii. set payment policy, including use of deposits, income guarantees	Chief Finance Officer	SFI 7.3
	Authorise 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 and execute concession arrangements	Chief Finance Officer	SFI 7.15
	Authorise research projects and clinical trials, including approvals to apply for research funding and approvals to undertake research, once considered by the Research and Development Committee 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

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Authorise funded training posts	Head of Learning and Development	Not within SFIs
	Tenancy agreements and licences Prepare 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. ~~Director of Facilities~~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 third parties (including leases and licences) i. execute documentation where the Trust Seal is not required ii. execute documentation where the Trust Seal is required	i. Chief Finance Officer ii. As per SFI 8e	SFI 7.4
	Approve rent based on professional assessment	Chief Finance Officer or nominated deputy	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

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): ○ To ensure trust-wide impacts have been understood within the case ○ To maintain consistent quality standard for cases going through for approval ○ Appendix A outlines the process for cases of value below £100k • Provide an approval recommendation to TMT on finalised business cases; • Test and confirm procurement strategy • Monitor development and delivery of business case pipeline

The business case process outlined below applies to all contract renewals and extensions as well as new revenue spend

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**
Chief Finance Officer (or nominated deputy)	Approval	Approval	Approval	Approval
Chief Executive		Approval	Approval	Approval
Finance & Performance Committee			Approval	Approval
Trust Board			Approval	Approval
NHSI				Approval

Value	**<£100k**	**≥£100k, <£500k**	**≥£500k, <£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 quotations (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.

Management of non-Contracted Spend			
	Description	**Consortium**	
1. Up to £5,000	*No requirement to evidence value for money*	5,000	Budget manager
2. £5,000 to £25,000	*Trusts responsible for quotation provision, BWPC operate a validation activity*	25,000	Divisional Operations Director or Executive Director or nominated Deputy
Written Quote Requirement	*The number of quotes required prior to a Purchase Order being progressed*	3	

Procedure (between SFI threshold & £25K)	**Procedure Detail**	**Consortium**
Quotation Process	*3 or more valid quotes provided*	PO Progressed
Quotation Process	*2 or less valid quotes*	STA
3. Above £25,000	Outcome Detail	Consortium
Tender Process (Local, OJEU, Quote)	*3 or more competitively priced bids received*	Recommendation Report
Tender Process (Local, OJEU, Quote)	*Less than 3 competitively priced bids received*	Recommendation report

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,
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

STA & Exception 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 Director

£100k to £1m
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Corporate Director **and**
Chief Finance Officer

£1m+
Director of Procurement **and**
Finance Business Partner/Divisional Finance **and**
Divisional Operations Director or relevant Corporate Director **and**
Chief Finance Officer **and**
Trust Board

6. Contract Signature

The following applies for contract signatures (after all relevant approvals have been given):

- **Up To EU threshold – Divisional Operations Director or relevant Corporate Director**
- **EU threshold to £2m – Chief Finance Officer**
- **Over £2m - Chief Executive**

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 Including property documentation and contractual arrangements where there is no consideration	Chair and Chief Executive, or in their absence, the designated acting Chair or Chief Executive	SO 30

be the current
t library of policies

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

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	~~Director of Facilities~~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 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 in accordance with Business Case approval limits

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

Payroll authorities

		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	
	- over 6 months length of contract	-	Chief Executive	

[1]Need to ensure fit with workforce plans

Bank, agency and locum staff	Within establishment		Extra to establishment	
	Within budget	Without budget	Within budget	Without budget
SoDA reference	11g		11h	
Nursing	(Deputy) Budget Manager	Director of Nursing **or** Medical Director and Chief Finance Officer **or** Chief Executive	Budget Manager	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
	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 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 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.	~~Director of Facilities~~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 to 13.22

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 ~~and Director of Facilities~~	SFI 13.21
	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
	Dispose of x-ray films	Radiology Departmental Manager\Clinical Director	SFI 13.26

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 Facilities~~Director of Operational Estates & Facilities iii. ~~Director of Facilities and~~ Chief Finance Officer	SFI 13.26
	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 ii. Chief Finance Officer iii. Chief Finance Officer **and** relevant Executive Director	SFI 13.26
	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 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 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

Report To:	Trust Board - Public		
Date of Meeting:	31 March 2022		
Report Title:	Quality Committee Upward Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary Isobel Clements, Senior Corporate Governance Officer & Policy Manager		
Executive/Non-executive Sponsor (presenting)	Kelly Macfarlane, Non-Executive Director, on behalf of John Iredale, 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		**X**
Recommendation:	The Trust Board should: • Receive the report for assurance and note the activities Quality Committee (QC) has undertaken on behalf of the Board. • Approve the Quality Priorities for 2022/23. • Discuss the progress against implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance and Maternity services workforce plans.		
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 April 2022.		

Executive Summary	
The report provides a summary of the assurances received and items discussed and debated at the deep-dive Quality Committee (QC) meeting held on 16 March 2022.	
Strategic Theme/Corporate Objective Links	**Provider of high-quality patient care** **Employer of choice**

Board Assurance Framework/Trust Risk Register Links	Link to BAF risk SIR14 relating to clinical complexity, risk COV 2 relating to overwhelming effects of Covid-19 locally and risk SIR1 relating to lack of capacity affecting performance and patient safety.
Other Standards Reference	CQC Standards.
Financial implications	No financial implications identified in the report.
Other Resource Implications	No other resource implications identified.
Legal Implications	None identified.
Equality, Diversity and Inclusion Assessment (EIA)	Process TBC
Appendices:	Ockenden Progress Report

1. Purpose

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

2.2 Trust Board should note that March's meeting was a deep-dive meeting.

3. Meeting on 16 March 2022

3.1 Quality Account Priorities and CQUINs

The Committee received a report on the proposed Quality Account Priorities and CQUINs for 2022/23. The proposed priorities had been endorsed by the Executive Team and the Trust Management Team and were aligned to the Trust's Quality Strategy. The proposed priorities were:

- Shared decision-making and supporting self-management
- Improving patient experience through reduced hospital stays ("right to reside") and personalised care
- Safe and excellent outcomes from emergency care
- Safe and excellent maternity care
- Providing excellent cancer services with ongoing support for patients and their families

- Ensuring the right clinical priorities for patients awaiting planned care and ensuring their safety

The proposed CQUINs were also presented for Quality Committee approval. The Committee were informed that due to the clinical negotiation required, it would be unlikely outcomes would be delivered in Quarter 1 as the Trust was only informed that CQUINs would be required for 2022/23 at the end of January 2022. NBT had requested that the region challenge the national team regarding delivery of CQUINs in Quarter 1.

CQUINs approved that NBT plans to deliver are as follows:

- CCG1 - Flu vaccinations for frontline healthcare workers
- CCG3 - Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions (n.b. this is from inpatient wards, not ED)
- CCG4 - Compliance with timed diagnostic pathways for cancer services Link to scheme
- CCG9 - Cirrhosis and fibrosis tests for alcohol dependent patients
- PSS1 - Achievement of revascularisation standards for lower limb Ischaemia
- PSS2 - Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery
- PSS4 - Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines

CQUINs to be confirmed following further scoping:

- CCG6 - Anaemia screening and treatment for all patients undergoing major elective surgery Link to scheme
- CCG8 - Supporting patients to drink, eat and mobilise after surgery (DREAMing) Link to scheme
- PHE – scheme to be confirmed

The Committee discussed the Priorities and CQUINs, acknowledging the challenging breadth of scope but also noting that they had been aligned to NBT's ongoing improvement work. The next steps were to operationalise the priorities in order to measure progress and optimise benefits to staff and patients.

The Committee agreed that the Quality Priorities and CQUINs were appropriate. The Board is asked to note approval of the CQUIN schemes, and to approve the Quality Priorities outlined above.

3.2 Falls deep-dive – Overview of Improvement Work

Nicolas Seaton, Patient Safety Manager, and Bev Davies, Matron, attended to present

The Committee received a presentation setting out an overview of the improvement work undertaken in relation to Falls by the Falls Academy. The NBT Falls Academy was formed

in September 2020, taking a network approach to overseeing and leading on the falls' improvement work, co-ordinating insights and involvement, and developing knowledge and skills.

The Committee noted the impact of the pandemic, which had affected the improvement work and had posed unexpected challenges with unpredictability of activity, staffing and patient mixes in clinical areas. However, the Committee noted that despite these challenges, the Falls Academy had been able to:

- update and launch a new policy
- develop and prepare for the launch of a new multi-factorial risk-assessment tool (aligned to NICE guidance and the new Electronic Patient Record)
- Progressed training and education
- Closely engage with key wards in developing and testing new approaches

Discussion also touched on the need to balance the risk of patients falling alongside ensuring that they are not at risk of deconditioning through lack of opportunity for physical exercise.

3.3 Maternity

Juliette Hughes, Divisional Director of Nursing, and Claire Weatherall, Divisional Operations Director, W&CH attended to present.

Perinatal Quality Surveillance Matrix (PQSM Data Dashboards)

The Committee received a report updating on the PQSM, including an overview of insights and emerging learning from identified incidents and issues.

The Committee discussed the need to ensure focus and compliance with Foetal Wellbeing Training. The Division confirmed that improving this training compliance is a Divisional safety priority, with additional training sessions in place and staff being released to undertake the training. The expectation is that training compliance will be at 88% by the end of May 2022.

The Committee welcomed the update, and formally noted the dashboard on behalf of Trust Board (also received in the Integrated Performance Report at Board).

Workforce Overview (Action 88)

The Committee received an update providing an overview of the workforce position within the Women's and Children's Division. This set out details regarding divisional sickness absence, COVID related absence, staff turnover and vacancy rates.

The Committee welcomed the overview and requested further information on the risk profile resulting from workforce challenges to come to the next meeting.

Ockenden assurance toolkit action update

The Committee received a paper outlining the Trust's compliance with recommendations from the Ockenden Report. The Committee formally noted the Maternity services assessment and assurance tool and NBT's current compliance.

NHS England has requested that progress is discussed at public Board before the end of March 2022, covering 'classification, progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance; and Maternity services workforce plans'.

Other Maternity items

Due to time constraints, the remaining Women & Children's items were postponed to April's meeting (Progress against Antenatal Screening Appreciative Enquiry, W&CH Improvement Programme – proposed closure and BAU, and Strategic Operational Priorities). The Workforce overview discussion would also be completed at the April QC.

3.4 Other items:

The Committee also received the following items:

- Sub-committee upward report(s):
  - Clinical Effectiveness & Audit Committee
  - Patient Safety & Clinical Risk Committee
  - Drugs & Therapeutics Committee
  - Quality Committee forward work-plan 2022/23

4. Identification of new risk & items for escalation

None identified.

5. Recommendations

The Trust Board should:

- Receive the report for assurance and note the activities Quality Committee (QC) has undertaken on behalf of the Board.
- Approve the Quality Priorities for 2022/23.
- Discuss the Ockenden progress: implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance and Maternity services workforce plans.

Report To:	Quality Committee		
Date of Meeting:	15th March 2022		
Report Title:	Compliance with the Recommendations in the Ockenden Report: Progress Update		
Report Author & Job Title	Jodie da Rosa, Lead for Quality and Safety Fiona Scriven, Quality Lead Practitioner Julie Northrop, Interim Head of Midwifery		
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Director of Nursing & Quality and Board Maternity Safety Champion Kelly Macfarlane, Non-Executive Safety Champion		
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
Recommendation:	The Trust Board is asked to **note the following report** and summary below. The Trust Board is asked to **note NBT's current compliance** with the recommendations from the Ockenden report. An action plan has been written, and work is continuing both within NBT and across the LMS. The Trust Board is asked to **note that, in the coming months, NBT's action plan may change** to reflect the findings of the full report expected by 24th March 2022.		
Report History:	Regular reporting bi-monthly, last received January 2022		
Next Steps:	W&CH will: • Await publication of final Ockenden report, expected by 24th March 2022 • Provide update to Quality Committee following publication of the final report		

Executive Summary

Following the initial publication of the Ockenden Report in December 2020, all Trusts were required to submit to their Board a completed Maternity Services Assessment and Assurance Tool. The tool detailed NBT's position with all seven Immediate and Essential Actions (IEAs) as well as three other topics of focus (Workforce, Leadership and NICE Guidance).

NBT were then required to submit evidence to the Central Support Unit demonstrating compliance with the IEAs and additional areas of focus. NBT was found to be fully compliant with 106 of the 122 criteria (87%). A local action plan has been written to address all partially- and non-compliant criteria from this submission. Leads have been assigned to oversee the actions associated with individual Immediate and Essential Actions. A progress review of this action plan has been included as a standing agenda item in monthly specialty meetings and the Trust Board has also been updated with progress, most recently in January 2022.

In preparation for the publication of the final Ockenden report, expected by March 24th 2022, all Trusts have been requested to share with Trust Board their implementation progress of the Ockenden Report Initial Report using the same tool that they completed in December 2020. This can be found in Appendix 1 and includes a detailed breakdown of the implementation progress.

Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services
Board Assurance Framework/Trust Risk Register Links	Risk 1211: IM&T **20** (IT connectivity within the community midwifery bases) Risk 1323: Workforce **16** (midwifery workforce) Risk 1276: Statutory duty/compliance **12** (obstetric staffing improvement enabling multidisciplinary working, and engagement with learning opportunities and service improvement) Risk 1163: Statutory duty/compliance **10** (anaesthetic staffing improvement to enable cover for the antenatal clinic and 24/7 presence on Central Delivery Suite) Risk 1278: Patient Experience **8** (Maternity Voices Partnership engagement) Risk 1079: Patient Safety **4** (staffing uplift to enable clinicians to attend mandatory training)
Other Standards Reference	Nil
Financial implications	Nil
Other Resource Implications	Nil

Legal Implications	Nil
Equality, Diversity and Inclusion Assessment (EIA)	Nil
Appendices:	Appendix 1: Maternity Services Assessment and Assurance Tool, March 2022

1. Purpose

1.1 This report is being submitted to provide Trust Board with a progress report towards the recommendations made in the Ockenden Report.

2. Background

2.1 In December 2020, the report "Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust" was published. This report included seven Immediate and Essential Actions (IEAs) and 27 Local Actions for Learning.

2.2 Following the initial publication of the Ockenden Report in December 2020 all Trusts were required to submit to their Board a Maternity Services Assessment and Assurance Tool. The tool detailed NBT's position with all seven IEAs as well as three other topics of focus (Workforce, Leadership and NICE Guidance).

2.3 NBT were then required to submit evidence to the Central Support Unit demonstrating compliance with the seven IEAs and additional areas of focus. NBT was found to be fully compliant with 106 of the 122 criteria (87%). A local action plan has been written to address all partially- and non-compliant criteria from this submission. Leads have been assigned to oversee the actions associated with individual Immediate and Essential Actions.

3. Current Position

3.1 In preparation for the publication of the final Ockenden report, expected by March 24th 2022, all Trusts have been requested to share with their Trust Boards implementation progress of the Ockenden Report Initial Report using the same tool as in 2020. This can be found in Appendix 1 and includes a detailed breakdown of the implementation progress.

4. Summary and Recommendations

4.1 The Trust Board is asked to note NBT's current compliance with the recommendations from the Ockenden report. An action plan has been written, and work is continuing both within NBT and across the LMS.

4.2 The Trust Board is asked to note that, in the coming months, NBT's action plan may change to reflect the findings of the full report expected by 24th March 2022.

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1	
Immediate and Essential Action 1: Enhanced Safety Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight. • Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. • External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death. • All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	
What do we have in place currently to meet all requirements of IEA 1?	The Local Maternity System, made up of NBT and UHBW, is well embedded with frequent and regular meetings between the Trusts. The Perinatal Quality Surveillance Matrix (PQSM) is used in lieu of a maternity dashboard and contains patient safety data, service user and staff feedback, workforce data, mandatory training compliance, and Maternity Incentive Scheme compliance. This is well embedded at NBT and is shared monthly internally (at specialty, divisional and Board level) and bimonthly externally (with the LMS). In line with national guidance, all cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death are referred to HSIB to lead on investigations. Reports into these cases published by HSIB include external clinical opinion. In line with the Ockenden Report, all accepted HSIB referrals are reported to STEIS along with all Serious Incidents. Data regarding the number of Serious Incidents is included in the PQSM which is reported monthly to Trust Board along with a cover sheet highlighting areas of focus and key issues, and bimonthly to the LMS. In addition, in line with the Serious Incident Framework, summary slides for all SIs are shared internally at specialty governance meetings, Patient Safety Group, Patient Safety Committee and Trust Board. To align with the Ockenden Report recommendation to follow the Serious Incident Framework, NBT Women and Children's Services have not yet

	implemented the Patient Safety Incident Response Framework (PSIRF) that has been introduced elsewhere in NBT. Following the publication of the full findings of the Ockenden Report, a decision will be made whether to continue with the Serious Incident Framework or to change to the PSIRF in line with the NHS Patient Safety Strategy.
Describe how we are using this measurement and reporting to drive improvement?	Collaboration is ongoing across the LMS to align data sources and reporting using the PQSM. A Local Maternity System Task Group is reviewing all Ockenden recommendations and formulating agreed priorities that will provide the greatest benefits for patient safety, experience and outcomes. This is also a reflection of a positive safety culture across the LMS provider organisations, with open, honest discussions about these priorities and how the many forms of current 'audits' do or do not contribute to actual care improvements. This cultural foundation provides very strong confidence that continuous improvement will be generated within the programme of work that is emerging.
How do we know that our improvement actions are effective and that we are learning at system and trust level?	Both PQSMs are regularly discussed at internal governance meetings and LMS meetings to identify areas of learning and improvement.
What further action do we need to take?	No further action required at this time – plan to continue current activity.
Who and by when?	N/A
What resource or support do we need?	N/A
How will mitigate risk in the short term?	N/A

Immediate and essential action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard. • Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. • The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. • Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	
What do we have in place currently to meet all requirements of IEA 2?	Kelly Macfarlane is the Non-Executive Board Level Maternity Safety Champion. In response to the evidence submission requirements, a job description for the Maternity Safety Champions has been clarified (previously it was included in the Safety Champion Meeting Terms of Reference). In response to the Ockenden Report's publication, the role of Service User Experience Lead was created and service user feedback is now included in all specialty and divisional governance meetings as a standing agenda item. Funding for this post has now been secured and recruitment is underway. Quarterly reports from the Service User Experience Lead identify themes from service users, claims, complaints, LRMs and incidents, and these are used to inform service improvements. Service User Experience is also included in the PQSM, which is shared at Trust Board and the LMS. To include the service user voice more fully, NBT has reached out to the Maternity Voices Partnership and, from March 2022, minutes of governance meetings will be shared with the MVP Chair and a MVP representative will attend Maternity Safety Champion meetings. A programme of maternity safety walkarounds is in place, and these are led by with the Head of Midwifery and Continuous Improvement and Learning Lead to engage with staff and service users and identify areas for learning. Learning and any actions are then shared with the Maternity Safety Champions.
Describe how we are using this measurement and	Service user feedback is included in all specialty and divisional governance meetings as a standing agenda item. Quarterly reports identify themes from service users, claims, complaints, LRMs and incidents, and these are

reporting to drive improvement?	used to inform service improvements. Service User Experience is also included in the PQSM, shared at Trust Board and the LMS.
How do we know that our improvement actions are effective and that we are learning at system and trust level?	Service User Experience is included in the PQSM, shared at Trust Board and the LMS. Learning identified from services users is shared on local action plans and informs quality improvement projects.
What further action do we need to take?	1) Following presentation of the results of the CQC and Picker Report, the Service User Experience Lead and General Manager are developing a process to formalise the use of service user insight to inform business planning. 2) The Head of Midwifery and Continuous Improvement and Learning Lead met with the MVP on 28th February 2022 and agreed a workload plan for the year, enabling coproduction and service development. 3) Maternity Clinical Quality Assurance Task Group (see IEA1) to agree definition of "independent senior advocate" to ensure that a suitable advocate is available to service users - currently awaiting direction from NHSE/I re role definition and responsibilities
Who and by when?	1) Gina Augarde and Melanie Charman, March 2022 2) Julie Northrop, March 2022 3) Oversight by LMS MCQ Assurance Task Group (awaiting NHSE/I), next meeting planned for 24th March 2022
What resource or support do we need?	1) Nil 2) No immediate need for resource, see Risk 1278 for full details (Patient Experience, risk = 8); may need to explore additional MVP resource with LMS. 3) Nil at present, to awaiting further update from NHSE/I
How will mitigate risk in the short term?	1-2) Service user feedback is now included in all specialty and divisional governance meetings as a standing agenda item. Quarterly reports identify themes from service users, claims, complaints, LRMs and incidents, and these are used to inform service improvements. Service User Experience is also included in the PQSM, shared at Trust Board and the LMS.

	3) Service User Experience Lead and Professional Midwifery Advocates (who support women through the Birth Afterthoughts service) both in place

Immediate and essential action 3: Staff Training and Working Together Staff who work together must train together • Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. • Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. • Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced, and used for this purpose only.	
What do we have in place currently to meet all requirements of IEA 3?	Multidisciplinary training and working are well embedded at NBT, although training was virtual (as opposed to in person) from March 2020 to August 2021. In person training has recommenced in this training year. Multidisciplinary, consultant-led ward rounds take place on the Central Delivery Suite three times a day Monday-Friday, and twice a day at weekends (although not overnight).
Describe how we are using this measurement and reporting to drive improvement?	Multidisciplinary training attendance and the occurrence of consultant-led ward rounds are reported on the PQSM. This is shared monthly at specialty and divisional governance meetings and the Trust Board, and bimonthly with the LMS.
How do we know that our improvement actions are effective and that we are learning at system and trust level?	Trends are visible on the PQSM, and any concerns are identified and acted upon at specialty or divisional governance meetings.
What further action do we need to take?	1) Uplift to backfill all staff groups to attend training and learning opportunities 2) Increase in leadership time for consultants to support learning and service improvements-business case in progress 3) Uplift to consultant staffing to enable day and night ward rounds seven days a week; a business case for this has been accepted and approved. Recruitment is now under way.

	4) Uplift to anaesthetic consultant cover to include evenings and weekend cover for Central Delivery Suite, and Antenatal Clinic cover; a business case is in progress 5) Improve data capture for monitoring ward round compliance-exploring electronic systems e.g. Birth rate plus 6) Confirmation from Director of Finance that external funding allocated for the training of maternity staff is ring-fenced and used for this purpose only, including backfill (NB: Likely to be required for future evidence submissions) 7) Budget statements will be required to evidence that external funding allocated for the training of maternity staff is ring-fenced and used for this purpose only, including backfill (NB: Likely to be required for future evidence submissions) 8) Provide reports to the LMS confirming that external funding allocated for the training of maternity staff is ring-fenced and used for this purpose only, including backfill (NB: Likely to be required for future evidence submissions)
Who and by when?	1-4) Business cases in progress coordinated by Melanie Charman, June 2022 5) Nicola Chinnock, March 2022 6) Claire Weatherall, March 2022 7) Interim Finance Business Partner (John Davey), March 2022 8) Julie Northrop/Juliette Hughes, March 2022
What resource or support do we need?	1) Financial support as per business case. Bank staff may be required to provide backfill and procurement of additional training facilities to enable training to continue 2) Financial support as per business case 3) Financial support as per business case 4) Financial support as per business case

	5) Support to implement Radar (when launched) to enable electronic data collection 6) Written support from Director of Finance and his team, with plan made by divisional team for allocation of resources 7) Provision of information by finance team 8) Nil
How will mitigate risk in the short term?	1-4) Multidisciplinary training ongoing with bank staff used to backfill if necessary 5) Data capture currently on paper, then collated and reported on PQSM 6) Nil required 7) Nil required 8) Nil required

Immediate and essential action 4: Managing Complex Pregnancy There must be robust pathways in place for managing women with complex pregnancies Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. • Women with complex pregnancies must have a named consultant lead • Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	
What do we have in place currently to meet all requirements of IEA 4?	Ensuring robust pathways for women with complex pregnancies is strongly linked to the improvement work that has been ongoing in Antenatal Clinic as part of the W&CH Improvement Board. This includes reviewing care pathways, development of new midwife-led pathways, and MDT (Multidisciplinary Team) care plans to be recorded electronically on the Maternity Information System (Euroking). This will be further supported by the LMS-wide procurement of a new Maternity Information System which will facilitate documentation of standardised risk assessments; the scoring phase of the procurement process started on 21st February. There is ongoing development of a Maternal Medicine service across the LMS. There has been successful joint recruitment to the new post(s) of LMS Maternal Medicine Specialist Midwife across BNSSG. NBT successfully expressed interest in becoming the host maternal medicine network lead for the South West. Women identified for consultant-led care are allocated a named consultant. The Maternity Clinical Quality (MCQ) Assurance Task Group that has been set up to facilitate discussion across the LMS about the response to the Ockenden report involves discussions including agreeing the definitions of "complex pregnancy" and "early specialist involvement", in order to enable standardised monitoring and reporting.
Describe how we are using this measurement and reporting to drive improvement?	So far, this has been monitored and reported as part of the W&CH Improvement Board. Agreement of the definitions of "complex pregnancy" and "early specialist involvement" will inform the methodology for measuring improvement going forward.
How do we know that our improvement actions are	This has been monitored and reported as part of the W&CH Improvement Board

effective and that we are learning at system and trust level?	Agreement of the definitions of "complex pregnancy" and "early specialist involvement" will inform the methodology for measuring improvement going forward.
What further action do we need to take?	1) Definitions of "complex pregnancy" and "early specialist involvement" need to be agreed by the LMS; discussions ongoing as part of the MCQ Assurance Task Group 2) How agreement and involvement of the woman should be documented needs to be agreed by the LMS to ensure aligned monitoring; discussions are ongoing as part of MCQ Assurance Task Group 3) Identify lead obstetrician to represent NBT during work with the LMS and regional team on development of a maternal medicine network (NB need to provide dedicated job plan time) 4) New specialist clinics being developed (eg Multiple Pregnancy), including midwife-led clinics 5) Ongoing improvement work within ANC exploring correct named consultant and use of electronic white boards to support identification of correct named consultant 6) Ongoing procurement of new electronic maternity information system that will include standardised risk assessments at each contact
Who and by when?	1) LMS MCQ Assurance Task Group, next meeting planned for 24th March 2022 2) LMS MCQ Assurance Task Group, next meeting planned for 24th March 2022 3) General manager with Speciality Lead to explore Maternal Medicine Obstetric Lead within job plan review by March 2022 4-5) General Manager and ANC Lead. Work ongoing, work commenced on improving multiple pregnancy clinical pathway 6) Michelle Mayer, procurement to be confirmed by end of March 2022

What resource or support do we need?	1) Nil 2) Nil 3) Funding to be agreed for additional Obstetric Leadership roles within PA's 4) Nil at present 5) Nil at present 6) Nil at present
How will mitigate risk in the short term?	1) Nil required 2) Nil required 3) Nil required 4) Nil required 5) Nil required 6) Nil required

Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	
What do we have in place currently to meet all requirements of IEA 5?	Various risk assessments take place and are documented at each antenatal contact. In addition to this, clinicians risk assess women holistically throughout their pregnancy and any identified need for referral is documented. Improvement work is underway. Stamps have been ordered to enable standardised documentation of risk assessments of the woman's clinical need and intended place of birth at every antenatal contact. This will be further supported by the LMS-wide procurement of a new Maternity Information System which will facilitate documentation of standardised risk assessments; the scoring phase of the procurement process started on 21st February. We have completed a successful pilot in the alongside midwifery-led birth centre of an Intermittent Auscultation Hourly Assessment and a Midwifery Led Intrapartum Risk Assessment Tool, with a plan to extend the use of these to other midwifery-led settings. This is currently being audited to measure how well it is now embedded in practice. A Local Maternity System Task Group is reviewing all Ockenden recommendations and formulating agreed priorities that will provide the greatest benefits for patient safety, experience and outcomes. This is also a reflection of a positive safety culture across the LMS provider organisations, with open, honest discussions about these priorities and how the many forms of current 'audits' do or do not contribute to actual care improvements. This cultural foundation provides very strong confidence that continuous improvement will be generated within the programme of work that is emerging.
Describe how we are using this measurement and reporting to drive improvement?	There are audits within the division (such as reviewing all babies born with an unexpectedly low birth weight at term) which relate to standardised risk assessments in pregnancy, as specified in Safety Action 6 of the Maternity Incentive Scheme. However, there is no single standardised risk assessment used nationally for women in pregnancy. Due to this, compliance with risk assessment in pregnancy is difficult to measure.

	Discussions are ongoing between key stakeholders at both NBT and UHBW as part of a Maternity Clinical Quality Assurance Task Group in order to agree how this measurement should take place and be reported in a standardised but meaningful way. As a first comparative step, both maternity providers in the LMS are pulling together a master list of 'risk assessments' that exist across the maternity pathway. This list will be mapped against existing mandatory and locally directed clinical audits, or review of continuous monitoring data. This will in turn provide a view of any 'gaps' that exist and help with the establishment of a prioritisation process that can be reviewed regularly across the LMS to determine which risk assessments need to be audited and why. This recognises that manually auditing all forms of risk assessment is impracticable. This work will also inform the development and implementation of the LMS-wide maternity digital system that is now being procured. The ideal scenario will be for risk assessment data to be embedded as part of data capture at each contact to then generate risk information and automatic triggers for action. This is an embedded workstream within the LMS Task Group Terms of Reference.
How do we know that our improvement actions are effective and that we are learning at system and trust level?	All audits relating to Saving Babies' Lives as required by Safety Action 6 of the Maternity Incentive Scheme are completed and compliance reported. The delivery of a systematic approach to determining which forms of risk assessment benefit from audit and then the completion and review of those audit results will demonstrate a system level approach to learning through the LMS Task Group. Specific actions arising from those audits and their successful delivery will provide examples of learning application into practice.
What further action do we need to take?	1. Creation of a master record of all risk assessments within the maternity pathway (agreed across the LMS), and a review of all current audits (mandated, or locally selected) that currently exist across the LMS. This will enable agreement of an audit plan for a given financial year that is based upon areas of greatest need, for example linked to actual adverse events, or poor experience, or where new risk assessments have been added, or existing ones updated, and an audit will aid with implementation. 2. Implementation in NBT of a new clinical audit software system that will enable much stronger oversight of all clinical audits undertaken for Maternity, and the delivery of actions agreed as an output from those audits. This will enhance the governance oversight of how the audit learning is turned into actual improvement. 3. Improvement work commenced to improve use of existing Personalised Care and Support Plans in line with Maternity Incentive Scheme Safety Action 2 to support documentation of formal risk assessments. 4. New Personalised Care and Support Plan in development by LMS 5. Ongoing procurement of new electronic maternity information system that will include standardised risk assessments at each

	contact, with the LMS Task Group work referenced in points 1 & 2 above providing a critical information source to inform the system specifications.
Who and by when?	1) LMS MCQ Assurance Task Group, next meeting planned for 24th March 2022; responsibilities for creation of master list and agreed actions to be established at that meeting. 2) Paul Cresswell, update expected June 2022 3) Jodie da Rosa and Michelle Mayer, June 2022 4) Jessica Pepler and Ami George, March 2023. 5) Michelle Mayer, procurement to be confirmed by end of March 2022
What resource or support do we need?	1) Nil 2) Nil 3) Nil 4) Nil at present, resources may be required as project continues 5) Nil at present
How will mitigate risk in the short term?	1) Nil required 2) Nil required 3) Nil required 4) Improvement work commenced to improve use of existing Personalised Care and Support Plans in line with Maternity Incentive Scheme Safety Action 2 5) Nil required, current documentation continues

Immediate and essential action 6: Monitoring Fetal Wellbeing All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring. The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - • Improving the practice of monitoring fetal wellbeing • Consolidating existing knowledge of monitoring fetal wellbeing • Keeping abreast of developments in the field • Raising the profile of fetal wellbeing monitoring • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported • Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice • The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. • They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. • The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines	
What do we have in place currently to meet all requirements of IEA 6?	A Lead Obstetrician for Fetal Monitoring is in place, with dedicated time in her job plan; recruitment is underway to increase this role. Two Lead Midwives for Fetal Monitoring (0.4wte total) are in place, although their funding is currently through the LMS and is non-recurrent. The role of the Fetal Monitoring Leads includes the development and provision of a dedicated multiprofessional mandatory Fetal Wellbeing Study Day and running fortnightly departmental multiprofessional CTG meetings to provide more informal training.
Describe how we are using this measurement and reporting to drive improvement?	Compliance with the Fetal Wellbeing Study Day is reported on the PQSM. This is shared monthly at specialty and divisional governance meetings and the Trust Board, and bimonthly with the LMS.
How do we know that our improvement actions are effective and that we are learning at	Compliance with the Fetal Wellbeing Study Day is reported on the PQSM. This is shared monthly at specialty and divisional governance meetings and the Trust Board, and bimonthly with the LMS.

system and trust level?	
What further action do we need to take?	1) Substantiate the fetal monitoring lead roles 2) Clarify the job description of the fetal monitoring lead midwife role to explicitly include the above criteria 3) Continue working towards 100% compliance in the Fetal Wellbeing Study Day by all midwives and obstetricians by the end of the first year of training
Who and by when?	1) Melanie Charman, June 2022 2) Stephanie Withers, March 2022 3) Stephanie Withers, September 2022
What resource or support do we need?	1) Financial support 2) Nil 3) Support to enable training such as rooms and bank staff to backfill
How will mitigate risk in the short term?	1) Nil required 2) Nil required 3) Nil required

Immediate and essential action 7: Informed Consent All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected	
What do we have in place currently to meet all requirements of IEA 7?	We have a dedicated clinic for women choosing to birth outside of guidance ("Birth Choices") to enable full informed discussion and support of women's choices. Accurate, contemporaneous, evidence-based information is available throughout the antenatal, intrapartum and postnatal periods of care and is provided both verbally and written. Written information is available as leaflets, in the handheld maternity notes, on the NBT website, and on the My Pregnancy app. Information leaflets are often available in multiple languages, such as the Tommy's leaflet on Reduced Fetal Movements. In November 2021, a suite of information films (including information on modes and places of birth) was uploaded to the NBT website. Multiple Maternity guidelines reference patient choice (eg for caesarean section and IOL) to support informed decisions about care. The Personalised Care and Support Plans are designed to support decision making and facilitate informed consent.
Describe how we are using this measurement and reporting to drive improvement?	In the CQC Maternity Survey 2021, we performed above national average for both the amount of information given antenatally about place of birth and whether women felt they were offered a choice of place of birth. The survey also identified areas for improvement including women having the choice of location for their postnatal care.
How do we know that our improvement actions are effective and that we are learning at	The CQC Maternity Survey 2021 is an annual event (except 2020 due to COVID-19) and ongoing trends can be examined.

system and trust level?	
What further action do we need to take?	1) Improvement work commenced to improve use of Personalised Care and Support Plans in line with Maternity Incentive Scheme Safety Action 2 2) New Personalised Care and Support Plan in development by LMS 3) Consider exploring app and website activity to inform improvement 4) Consider using interim surveys to illicit views from women that provide more useful insight into the information they value and how best to provide this.
Who and by when?	1) Jodie da Rosa and Michelle Mayer, June 2022 2) Jessica Pepler and Ami George, March 2023 3) To raise with LMS MCQ Assurance Task Group, next meeting planned for 24th March 2022 4) To raise with LMS MCQ Assurance Task Group, next meeting planned for 24th March 2022
What resource or support do we need?	1) Improvement to the internet connectivity at community midwifery locations, see Risk 1211 (Extreme Risk 20: Daily Occurrence, Severe Impact *Poor functionality of trust wide system impacting service delivery, not readily resolvable*) 2) Nil at present, resources may be required as project continues 3) Nil at present, resources may be required as project continues 4) Nil at present, resources may be required as project continues
How will mitigate risk in the short term?	1) Improvement work ongoing including joint ownership of task throughout maternity service (may require additional administrative support) see Risk 1211 (Extreme Risk 20: Daily Occurrence, Severe Impact *Poor functionality of trust wide system impacting service delivery, not readily resolvable*) 2) Improvement work commenced to improve use of current Personalised Care and Support Plans in line with Maternity Incentive Scheme Safety Action 2 3) Not applicable, as service user feedback collected via other methods 4) Not applicable, as service user feedback collected via other methods

Section 2	
MATERNITY WORKFORCE PLANNING	
What process have we undertaken?	Workforce is included in the PQSM, shared regularly at Trust Board, with the LMS and at the Maternity Safety Champion meeting.
How have we assured that our plans are robust and realistic?	An assessment by Birthrate Plus is currently ongoing which will further inform workforce planning. The results of this are currently expected in April 2022.
How will ensure oversight of progress against our plans going forwards?	The maternity workforce is a Trust Level Risk (Risk 1323 = 16) and actions to mitigate are monitored through Divisional Governance processes. Once the Birthrate Plus exercise is completed recommendations will inform next steps.
What further action do we need to take?	Nil at present, business case is likely to be required following publication of the Birthrate Plus review
Who and by when?	Nil at present
What resource or support do we need?	Financial support may be required to resource the service as per the Birthrate Plus assessment once the results are published Financial support to use bank staff to fill current gaps in the workforce across the division
How will mitigate risk in the short term?	Use of bank staff to fill current gaps in the workforce across the division

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

NBT has an Interim Head of Midwifery (Julie Northrop) and a Divisional Director of Nursing (Juliette Hughes). Both posts are directly accountable to the Chief Nursing Officer/Executive Director. The Chief Nursing Officer is also the Executive Maternity Safety Champion.

Below are details of NBT's position in relation to the seven points detailed in the manifesto:

1) The RCM manifesto suggests that all trusts should have a Director of Midwifery at board level.
2) The Interim Head of Midwifery is in post and provides midwifery leadership and representation at external groups including the Local Maternity System and with the Regional Chief Midwife

3-4) The role of consultant and specialist midwives is being explored as part of ongoing improvement work in antenatal care

5) W&CH has a well-embedded and very successful research team that have a wide portfolio of projects within Maternity. The Practice Development Leads are the Lead Midwives for Education at NBT and work closely with clinicians and UWE to ensure the education and support of student midwives.

6) The Practice Development Team receive a grant from Health Education England to support post-registration education of midwives. NBT also provide a Leadership Programme which has been supporting midwives into leadership roles

7) Nationally, the Royal College of Midwives (RCM) has been on the panel for appointment of the Chief Midwifery Officer. This was echoed at the appointment of the Interim Head of Midwifery where the Chair of the NBT branch of the RCM was invited to be part of the focus groups prior to interview.

Report To:	Trust Board		
Date of Meeting:	31 March 2022		
Report Title:	Patient & Carer Experience Committee Report		
Report Author & Job Title	Kate Debley, Deputy Trust Secretary		
Executive/Non-executive Sponsor (presenting)	Kelvin Blake, Non-Executive Director and Committee Chair		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is recommended to receive the report for assurance.		
Report History:	The report is a standing item to each Trust Board meeting following a Patient & Carer Experience Committee meeting.		
Next Steps:	The next report to Trust Board will be to the June 2022 meeting.		

Executive Summary	
The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the Patient & Carer Experience Committee Meeting held on 16 March 2022.	
Strategic Theme/Corporate Objective Links	1. **Provider of high quality patient care** a. Work in partnership to deliver great local health services b. A Centre of Excellence for specialist healthcare 2. **Developing Healthcare for the future** a. Training, educating and developing our workforce 3. **Employer of choice** a. Empowered clinically led teams b. Support our staff to continuously develop 4. **An anchor in our community** a. Create a healthy & accessible environment
Board Assurance Framework/Trust Risk Register Links	Reports received support the mitigation of the following BAF risks: N/A
Other Standard Reference	Care Quality Commission Standards.

Financial implications	No financial implications as a consequence of this report.
Other Resource Implications	No other resource implications as a result of this report.
Legal Implications including Equality, Diversity and Inclusion Assessment	No legal implications
Appendices:	N/A

1. Purpose

To provide a highlight of the key assurances, any escalations to the Board and identification of any new risks from the Patient & Carer Experience Committee meeting held on 16 March 2022.

2. Background

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

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

3. Key Assurances & items discussed

3.1 Christine Fowler

Following the death of Christine Fowler, Chair of the Patient Partnership Group and patient representative on the Committee, some time was taken at the start of the meeting to reflect on the important contribution Christine made to improving patient engagement and involvement within the Trust.

3.2 Accessible Information Standard – Staff Story

The Committee received a staff story in relation to the work being undertaken to implement the Accessible Information Standard and the positive impact this is having on the experience of patients with additional needs including autism and visual and hearing impairments. The Committee noted the examples of positive feedback that had been received from patients and carers and welcomed the progress that had been made, particularly in relation to the hospital passport system.

The Committee discussed the importance of communication and engagement in order to ensure that patients and carers, GPs, Allied Health Professionals and schools, are all aware of the different services that are offered. The Committee were reassured that a communications plan is in development and requested that momentum also be maintained on this outside key disability awareness weeks.

3.3 Accessible Information Standard - Compliance Update

The Committee then received an update on progress towards formal compliance against the Accessible Information Standard and it was noted that the scope of the work is extensive. Full compliance with the Standard will require the Trust to record, flag, share and meet the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

The Committee heard that next steps will include creating a formal policy and procedure document which will clearly set out the specific actions required for compliance with the Standard, as well as the way that these actions should be achieved, and the roles and responsibilities of staff members. A training programme is also in development, together with a review of all patient information and potential alternative formats.

3.4 Maternity Patient Survey Report

The Committee received a presentation on the NHS Maternity Survey 2021 from the Divisional Director of Nursing for Women & Children's Health, and welcomed the Trust's ambition to be the top-rated Maternity service for patient experience within the next two years.

The Committee heard that the 2021 Survey had been broadly positive and that in most areas results were as anticipated. It was noted in particular that the highest scoring section of the Survey was the one in which women were asked about the staff involved in their care. The Committee acknowledged that the Covid pandemic had necessitated the restriction of certain services and noted that it looked forward to the results of future surveys outside the context of that level of restriction.

There was a discussion about the data provided by Picker, who conducted the Survey, and the Committee asked that the Division resubmit a request to Picker that analysis of the Survey results broken down by ethnicity also be provided. In addition, the Committee

welcomed the update that the Division are helping to support the Maternity Voices Partnership and Local Maternity System in their work to engage with communities that are not currently being reached effectively.

3.5 Patient Experience Risk Report

Following a request by the Committee in November 2021, the Divisional Directors of Nursing attended the meeting to discuss the highest scoring patient experience risks for each clinical division. It was noted that there were no new risks requiring escalation to Trust Board.

The Committee discussed the challenges for risk owners in identifying just one theme for each risk and noted that there can be significant overlap between the patient safety and patient experience themes. It was noted that wider work around risk is being undertaken within the organisation and the Committee were reassured that this issue would be considered as part of that work.

3.6 Patient Experience Internal Audit Report

The Committee received an update on progress against recommendations in the Patient Experience Internal Audit Report that had been delegated by Audit Committee for oversight in February 2021. It was agreed that assurance could now be provided to Audit Committee that all outstanding actions had been completed.

3.7 Q2 Patient Experience Report

The Committee received the Q2 Patient Experience Report and noted that there had been some delay in this reaching the Committee as a number of meetings had been stood down due to operational pressures. Key complaint themes remain Access to Services and Clinical Care & Treatment.

The Committee asked that consideration be given to sub-categorisation of the current complaint themes so that clinical divisions are more easily able to use this insight to improve services and provide assurance. The Committee also highlighted the importance of acting on feedback received from the Complaints Lay Review Panel.

3.8 Additional updates received on:

- Patient Experience Group Highlight Report
- Learning Disability & Autism Steering Group Highlight Report
- Integrated Performance Report – Complaints and Concerns (February data)

4. Escalations to the Board

4.1 No risks or items of concern were identified for escalation to Trust Board.

5. Recommendations

5.1 The Board is recommended to receive the Report for assurance.