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 26 November 2020
10.00 – 12.00

A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcome and Apologies for Absence:	Information	Chair	Verbal	10.00
2.	Declarations of Interest	Information	Chair	Verbal	10.02
3.	Minutes of the Public Trust Board Meeting Held on 29 September 2020	Approval	Chair	Enc.	10.05
4.	Action Chart from Previous Meetings	Discussion	Trust Secretary	Enc.	10.08
5.	Matters Arising from Previous Meeting	Information	Chair	Verbal	10.12
6.	Chair's Business	Information	Chair	Verbal	10.15
7.	Chief Executive's Report	Information	Chief Executive	Verbal	10.25
KEY DISCUSSION TOPIC					
8.	Patient Story: Presentation from Medicine Division regarding use of insight from improved qualitative FFT data *Charlie Molden (Patient Experience & Involvement Lead, Medicine) attending*	Discussion	Director of Nursing & Quality	Enc.	10.35
PEOPLE					
9.	Freedom to Speak-Up report	Information	Director of Corporate Governance	Enc.	10:55
10.	Research & Innovation Update *David Wynick & Becca Smith attending*	Information	Medical Director	Enc.	11:05
PERFORMANCE AND FINANCE					
11.	Integrated Performance Report	Discussion	Chief Executive	Enc.	11.20
GOVERNANCE & ASSURANCE					
12.	Patient & Carer Experience Committee Upward Report	Information	NED Chair	Enc.	11:40
13.	Quality & Risk Management Committee Upward Report	Information	NED Chair	Enc.	11:45
14.	Audit Committee Upward Report 14.1. Updated Standing Orders & SFIs	Information Approval	NED Chair	Enc.	11:50

No.	Item	Purpose	Lead	Paper	Time
	14.2. Covid-19 Appendix to SOs and SFIs	Approval			
CLOSING BUSINESS					
	Any Other Business	Information	Chair	Verbal	11:55
	Questions from the Public in Relation to Agenda Items	Information	Chair	Verbal	-
	Date of Next Meeting: Thursday 28 January 2021, 10.00 a.m. Virtual				
	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.				

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. • Lay Member of the Avon & Somerset Advisory Committee. The Committee is responsible for forming interview panels for the appointment of magistrates. • Director, Bristol Chamber of Commerce and Initiative. • Member of the Labour Party.
Ms Jaki Davis	Non-Executive Director	• Trustee of the Cheltenham Trust. • Trustees of the Friends of the Wilson Museum and Art Gallery in Cheltenham.
Mr John Everitt	Non-Executive Director	• Councillor, Newton St Loe Parish Council. • Member of Bath Abbey Appeal Committee. • Daughter works for NBT. • Trustee, Wellsway Multi Academy Trust – an education trust that manages approx. 20 schools.

Professor John Iredale	Non-Executive Director	• Pro-Vice Chancellor of University of Bristol.
		• Member of Medical Research Council.
		• Trustee of:
		  ○ British Heart Foundation
		  ○ Children's Liver Disease Foundation
		  ○ Foundation for Liver Research
		• Chair of the governing board, CRUK Beatson Institute.

Name	Role	Interest Declared
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 January 2021.
Mr Richard Gaunt	Non-Executive Director	• Non-Executive/Governor of City of Bristol College. • Local Board Governor of Colston's Girls' School. • Non-Executive Director of Alliance Homes, social housing and domiciliary care provider
Ms Kelly Macfarlane	Non-Executive Director	• Managing Director of Thames Water Utilities Ltd. • Vice President of The Institute of Customer Service. • Sister is Centre Leader of Genesiscare Bristol – Private Oncology. • Sister works for Pioneer Medical Group, Bristol.
Mr Ade Williams	Associate Non-Executive Director	• Superintendent Pharmacist and Director of M J Williams Pharmacy Group – NHS community pharmacy contractor and private vaccination services provider. • Practice Pharmacist, Broadmead Medical Centre. • Pharmacy Ambassador and Clinical Advisor, Pancreatic Cancer Action Charity. • Non-Executive Director Southern Health NHS Foundation Trust. • Trustee of the Self Care Forum Charity.
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 Andrea Young	Chief Executive	• Member of the University of the West of England (UWE) Board of Governors. • Bristol Health Partners gifted a Woodland Tree (£20 value) and a Bristol Old Vic Friends membership (£45 value)

Name	Role	Interest Declared
Ms Evelyn Barker	Chief Operating Officer & Deputy Chief Executive	• Nothing to declare.
Ms Helen Blanchard	Interim Director of Nursing and Quality (from 2 July 2018 to 7 November 2019) Director of Nursing and Quality (from 8 November 2019)	• Nothing to declare.
Dr Chris Burton	Medical Director	• Wife works for NBT. • Hospitality received from Royal College of Anaesthetists – dinner to the value of £40 on 26 February 2020. Invitation from Vice President of RCOA, who is employed by NBT as an anaesthetist.
Mr Neil Darvill	Director of Information Management and Technology (non-voting position)	• Wife works as a senior manager for Avon and Wiltshire Partnership Mental Health Trust.
Ms Jacqui Marshall	Director of People and Transformation (non-voting position)	• Nothing to declare.
Mrs Catherine Phillips	Director of Finance	• Hospitality received to the value of £735.68 for Patient Hotel Study tour of Denmark/Sweden hosted by St Monica's Trust. Hospitality included local transport and transfers, meals and tour guide/interpreter. NBT paid for flights and accommodation (February 2020).
Mr Simon Wood	Director of Estates, Facilities and Capital Planning (non-voting position)	• Member of Bristol City Council's Bristol One City Environmental Sustainability Board.

DRAFT Minutes of the Public Trust Board Meeting held on Thursday 24 September 2020 at 10.00am Nightingale Hospital Bristol and virtually via Microsoft Teams

Present:			
Tim Gregory	Non-Executive Director and Deputy Chair	Andrea Young	Chief Executive
		Evelyn Barker	Chief Operating Officer
Michele Romaine	Chair (present from minute item 10)	Helen Blanchard	Director of Nursing & Quality
		Chris Burton	Medical Director
Kelvin Blake	Non-Executive Director	Neil Darvill	Director of Informatics
John Everitt	Non-Executive Director	Catherine Phillips	Director of Finance
Jaki Meekings- Davis	Non-Executive Director	Jacqui Marshall	Director of People & Transformation
Richard Gaunt	Non-Executive Director		
Ade Williams	Associate Non-Executive Director (present from minute item 06)	Simon Wood	Director of Estates, Facilities & Capital Planning
LaToyah Mcallister-Jones	Associate Non-Executive Director (present from minute item 06)		
In Attendance:			
Xavier Bell	Director of Corporate Governance & Trust Secretary	Pete Bramwell	Head of Communications
		Isobel Clements	Corporate Governance Officer

Observers: Due to the impact of Coronavirus Covid-19, the Trust Chair took the decision to suspend non-urgent and non-essential meetings until further notice. The Trust Board met at the Nightingale Hospital Bristol (with social distancing) and 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 website.

Action

TB/20/09/01 Welcome and Apologies for Absence

Tim Gregory chaired the meeting on behalf of Michele Romaine, NBT Chair and welcomed everyone to the public meeting of the Board. Apologies were received from Kelly MacFarlane, Non-Executive Director (NED).

TB/20/09/02 Declarations of Interest

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

TB/20/09/03 Minutes of the previous Public Trust Board Meeting

RESOLVED that the minutes of the public meeting held on 30 July 2020 be approved as a true and correct record.

TB/20/09/04 Action Log and Matters Arising from the Previous Meeting

It was noted that Action 19 would be discussed later in the meeting and Action 22 was delayed due to Covid-19.

Matters Arising - Covid-19

Simon Wood, Director of Estates, Facilities & Capital Planning, updated the Board regarding Covid-19 measures taken in the hospital. Masks and hand sanitisers were available at all entrances to the building with the main entrance supervised by the security team. The last of the clear screens for reception areas were being established and the majority of offices were now Covid-19 secure areas. Covid-19 secure offices had a number of criteria to meet and were audited weekly. Lastly, clear screens between office desks were due to be being trialled in two offices.

Tim Gregory, NED and deputy chair, queried how NBT was ensuring staff stayed socially distanced in social areas in the Trust. Simon Wood replied that an additional canteen with 100 appropriately distanced seats had been provided until July 2021; distancing posters and signs acted as reminders; a Communications campaign had been relaunched; and 40% of chairs had been removed from Vu canteen. However, it was acknowledged that individual staff culture change of keeping socially distant was an ongoing challenge.

Tim Gregory further queried how the Trust was managing balancing staff working on-site and from home. Andrea Young, Chief Executive, highlighted that the flexible home working policy approved and disseminated the previous month provided guidelines to support those working from home and that completion of individual risk assessments had been helpful to highlight additional support required. It was felt that the Trust had the correct stance regarding making on-site offices Covid-19 secure and working from home achievable to enable individuals to be able to work efficiently from either venue, as appropriate. Jacqui Marshall, Director of People and Transformation, noted the Trust was still learning from the situation and huge societal change. In reflection of this, the recently released NHS People Plan stipulated that all NHS roles must be advertised as 'flexible working' from January 2021.

After a query regarding sensitivity of patient information and people working from home, Neil Darvill, Director of IM&T, noted that the biggest patient information risk was from papers left in inappropriate places. This was now largely mitigated due to NBT's digitisation of medical records.

RESOLVED that updates on the Action Log and discussion regarding Covid-19 as a matter arising be noted.

TB/20/09/05 Chair's Business

John Iredale, NED, updated the Board regarding the Acute Services Review (ASR). The first ASR Programme Board took place the previous week and was a joint committee with University Hospital Bristol and Weston (UHBW) to review acute services across Bristol. The Programme Board was chaired by John Iredale for NBT and Jane Nee for UHBW and supported by Trust Secretaries from both organisations. Alongside approval of the Terms of Reference, three major work-streams were agreed at the ASR Programme Board:

- Which priority clinical pathways to review;

- How change can be delivered in partnership;
- Future programme of change.

The Programme Board also reviewed the project initiation document and requested that the Memorandum of Understanding be more aspirational.

Kelvin Blake, NED, queried how NBT Board and the public would be kept informed of ASR work. John Iredale responded that all ASR documentation was available on Diligent reading room for NEDs to view and directed NEDs to the project initiation document in particular. An action regarding how to disseminate the work wider had been taken by ASR Board members following the first meeting.

RESOLVED that the Chair's briefing be noted.

{LaToyah McAllister-Jones and Ade Williams joined the meeting}

TB/20/09/06 Chief Executive's Report

Andrea Young, Chief Executive, provided an update on five key areas:

- The system was continuing progress regarding becoming an Integrated Care System (ICS). The ICS development plan would be submitted to the region the following day and detailed how the system would oversee performance management, organisational development and quality and outcomes. More work with Boards and Executive Leaders would occur in the upcoming months. BNSSG expected to become a shadow ICS by the end of November 2020, though work was required to define what an ICS meant in practice as legislation continued to assign accountability to individual organisations;
- The Trust had been accepted as an early adopter of the new Patient Safety Incident Reporting which was in line with development of a Just Culture as presented at July's Trust Board;
- The Weston Covid-19 Outbreak Report had been published in the week prior. NBT was keen to review the report in order to garner learning. It was noted that NBT had no hospital acquired Covid-19 cases since June 2020 and remained vigilant in its Infection Prevention Control (IPC) procedures. In addition, BNSSG Covid-19 cases per 100,000 population remained low compared with national figures;
- A highly positive CQC quarterly meeting took place in the week prior. CQC monitoring visits were expected in the Emergency Department (ED), Maternity and Outpatients in the upcoming months;
- In October the Trust would formally launch NBT Black History Month with a large programme of events scheduled to celebrate black people's contribution to NBT and the wider community. Events organised included the formal opening of the Princess Campbell

Office. Princess Campbell's family and Asher Craig, Bristol Deputy Mayor, were expected at the event which would be kept to government guidelines regarding Covid-19.

Tim Gregory queried how Primary Care (PC) was dealing with challenges to activity in light of Covid-19. Andrea Young responded that PC was struggling with PPE and maintenance of services on-top of beginning a large flu vaccine campaign. No specific concerns had been raised by individual local practices, likely due to the locality approach and OneCare support. NBT was working closely with PC leaders regarding urgent care and increasing community-based support. In addition, it was noted that BNSSG had been allocated £340k to up-scale NHS 111 to support urgent care referrals during winter. It was agreed that being open for referrals for diagnostics and outpatients and for advice and guidance was the best way that NBT supported PC.

RESOLVED that the Chief Executive's Report be noted.

TB/20/09/07 Integrated Performance Report

Evelyn Barker, Chief Operating Officer and Deputy Chief Executive, presented the overall positive September Integrated Performance Report and highlighted the following key points:

- ED attendance had risen to 95% of attendances for the same time the previous year following the dip in attendances during the pandemic. ED four-hour performance was strong and there had been no 12 hour trolley waits. NBT was the top performing major trauma centre in the country including ambulance handover times;
- RTT was significantly impacted in NBT and waiting list size had increased overall due to increased referrals and a reduction in capacity due to Covid-19. The Trust had a back-log in 52 week waits with 797 people now waiting more than 52 weeks. This position was reflected nationally and NBT was following Royal College guidance regarding prioritisation of waiting patients.

During the ensuing discussion the following points were noted:

- John Everitt, NED, suggested that when compared to other Trusts, NBT compared favourably, and this at present this was more useful than comparison to national targets. However, John queried when new trajectories would be created for the Trust and Evelyn Barker confirmed work was ongoing and would be presented to Finance and Performance Committee (FPC) for approval in October;
- John further queried the impact on community organisations from delays to diagnostics and growing waiting lists. Evelyn responded that Quality & Risk Management Committee (QRMC) was reviewing the process of measuring harm for those who wait. It was noted that the Trust was just one element of the healthcare system and the STP were anxious to understand the community impact. Chris

Burton, Medical Director, reassured the Board that although an answer had not yet been landed, work was ongoing to assess harm and Acutes had opened referral lists to ensure patients waiting were on the system and managed. Evelyn Barker confirmed NBT's waiting lists were being actively managed with consultant interaction;

- Kelvin Blake, NED, raised concern regarding high bed occupancy rates and what impact this was having on emergency admissions. Evelyn Barker agreed that due to Covid-19-nessecitated bed pathways of Yellow, Green and Blue, bed capacity at NBT had reduced and bed occupancy was at 92% when the aim was 85% to allow for flex and flow. The Trust was investigating all possible resolutions including purchasing community beds alongside the CCG. This would be further discussed in the Winter Plan due at Private Trust Board;
- Tim Gregory queried use of the Independent Sector (IS). It was confirmed the national IS contract was currently in place until November 2020 but NBT's IS theatre productivity at Emerson's Green was reduced as staff had to factor in travel time;
- Tim further queried how the Trust planned to reassure patients, public and staff that services were safe and robust. It was confirmed that staff communications had been distributed that week reassuring staff that the Trust was robustly preparing for winter and a potential second wave of Covid-19. External communications were ongoing through various forums including direct briefings to MPs;
- NBT's high caesarean section rates were also discussed. Helen Blanchard, Director of Nursing and Quality, informed the Board that Women & Children (W&CH) division were committed to understanding the rates more clearly as requested by the Board. On behalf of the Board, September's QRMC had discussed the issue in-depth through initial analysis and hypotheses creation regarding what was driving the increased C-section rates. Reasons hypothesised included strong enactment of the NICE guidance stating women should be able to choose their method of delivery and many opting for a caesarean; and higher numbers of women being induced and then choosing caesarean due to prolonged labour times. In addition, NBT had seen an increase in Planned, Category Three C-sections and a similar decrease in urgent C-sections. Lastly, it was suggested that outcomes at NBT were comparatively very good such as lower rates of cerebral palsy. Chris Burton reassured the Board that the increased C-section rates were also likely due to a national drive to reduce perinatal mortality as the UK was higher than EU comparators. This drive had resulted in increased intervention during births and significantly higher medicalisation. John Iredale, NED and QRMC chair, further assured the Board that the C-section rate issue was nuanced and that due to good outcomes, the Committee was not highly concerned. QRMC

would receive further analysis of the last six months of C-Section data (April – September 2020) at its November meeting;

- Richard Gaunt, NED, noted that RAG ratings and benchmarking within the IPR was helpful for analysing performance statistics and requested that those performance indicators without a benchmark be provided with one. It was explained that those without a benchmark was due to there not being a national target however it was agreed the Trust could provide its own benchmark targets;
- Chris Burton highlighted that the Trust had seen a small increase in Covid-19 cases (less than 10) with no hospital acquired infections;
- Chris Burton further highlighted that comparator data for mortality would be difficult to interpret within the current context of changing activity and patient types.

RESOLVED that:

- **The Integrated Performance Report was noted;**
- **Work be carried out to provide benchmarking for those performance indicators currently without a benchmark;**
- **The Provider Licence Compliance Statements be approved;**
- **Staff were thanked for accomplishments in difficult circumstances.**

EB/CB/ HB

TB/20/09/08 Medical Appraisal And Revalidation – Annual Report

Chris Burton, Medical Director, presented the Medical Appraisal and Revalidation Annual Report for ratification. The Trust had chosen to complete the report as good practice though NHSE had suspended the absolute requirement due to Covid-19. People and Digital Committee had reviewed the report in detail and noted the report reflected that the system was working well. The Trust had also committed to a further internal audit later in the year.

Andrea Young linked the report to the number of ongoing conversations regarding giving patient's assurance regarding the safety of hospital. She also thanked the team and in particular Nick Standen for their impressive work providing quality assurance to the Board and reflecting the commitment to learning that NBT colleagues had.

RESOLVED that the Board reviewed the content of the report for information and agreed that the Chief Executive sign the statement of compliance on behalf of the Board.

TB/20/09/09 People Strategy

Jacqui Marshall, Director of People and Transformation, presented the People Strategy for final approval. The strategy had been through extensive consultation and was created as an accessible document for both an internal and external audience. It was noted that encompassing lived experience had been critical to creation of the Strategy and that the main focus of the Trust was to ensure it was a compassionate and

inclusive employer that was an anchor of the community. The NBT People Strategy 2020-2025 detailed three key strategic themes:

- **Great Place to Work** ("Valuing you" EDI Strategy; Just Culture; Voice; Wellbeing built into appraisals);
- **Growing and Developing our Workforce** (Flexible self-directed learning; e-Passports; Growing international pipeline; Expanding apprenticeships; Flexible Working; Retention Programme);
- **Better People Support** (Easy to use Policies; ESR – electronic files, line manager and self-service; Real time HR Data; HR Balanced Scorecard).

Jacqui Marshall proceeded to detail a number of initiatives already underway at the Trust and highlighted achievements to date such as a focus on HR case work and associated legal spend that had reduced external legal spend on HR dramatically.

Andrea Young echoed the vision of the People Strategy and emphasized that the Trust must ensure staff felt cared for and valued as well as being innovative in employment. The latter was likely to be especially pertinent as the Trust expected to have a large role in recovery from Covid-19 regarding providing jobs and careers. The Trust would continue to aim for having a choice of candidates who would embrace the just, open, transparent and compassionate culture.

LaToyah McAllister Jones and Ade Williams, Associate NEDs, both commended the Strategy and noted that the Equality, Diversity and Inclusion (EDI) agenda was significant on a local, national and global scale so they were pleased to see NBT leading the way as thought leaders and embedding positive change.

LaToyah queried how NEDs and the Board would be able to track progress against the Strategy. Jacqui Marshall noted that key measures of success would be sustained improved retention and reduction in vacancies; improved wellbeing offers and reduction in sick absence; improved satisfaction / motivation measured by SAS; Pulse Survey results, Exit and Happy App Data; improved development career progression offer; and improved inclusivity / WRES / WDES scores.

Ade Williams further queried when specific targets would be available. It was confirmed that a HR and Organisational Development review would begin in October 2020 to provide hard targets. John Everitt requested hard targets for the People Strategy that linked with overall Trust objectives and Strategy. Jacqui Marshall responded that yearly People targets were agreed as part of annual business planning, overseen by People and Digital Committee, and some performance objective measurements were detailed within the IPR.

It was further noted that the People Strategy provided a real opportunity for system-wide working with PC, local authorities and community care. Jacqui Marshall confirmed she would ensure all initiatives were linked.

RESOLVED that Trust Board approved and commended NBT People Strategy 2020-2025 and agreed progress would be tracked through People and Digital Committee.

Michele Romaine joined the meeting

TB/20/09/10 Patient & Carer Experience Committee (P&CE) Upward Report

Kelvin Blake, NED and P&CE Committee Chair, presented the Patient & Carer Experience Committee Upward Report and raised the issue of duplication between P&CE Committee and the Patient Experience Group which was its subsidiary committee. The paper included a number of appendices to allow Trust Board sight of important elements of patient engagement:

Complaints Annual Report - Identified that complaints had reduced which indicated that the PALS system was working.

CQC Inpatient Survey Results
Helen Blanchard presented the CQC Insight Survey Results. Improvements in twelve performance indicators and the composite score were evidenced which reflected NBT's 'Good' CQC rating and meant that NBT was in line with other Trusts.

Results of the National Maternity Survey 2019
Helen Blanchard commended the 100% score in patients feeling treated with respect and dignity (100% was rarely seen) and highlighted the importance of this for patient experience. It was hypothesised that the deterioration of the score regarding women being provided with a phone number was likely due to changes within community teams. However, the report provided useful areas of focus for the Trust.

Michele Romaine, NBT Chair, queried why scores were low for knowing where to have check-ups. Helen Blanchard responded that the score was low nationally and hoped that implementation of the 'Continuity of Carer' programme to allow women to know and develop trust with those looking after them would increase this score.

New model for bringing patient stories to Board (action from July)
Following discussion, it was agreed that the Board should receive staff and patient stories from November 2020 through a range of methods and linked to strategic themes where possible.

RESOLVED that:

- **Lead executives would discuss what was reported to P&CE;** **HB/KD**
- **An annual plan of patient and staff stories to Board be created and begun at November 2020 Public Trust Board;** **HB**
- **The first quarter of patient/ staff stories should be from Maternity, Outpatients and Emergency Department as these were the focus areas for CQC monitoring visits.**

TB/20/09/11 Quality & Risk Management Committee Upward Report

John Iredale, Non-Executive Director, presented the Quality & Risk Management Committee Report for assurance.

RESOLVED that the Quality & Risk Management Committee be noted.

TB/20/09/12 Audit Committee Upward Report

Jaki Meekings-Davis, NED and Chair of Audit Committee, presented the Audit Committee Upward Report for assurance. It was brought to the Board's attention that an external visits matrix had been created for effective tracking of regulatory visits and outcomes.

RESOLVED that the Audit Committee Upward Report be noted and Jaki was thanked for her service to the Audit Committee.

TB/20/09/13 Any Other Business

Michele Romaine, Chair, noted that the meeting was Jaki Meekings-Davis' last Board meeting as a NED. On behalf of the Board, Jaki was thanked for her extensive contribution as a valuable NED and Audit Committee Chair. Jaki responded that working at NBT was a fantastic experience and opportunity and she wished the organisation every success, and the strong leadership team all the best.

TB/20/09/14 Questions from the public – None received

TB/20/09/15 Date of Next Meeting

The next public meeting of the Board is scheduled to take place on Thursday 26 November 2020, 10.00 a.m. The Board will meet virtually. 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 12.05 pm

DRAFT

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
30/01/2020	Patient Story / Staff Story	TBC/20/01/04	19	Patient story advance six month plan to be created for patient and staff stories with sufficient secondary options to ensure a staff/patient story is brought to the Board	**Helen Blanchard Director of Nursing & Quality**	Sep-20	Yes	**Open**	Annual plan for patient and staff stories to be created beginning Nov 2020. First few to focus on W&CH, Outpatints and ICU as CQC focus areas	24/09/2020
30/01/2020	Board member's walk-arounds	TBC/20/01/09	22	A Board workshop/ seminar to reach a shared decision on NED and Exec walk-arounds, including staff perspectives, to be organised	**Xavier Bell, Director of Corporate Governance**	TBD	Yes	Delayed	Delayed until hospital restoration plan phase 2 & 3 complete	28/05/2020
24/09/2020	Integrated Performance Report	TB/20/09/07	39	Work be carried out to provide benchmarking for those performance indicators currently without a benchmark	**Evelyn Barker, COO/ Chris Burton, MD/ Helen Blanchard, DoN and Quality**	Jan-20	Included in regular IPR item	Closed	As much benchmarking as possible has been included. An IPR review is scheduled for March/April 2021 where development of local targets where national ones don't exist will take	18/11/2020
24/09/2020	Patient & Carer Experience Committee Upward Report	TB/20/09/10	40	Lead executives to discuss what is reported to P&CE	**Helen Blanchard Director of Nursing & Quality**	Jan-20	Yes	Closed	Kelvin, Helen, Gill, Kate and Su met on 26 Oct and discussed work plan.	26/10/2020

NHS North Bristol NHS Trust

Use of insight from improved qualitative FFT data

Medicine Division

November 2020

Exceptional healthcare, personally delivered

Friends & Family Test

NHS North Bristol NHS Trust

1. Sharing / using / learning from feedback

2. Engagement

3. Next steps

Friends & Family Test

1. Sharing, using & learning from feedback:

Sharing FFT qualitative feedback data through DGB & DMB monthly:

As part of the monthly Patient Experience Report, the Patient Experience Lead includes Divisional FFT data and content within the report. This is taken to both Divisional Governance Board and Divisional Management Board each month.

(Example of FFT content taken from a previous Patient Experience report APPENDIX 1):

Microsoft
werPoint Presentat

Friends & Family Test

1. Sharing, using & learning from feedback:

Sharing FFT qualitative data through Specialty Governance Meetings monthly:

FFT data is made available at Specialty level each month so staff can see how they are scoring and what their patient's are saying about the Service. This is done each month for all 13 Specialties across Medicine.

The Medicine Lead presents a 3 page report for every Specialty outlining their scores, response rates and feedback (both positive & negative). These monthly reports are shared to recognise good practice and to encourage learning from any negative feedback and themes:

(Example of AMU FFT July 2020 report on next slide)

Friends & Family Test Results

AMU **July 2020**

Patient feedback response rate & overall rating

24%

Response Rate

Positive: 94.83%

Negative: 2.87%

Ratings

- 94.8% positive recommend scores
- 2.8% negative recommend scores
- 24% response rate
- 174 surveys received in total:
  - 124 via SMS text service
  - 50 via Voicemail feedback service

Most frequently sighted words against positive comments:

Friends & Family Test Results

AMU **July 2020**

Patient feedback

Top Themes

Positive
Staff – **49**
Clinical treatment - **19**
Waiting Times – **14**

Negative
Communication - **5**
Staff -**3**
Waiting Times - **3**

Voicemail feedback

AMU 1 July.wav

AMU 2 July.wav

Sample of feedback

STAFF
"As it was very good care the nurses and doctors are so good and its the best hospital"

"The service was so quick and efficient. The staff were really lovely."

CLINICAL TREATMENT
"Excellent facilities, good communication, lovely staff with great"

COMMUNICATION & STAFF
"Communication was very poor from day nurse. I never even got a hot drink for few hours"

Friends & Family Test

1. Sharing, using & learning from feedback:

FFT voicemail clips:

From 1 April 2019 to 31 March 2020, Medicine received:

- 29,296 FFT surveys in total
- 11,029 of these were left via interactive voicemail message (IVM)

How Medicine are currently using this feedback:

- Shared with staff on an ad hoc basis
- Embedded into reports previously mentioned
- Used at Divisional Management Board to share positive patient experiences with the Senior Management Team each month
- Shared at Divisional Governance Board each month to highlight good practice
- Shared at each Specialty Governance Meeting

Friends & Family Test

NHS North Bristol NHS Trust

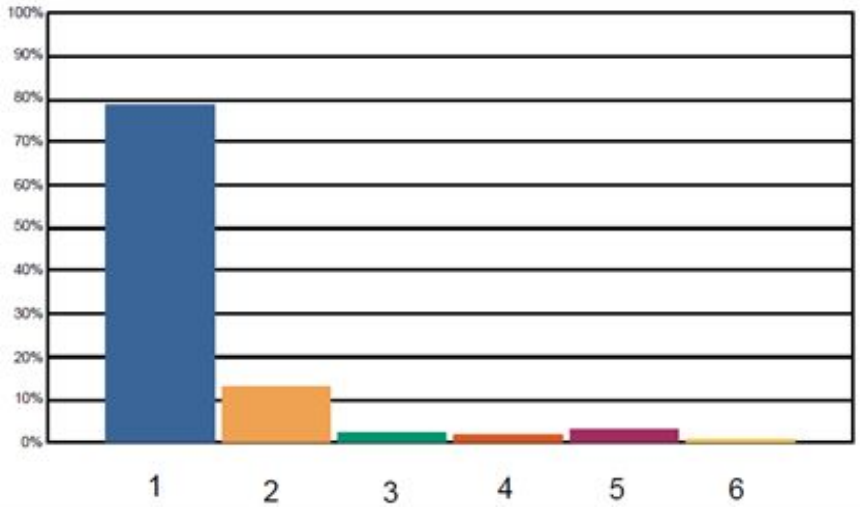
1. Sharing, using & learning from feedback:

Positive Feedback:

It is important that positive feedback received via FFT is shared across the Division and Specialty teams to recognise good practice, and to make sure staff feel valued and appreciated by their service users.

From 1 April 2019 to 31 March 2020, Medicine's FFT results were as follows:

Overall Scores



Response Option	Responses	Percentage
1 - Very good	22,978	78.43%
2 - Good	3,865	13.19%
3 - Neither good nor poor	784	2.68%
4 - Poor	525	1.79%
5 - Very poor	894	3.05%
6 - Don't know	250	0.85%

Friends & Family Test

1. Sharing, using & learning from feedback:

Example 1

Friends & Family Test

1. Sharing, using & learning from feedback:

Example 2

ACUTE MEDICAL UNIT

"THE 2 PEOPLE WHO LOOKED AFTER ME WERE OUTSTANDING, POLITE, PROFESSIONAL. FIRST CLASS DEPARTMENT, FIRST CLASS STAFF. KEEP UP THE GOOD WORK"

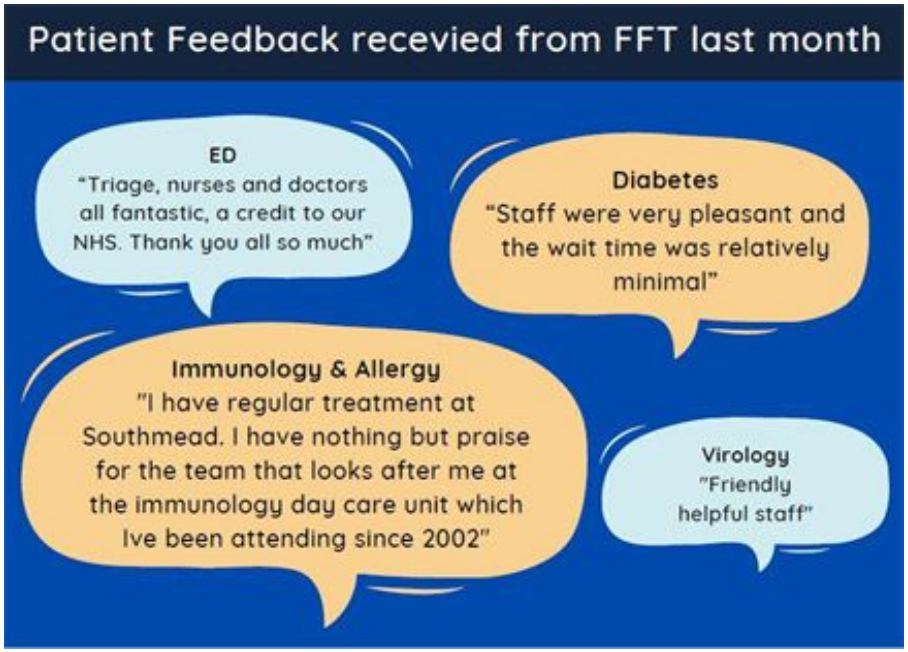
Medicine Division

From the Medicine Patient Experience Team.
Feedback taken from Friends & Family survey

Friends & Family Test

1. Sharing, using & learning from feedback:

Newsletter:
Medicine are including positive feedback and learning in a newly developed Medicine Patient Experience Newsletter. 2 samples can be seen below:



Friends & Family Test

2. Engagement:

FFT Champions:

Each Specialty/Ward have been asked to nominate a staff member to be their chosen FFT champion that Medicine can work closely with. This is normally the B7 Ward Manager or Senior Nurse for the Specialty. This has been agreed as a Trustwide approach for all Divisions, agreed at DPEG by Head of Patient Experience.

FFT Champion role description & the work involved:

- To be the key contact within each specialty for all FFT related work
- Act as a champion to promote and share FFT within your specialty
- Receive training on the ENVOY system so they are confident in pulling reports and reviewing their feedback
- Working with Divisional Patient Experience Leads to create “You Said, We Dids” and Action Plans from feedback, including acting on real time feedback
- Monitoring themes and trends on feedback within their Specialty
- Produce weekly positive feedback sharing, and monthly FFT reports sharing
- Work with Patient Experience Leads to improve response rates

Friends & Family Test

2. Engagement:

FFT roll-out and engagement:

- Identifying FFT champions for each Specialty/Ward
- Sharing feedback:
  - Positive feedback weekly messages
  - Monthly Feedback reports including all positive comments (report to include specialty scores, and feedback voice clips)
- Negative feedback alerted to the relevant specialty/team. Review feedback and where appropriate, create an action plan / YSWD action poster from the feedback. Ensure teams act on it, and print the YSWD poster to display on the ward/waiting areas (where appropriate)
- Monthly FFT Divisional reports including themes
- Creative ways of sharing the voice clips feedback

Friends & Family Test

2. Engagement:

Acting on negative feedback:

There needs to be a robust system for capturing and reviewing the negative feedback received, and feeding it back to teams in a constructive way, allowing staff to act on feedback so we can learn from experiences and improve our services.

There are two tools built into the Healthcare Communications system Envoy to enable learning from feedback:

1. **Action Plans**
2. **“You Said, We Did” Tool / Poster**

It will be the role of the FFT champions to review feedback routinely, and highlight any negative feedback that the team can learn from, and to create an action plan/ “You Said, We Did”.

This is in the early stages of roll-out, but Medicine have successfully carried out 2 “You Said, We Did” actions recently.

(examples on next slide):

Friends & Family Test

2. Engagement:

"You Said, We Did" examples

The Friends and Family Test

You Said, We Did

Service	Month
Medicine|L5 Gate 28a	July

Your Comments Count...

You Said	We Did
"Felt like I was not being listened to about the main reason for being admitted. Had to have someone to speak on my behalf to get any one to understand what I was saying. Nurses were not helping when I needed it and I was left in bed when I had been asking to get up for 4 hours. Most staff didn't know how to use the hoist"	*" We have reminded all staff to listen careful to the wishes of their patients We have also checked that statutory manual handling training is up to date and asked for all staff to update or seek additional training for hoist use"*

The Friends and Family Test

You Said, We Did

Service	Month
Medicine|L0 Gate31	August 2020

Your Comments Count...

You Said	We Did
"Communication was very poor from the day nurse. I never even got a hot drink for a few hours."	"Importance of high quality communication added to ward safety briefings each morning for a two week period. Housekeepers asked to increase beverage rounds during the day. Ongoing ward based teaching about nutritional needs for every patient with every member of the multidisciplinary ward team."

Friends & Family Test

3. Next steps:

Pilot Wards

The Head of Patient Experience has asked Divisions to select up to 5 wards/specialties to act as pilots for working closely with to try and fully embed FFT across their service, working with the chosen FFT champion. Medicine have chosen: 9A, Endoscopy, Diabetes, AMU *(on hold during covid-19 spike).*

Some feedback already received from the piloting wards:

9A:

- Some patients are lacking capacity so unable to fill out the surveys
- Moving our patients to Elgar, so they sometimes get missed.
- Staff forgetting to give surveys out in the morning when a patient is discharged

Endoscopy:

- We are not receiving the monthly reports that we used to, and they don't seem consistent

Diabetes:

- How can I see all our feedback relating to Diabetes specifically, as the nursing care we provide covers multiple wards.

Friends & Family Test

3. Next steps:

The Medicine Patient Experience Lead continues to provide and present FFT feedback and data to Divisional and Specialty Meetings. Learning from feedback and owning feedback at local level are the next big steps to fully incorporate FFT into team culture and practice. Some of the upcoming steps to take are:

- Continue engaging with FFT champions for team and local ownership
- FFT processes and approach continually reviewed at DPEG (aligned with ongoing changes to National Guidance).
- Exploring ways to engage in real-time feedback (due to the national NHSE changes)
- Quality boards on each ward, to include FFT feedback & YSWD examples
- Looking at how we can improve response rates and positive outcomes
- How appropriate completing feedback is for certain patient cohorts and how we engage with harder to reach patients
- How we engage with FFT during Covid-19

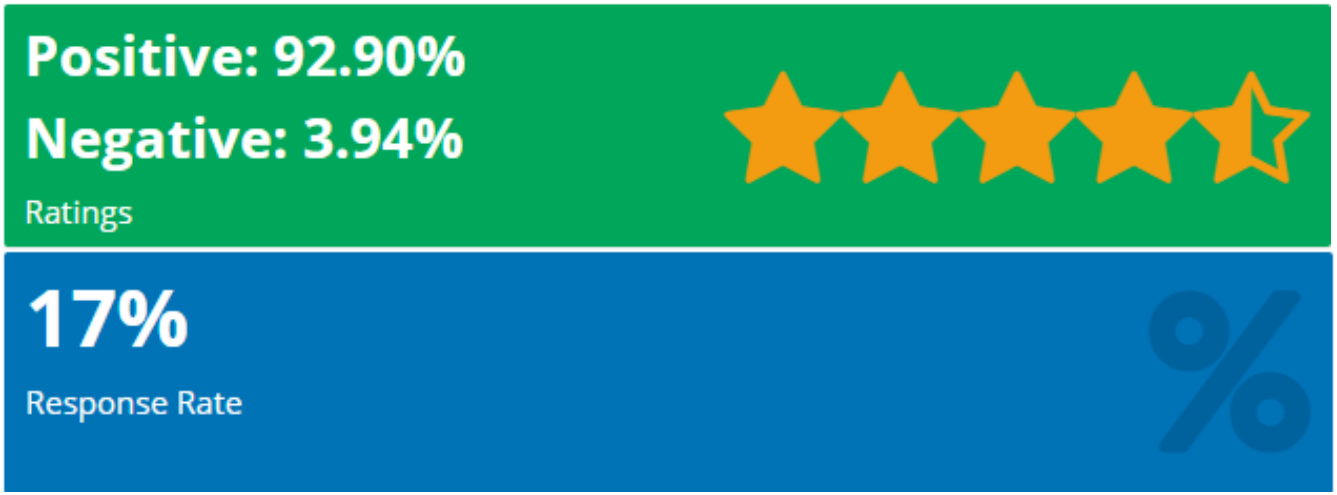
Friends & Family Test

Questions?

APPENDIX 1
Friends & Family Test

In November 2019 the FFT result across Medicine indicated that:

- 92.9% of patients said they would recommend our services to family and friends
- 3.94% said they would not recommend our services to family and friends
- 3.16% said they neither would not wouldn't recommend our services
- Medicine achieved a response rate of 17% from all contacts made (2% higher than October):



All data and positions accurate at time of writing report on 10 December 2019

APPENDIX 1

Friends & Family Test

Breakdown of FFT results from November 2019 (30 day overview):

30 Day Overview

Survey Status	No. of Discharges	% of Total
Survey Sent	8613	59.15%
Message not scheduled due to error	2750	18.88%
Excluded due to Survey Fatigue Protection	2720	18.68%
Excluded due to opt-out	479	3.29%
Manually Entered Response from Postcard	35	0.24%
FFT open survey	3	0.02%

Question 1	Ratings Received	Response Rate
IVM	971	06.67%
Online Survey Once Patient is home	3	00.02%
Paper Survey	35	00.24%
SMS	1429	09.81%
Totals	**2438**	**16.74%**

All data and positions accurate at time of writing report on 10 December 2019

APPENDIX 1

Friends & Family Test

Themes:
Below is a list of the top themes from patient feedback received across Medicine in November 2019:

Top 10 Themes

+ Positive		− Negative	
1. Staff	672	1. Waiting time	43
2. Waiting time	251	2. Staff	36
3. Clinical Treatment	194	3. Communication	32
4. Environment	86	4. Clinical Treatment	22
5. Communication	85	5. Environment	12
6. Catering	18	6. Discharge	7
7. Discharge	15	7. Catering	4
8. Staffing levels	9		

(More in depth analysis will be included in our Quarterly Quality Report for Q3)

All data and positions accurate at time of writing report on 10 December 2019

APPENDIX 1

Friends & Family Test

Wordcloud: Words associated with positive feedback received in November 2019 across Medicine. Some of the most used words associated to positive scores were:

- Attitude
- Caring
- Efficient
- Environment
- Friendly
- Professional
- Nurses
- Polite
- Communication

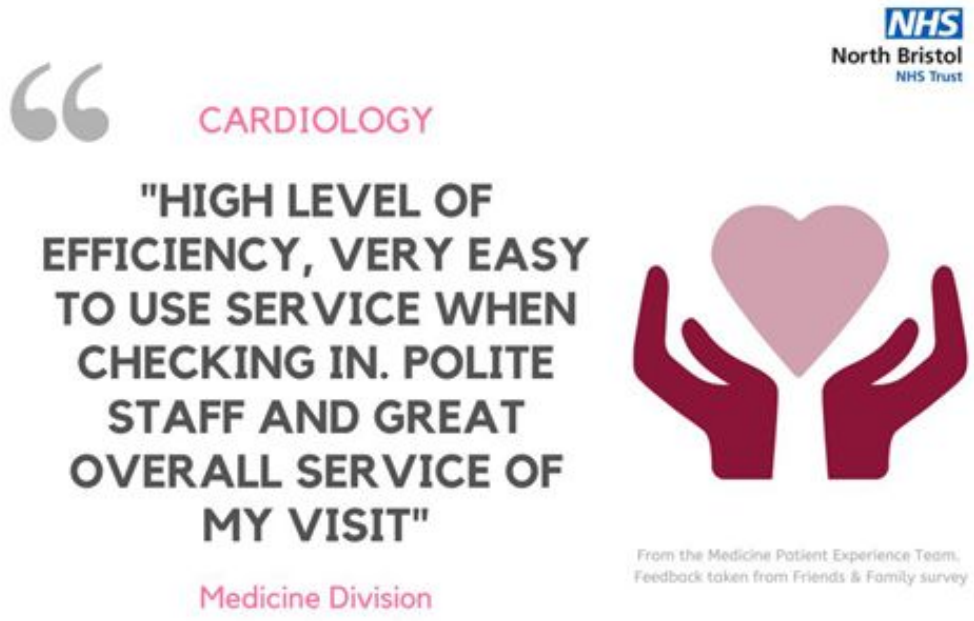
All data and positions accurate at time of writing report on 10 December 2019

APPENDIX 1

Friends & Family Test

Weekly positive patient feedback cards.

We have now started sharing random snippets of positive feedback across the Specialties weekly to encourage staff to review feedback and recognise positive experiences patients and families are having within their Specialties. Below is an example:



All data and positions accurate at time of writing report on 10 December 2019

APPENDIX 1

Friends & Family Test

What are our patients saying?

Below are some random voice message clips taken from November 2019's FFT feedback.

Gastroenterology.wav

ENDOCRINOLOGY.wav

Respiratory.wav

All data and positions accurate at time of writing report on 10 December 2019

APPENDIX 1

Year to date position

Patient Experience Trajectory (Q1 & Q2 2019)

Below is an overview of number of complaints received and the FFT data since April 2019 giving an overview of our position YTD.

	Indicator	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	YTD
Patient Experience	Complaints - number received	25	23	22	28	22	15	18	21	174
	Complaints - response rate	64%	86%	81%	91%	100%	100%	100%	100%	90%
	Number of Complaints referred to PHSO	0	1	1	0	1	0	0	0	3
	PALS Concerns - number received	12	14	6	17	12	12	10	3	86
	Compliments - number received	22	1	9	11	10	12	9	7	81
	F&F test - % would recommend	88.3%	92%	90%	89%	92%	93%	92%	93%	91.2%
	F&F test - % wouldn't recommend	7.9%	4.8%	5.3%	6.9%	4.6%	3.6%	4.3%	3.9%	5.2%
	Number of FFT forms received	1858	2774	2702	2707	2519	2679	2577	2437	20253
	FFT - % response rate	12.0%	16.0%	16.0%	15.0%	15.0%	14.0%	15.0%	17.0%	15.0%

All data and positions accurate at time of writing report on 10 December 2019

Report To:	Trust Board		
Date of Meeting:	26 November 2020		
Report Title:	Freedom to Speak Up Bi-Annual Report November 2020		
Report Author & Job Title	Millie Warrington, Staff Engagement & Wellbeing Consultant		
Executive/Non-executive Sponsor (presenting)	Xavier Bell, Director of Corporate Governance & Trust Secretary		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	Board are asked to: • Discuss the report and findings; • Review the FTSU data triangulated against other information, including the 2020 Pulse Surveys undertaken throughout Covid-19; and • Review progress against the FTSU action plan and note the plans to update this document.		
Report History:	Bi-annual Freedom to Speak Up Board report reviewed at Trust Board on 29 November 2018, 30 May 2019, 28 November 2019 and 28 May 2020		
Next Steps:	• Induct new Lead FTSU Guardian, and implement new FTSU approach and restructured network; • Refresh FTSU vision & strategy; • Continue to support and promote Freedom to Speak Up at North Bristol NHS Trust.		

Executive Summary
Freedom To Speak Up (FTSU) Guardians have been in place at North Bristol NHS Trust (NBT) since November 2017 and the programme has been continually developing over time. In early 2020, the Board approved plans for a restructure of the FTSU Guardian network through the creation of a Lead FTSU Guardian post to align NBT with best practice as highlighted by the National Guardians Office. An appointment to the Lead FTSU Guardian has now been made, with the individual due to take up the post on 18 January 2021. Whilst this is in progress North Bristol Trust continues with the prior arrangement and has a current network of 10 FTSU Guardians in place, from various substantive roles across the trust. Throughout the Covid-19 pandemic local communications around FTSU feature in the regular (currently daily) operational update, and in October a roadshow took place around the trust to

promote FTSU and raise awareness.

Exploring the most recent data available both nationally and internally at NBT, this report highlights the significant drop in the number of concerns raised at NBT throughout Q1 and Q2 2020/21, and triangulates the speaking up data with the findings from the local pulse surveys. The data indicates that whilst the reasons for concerns being raised at NBT aligns generally with the national position, the overall number of concerns raised is consistently lower at NBT than is being reported nationally (although comparative data is not yet available from the last two quarters). The data also highlights a high proportion of concerns being raised anonymously at NBT, which could be a reflection of perceived barriers across the trust in relation to speaking up.

In summary, the data indicates a drop in the number of concerns being raised at NBT when compared with 2019/20 and a reduction when compared to the national average reported by the NGO. It is believed that by putting in place a Lead Guardian with protected time to provide a more focused and proactive FTSU offering, this situation will improve.

It is recommended that, as part of the implementation of the new approach, the new Lead Guardian undertakes a review across the trust to identify barriers to speaking up, whilst also exploring why there is a high percentage of concerns being raised anonymously and incorporate any findings into an update of the FTSU action plan.

Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** **2. Employer of choice**
Board Assurance Framework/Trust Risk Register Links	A robust FTSU function plays a part in being an employer of choice, and provides an avenue to staff to raise issues and concerns. It is a key control to the various workforce and patient safety/experience risks recorded on the BAF and the Trust risk register.
Other Standard Reference	CQC Well-Led Framework
Financial implications	N/A
Other Resource Implications	The current FTSU function relies on volunteer guardians, who hold substantive roles within the Trust. The time pressure on guardians was identified as a key limitation on the function in 2019.
Legal Implications including Equality, Diversity and Inclusion Assessment	N/A
Appendices:	None

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1. Purpose

1.1 The purpose of this report is to update the Board on Freedom To Speak Up (FTSU) activity at North Bristol NHS Trust (NBT) over the past 6 months; providing information on the nature of concerns raised; comparing this activity where possible to the national picture, relevant internal data and report on progress made against agreed actions.

2. Background

2.1 Freedom to Speak Up Guardians have been in role since November 2017. The infrastructure is in place with the number of Freedom to Speak Up Guardians decreasing slightly in recent months down to 10, due to retirement and rotations of the Trust's junior doctors. The Guardians continue to represent key employee groups and levels of seniority (although the medical staff group is not currently represented, and the group does not reflect the diversity of the NBT workforce).

2.2 Recruitment of the new Lead FTSU Guardian has now concluded and an appointment has been made. The individual will be taking up post from 18 January 2021.

2.3 In May 2020 the Board received a report triangulating internal FTSU data with nationally available data and internal results of the 2019 NHS Staff Survey. This report indicated that whilst NBT was relatively aligned with the National detail around FTSU there was still progress to be made in relation to embedding FTSU at NBT.

3. How NBT Compares to the National Picture

3.1 At the time of writing this report, data for Q1 and Q2 2020/21 was unavailable from the National Guardian's Office for comparison. The data in this report includes national data up to Q4 2019/20 and internal data up to Q2 2020/21.

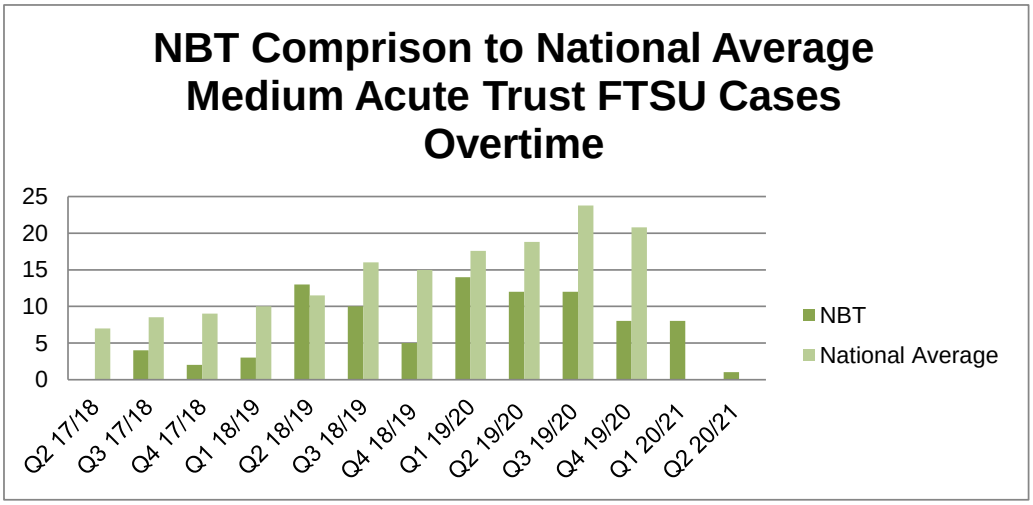

Chart 1: NBT Comparison with National Average Medium Acute Trust FTSU Cases

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3.2 Chart 1 shows the comparison with the national average for Medium Acute Trusts[1] up to Q4 2019/20, this data highlights that concerns raised at NBT continue to fluctuate, similarly to that seen nationally but it also shows that the number of concerns raised at NBT are consistently lower than that of the national average.

3.3 The data held internally for NBT shows a substantial reduction in concerns being raised throughout 2020/21 when compared with 2019/20 and in particular Q2, with only one concern having been raised across the Trust. Without the national returns available for comparison it is not possible to understand whether this is a trend seen nationally at this time.

3.4 This could be a reflection of natural fluctuations but it may also be indicative of the extraordinary period of the Covid-19 pandemic. Anecdotal feedback from Guardians at NBT indicate that staff feel they have a greater opportunity to raise concerns locally as a result of Covid-19 due to local briefings and communications having stepped up during this period.

3.5 Chart 2 below shows the comparison between NBT and the national average for medium acute trusts over the 12 month period throughout 2019/20.

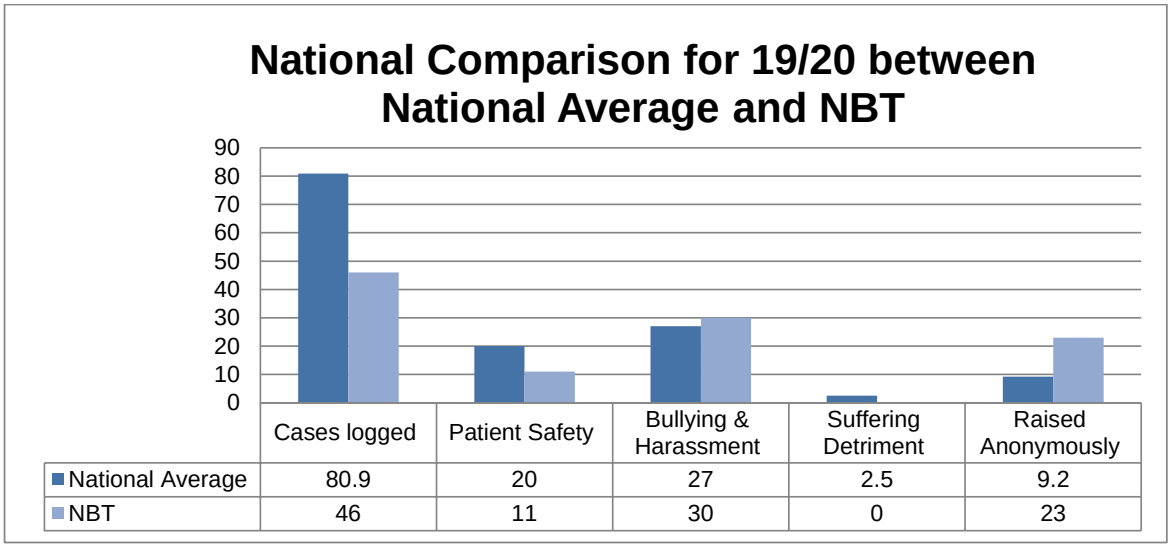

Chart 2 – National Average Comparison for 19/20
NB: 5 concerns in Q1 & Q2 were not categorised within Bullying & Harassment or Patient Safety

3.6 This data shows that over time, in comparison, whilst the reason for concerns being raised is relatively aligned with the national average, the overall number of concerns is considerably lower, potentially suggesting that more work needs to be undertaken at NBT to further embed a culture of speaking up, equally this could indicate that other channels are being considered when raising concerns.

[1] Medium Acute Trusts are all Acute Trusts with a workforce between 5,000 and 10,000

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3.7 However, it should also be noted that as a percentage, the overall number of concerns raised in NBT during 2019/20 was significantly higher than in 2018/19. The NGO Annual report details the total number of concerns raised between 1 April 2019 and 31 March 2020 increasing by 32% in comparison to 2018/19. Internally at NBT the total number of concerns raised in 2019/20 increased by 48% from 2018/19. This suggests that awareness of FTSU as a route to raise concerns at NBT has been improving over time.

3.8 Nationally the average proportion of concerns raised anonymously is 13% whereas at NBT it is 67%. The Annual Speaking Up Data Report[2] suggests that '*leaders in organisations where people are speaking up anonymously need to consider whether the organisation's speaking up arrangements and culture meets the needs of its workers and act to remedy this'.* With the planned structural changes to the FTSU network, it presents an opportunity for the lead Guardian to explore and further understand any barriers in place around speaking up with confidence.

3.9 Reassuringly, the number of concerns raised in which individuals recorded suffering a detriment as a result of speaking up has remained at zero throughout 2019/20 and the first half of 2020/21; however this could be a result of the high numbers of concerns raised anonymously.

3.10 When looking specifically at staff groups raising concerns, the below table shows the comparison between that recorded nationally in 2019/20 and the internal concerns for the same period at NBT, with the third column showing the breakdown by staff group for concerns raised internally in Q1 and Q2 2020/21.

Group	National Average 2019/20	NBT 2019/20	NBT 2020/21
Nurses	28%	26%	22%
Administrative/Clerical	19%	22%	22%
Other	14%	7%	0%
Allied Healthcare Professionals	13%	4%	0%
Healthcare Assistants	8%	0%	0%
Doctors	6%	7%	11%
Corporate Services	5%	0%	0%
Cleaning/Catering/Maintenance/Ancillary	4%	15%	45%
Midwives	2%	7%	0%
Pharmacists	1%	0%	0%
Dentists	0%	0%	0%

Chart 3: NB: Not all concerns logged have job type recorded

[22] https://www.nationalguardian.org.uk/wp-content/uploads/2020/10/201920_ftsug_su_data_report.pdf

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3.11 The proportions of staff groups raising concerns are relatively aligned with that reported nationally. At NBT a higher percentage of Cleaning, Estates and Ancillary staff are raising concerns than the national average shows, although this could be due to the visibility of the Guardian within the division and a culture of speaking up being fully embedded. No concerns during 2019/20 or to date in 2020/21 are being raised by Pharmacists or Healthcare Assistants, and whilst nationally reported concerns by these staff groups is low, the new Lead FTSU Guardian will be asked to consider focused communications and to ensure these staff groups have access to the NBT Guardian network.

3.12 Charts 4 and 5 below show the data breakdown for speaking up concerns recorded for Q1 and Q2 2020/21 at NBT, highlighting that of all the concerns raised during Q1 and Q2 none of the concerns related to patient safety, and 67% of the total number of concerns were raised anonymously.

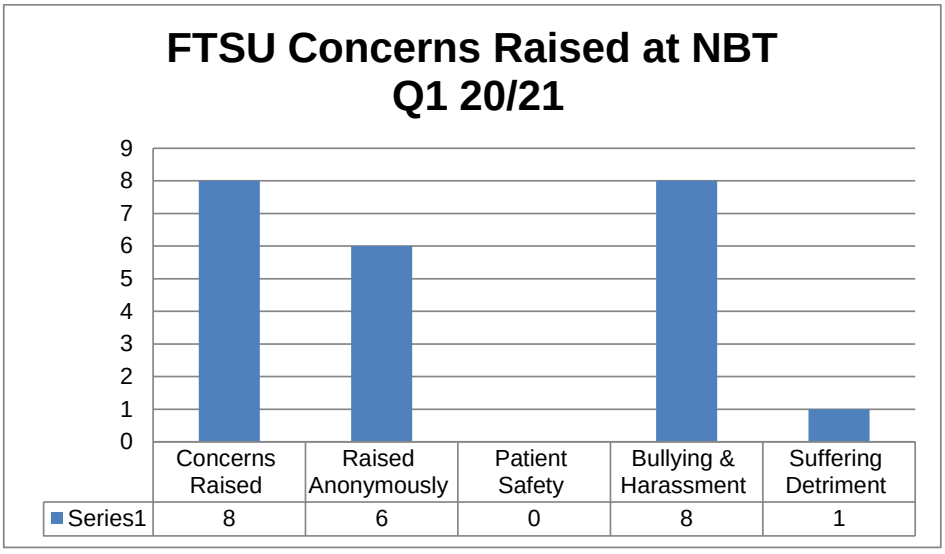

Chart 4: Q1 Breakdown of concerns recorded at NBT

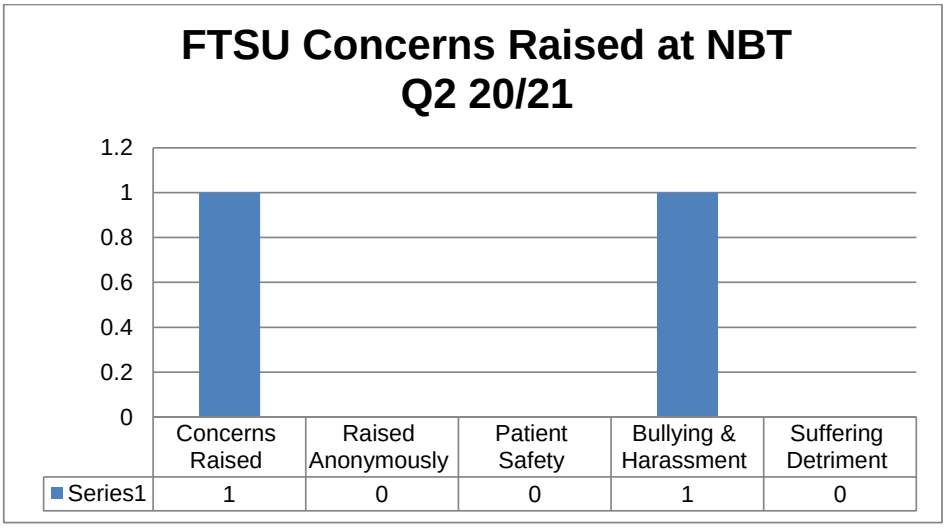

Chart 5: Q2 Breakdown of concerns recorded at NBT

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3.13 The significant drop in patient safety concerns being raised could be due to staff accessing alternative channels to speak up however further investigation would be required to understand this in more detail, such as reviewing the number of patient safety incidents logged via Datix.

3.14 To fully understand why a consistently high number of concerns are raised anonymously further investigations would be required for each concern raised, such as feedback from the individual specifically focusing on why they chose to raise the concern anonymously.

4. Triangulation of Speaking Up Data Against Other Data

4.1 In May 2020 the board report triangulated speaking up data against the Staff Survey results from 2019, as the 2020 Staff Survey is still live at the time of writing this report, it hasn't been possible to use this data, although results will be available from early 2021 and reviewed in May 2021.

4.2 Throughout Covid-19 local pulse surveys have been introduced at NBT as a check-in with the wider workforce in order to gain insight and measure the impact of the pandemic. The findings from each pulse survey have been reviewed and triangulated against the speaking up data available for the correlating time period.

4.3 Whilst the pulse surveys focus on a range of topics, one key question which was covered consistently throughout the surveys focused on the quality of patient care, which can be viewed in line with the lack of concerns raised in relation to patient safety through speaking up.

4.4 Snapshots from each survey are shown below, highlighting that consistently throughout Q1 and Q2 staff responding to the pulse surveys confirmed that they were able to continue providing a safe, high quality service to patients, only reducing by 0.1% in the last survey.

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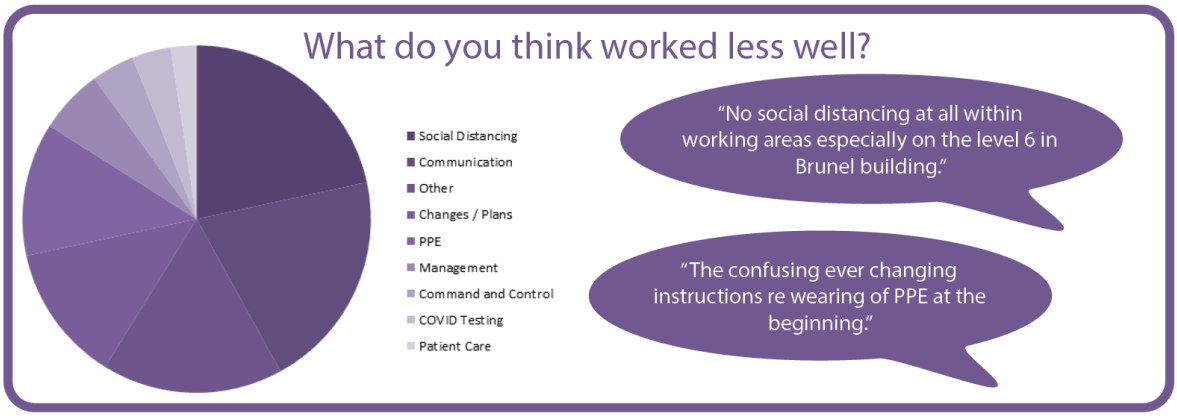

Pulse Survey 1 Responses: 22 May 2020

Pulse Survey 2 Responses: 18 June 2020

Pulse Survey 3 Responses: 30 June 2020

Pulse Survey 4 Responses: 17 July 2020

4.5 It should be noted that whilst the pulse survey findings give an insight into the general mood within the trust, it is not an absolute representation of the total workforce.

5. Summary of Data Analysis Findings

5.1 In summary, based on the comparison with nationally available data for 2019/20 and the key findings from the annual report, the data suggests that NBT still has progress to make in aligning itself with the national average and ensuring that speaking up becomes embedded within the culture across all departments and staff groups.

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5.2 Based on the advice in the 2019/20 Annual FTSU Report and reviewing the internal data in line with this, it does suggest that further work needs to be carried out in relation to ensuring staff feel supported to speak up without the need to remain anonymous. The annual report from the NGO indicates that not only does this have implications relating to the ability to investigate the concern fully, and provide feedback, but it may also be indicative of a deeper culturally embedded fear of repercussion. The new Lead FTSU Guardian will link in with the existing work in the Trust relating to Just Culture and Psychological Safety to explore ways that the FTSU function can support work in this area.

5.3 The lack of patient safety concerns being raised will be monitored over the coming months, and the new Lead FTSU Guardian engage with quality and clinical colleagues to determine whether issues are being raised via other routes.

6. Communications Update

6.1 The Daily Operational Update includes access links to the FTSU network, encouraging staff to speak up should they have concerns.

6.2 In October 2020 a FTSU roadshow took place to promote Speaking Up Month, which saw Guardians tour the trust and visit departments to raise awareness and the profile of the network.

6.3 The appointment of the new Lead FTSU Guardian represents an opportunity to re-launch the FTSU function. A communications plan will be worked up for launch in the new year.

7. Vision, Strategy, Action Plan and Regulatory Guidance

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

No	Action	Owner / Date	Progress
1	A 6 monthly report to be provided to Board, from November 2018	Xavier Bell; New Freedom to Speak Up Guardian From Nov 2018	Complete Regular 6 monthly report being shared at Board meetings (Public).
2	Guardian meetings to cover the recommended items at least quarterly:	Xavier Bell; New Freedom to Speak Up Guardian From Dec 2018	Complete Guardian meetings have been held quarterly since November 2017. All items recommended by NHSI are now included as a standard agenda.

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3	Recruit more FTSU Guardians from diverse / vulnerable groups eg BAME; *and different levels of seniority and job types.*	Xavier Bell; New Freedom to Speak Up Guardian	**Re-opened** The structure and make-up of the Guardian network will now need to be reviewed in light of the appointment of the new Lead FTSU Guardian. There is an opportunity to review how the network works, and a focus on improving representation from currently under-represented staff groups.
4	Non-Executive Director to instigate and lead an auditing approach of concerns raised.	Kelly Macfarlane Annually beginning 2019	This will be progressed by the new Lead FTSU Guardian, with advice from the National Guardian's Office.
5	Communication to the Trust as a whole about Freedom to Speak Up:	Freedom to Speak Up Guardian Communications Oct 2018 - *ongoing*	Ongoing Under review at each quarterly Guardian meeting. A more proactive approach should now be possible, underpinned by a Lead FTSU Guardian with protected time.
6	Leadership development framework and programme to be developed to support Freedom to Speak Up principles / behaviours . To be delivered and monitored through the Workforce Committee.	Learning & Development Team Nov 2018 onward	Ongoing This work will be taken forward as part of the OneNBT Leadership programme and the Just Culture training, ensuring that the leadership development aligns with FTSU behaviours.

7.2 A key priority for the new Lead FTSU Guardian will be to work with the Director of Corporate Governance, the NED Lead for FTSU and the Guardian Network to complete a refreshed Board/Organisational self-assessment, refresh the FTSU vision and strategy and update the improvement plan. This will include a focus on the following areas:

- Alignment with other work-streams in the Trust, such as staff voice, just culture and psychological safety;
- Engagement with the Trust's BAME Networks via the network chairs;
- A proactive and tech-savvy communications and awareness-raising strategy.

8. Recommendations

Board are asked to:

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Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.

- Discuss the report and findings;
- Review the FTSU data triangulated against the 2020 Pulse Surveys undertaken throughout Covid-19; and
- Review progress against the FTSU action plan and note the plans to update this document.

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Take Part
Be Involved
in research

NHS
North Bristol
NHS Trust

Research at NBT:
Year 3 of the 5-year strategy

Becca Smith, Deputy Director of Research
David Wynick, Director of Research

www.nbt.nhs.uk/research

Delivering the year 3 priorities

- **Increase** research focussed on Trust priority areas
  - Funded research into psychological impact of COVID on staff, the efficacy of home spirometry testing, and Long COVID – total value £54k
  - Developing research in urgent and emergency care

- **Improve** regional equity for research led by NBT
  - Leading the logistics of the COVID vaccine trial programme expanding outside Bristol to Bath, Swindon and Gloucester
  - Set up a programme of work to look at delivery of stroke research across the wider region

- **Support** a talented workforce for the future
  - Introduced a new 360 review tool
  - Supported clinical skill updates

- **Increased** our research grant portfolio- £22 million, 20th acute Trust nationally
  - Combined Bristol grant position is 5th nationally
  - £31.2million for grants we collaborate on

Patients as partners in research

- Set up new systems so patients can virtually contribute to our research design
- Despite halting over 200 studies NBT still recruited over 840 participants to non-COVID research studies since 1st April 2020.
- In 2019/2020 we included 5745 patients and staff into 207 research studies

Support and nurture a sustainable, skilled workforce

- Supported 7 staff (~5%) to join leadership training or higher degree modules
- Redeployed a third of our workforce to clinical and support roles across the Trust
- Supported a move to virtual working to reduce our carbon footprint (before COVID)

Research will be visible in the day to day business of the Trust

- Supporting Medicine to develop an urgent and emergency care research strategy
- COVID research portfolio has engaged new areas of the Trust and provided high profile media interest

Work with our regional partners

- Broadened our integrated respiratory research team to provide support and mentorship to other acute trusts
- Major input and leadership from NBT staff into many of the BHP Health Integration Teams
- Academic Health Science Centre designation

www.nbt.nhs.uk/research

Academic Health Science Centre designation

- Bristol Health Partners is one of only eight designated AHSCs
- Mission: to help create better, more equitable, appropriate and sustainable health and care across BNSSG
- Broad ranging research programmes and cross-cutting themes that focus on our expertise in population health sciences

University of Bristol

UWE Bristol University of the West of England

Bristol City Council

North Somerset Council

South Gloucestershire Council

Delivering for you

Sirona care & health

NHS

Avon and Wiltshire Mental Health Partnership NHS Trust
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
NHS Blood and Transplant
North Bristol NHS Trust
University Hospitals Bristol and Weston NHS Foundation Trust

AHSC priorities

- Align our research strengths with BNSSG priorities
- Focus on addressing health inequalities
- Support our Health Integration Teams
- Work with regional AHSN and NIHR infrastructure
- Use our AHSC status to compete globally to recruit to and retain our local workforce
- Increased diversity of patient and public contributor population

Year 4 priorities

- **Increase** research focussed on Trust and STP priority areas
  - Align our portfolio to the BNSSG priorities
  - Non-COVID research delivery supported back to previous levels
- **Improve** regional equity for research led by NBT
  - Improve culturally appropriate research and tools to facilitate, enable and encourage wider cultural and ethnic participation in research
  - Engage the wider cultural and ethnic population to help direct the research focus for NBT
- **Support** a talented workforce for the future
  - Focus on succession planning to support career pathways
- **Develop** training for the patients that work with us as research partners
- **Increase** awareness of research in all staff groups based on the results of the NBT-led SATiRe study

COVID research

- The public has never been more interested in research
- NBT recruited over 2225 participants to COVID-19 studies, including 117 into interventional trials and 643 into vaccine studies
- Delivered the 3rd highest recruitment to the Oxford vaccine study
- Increased staff engagement
- Working with other providers across the region to ensure workforce resilience – sharing staff to manage peaks in activity
- Rapid results from RECOVERY COVID trial are now standard care, demonstrating the immediacy of research
- Won a prestigious NIHR grant to study aerosol generation in clinical settings

www.nbt.nhs.uk/research

Discover & Aerator Studies

Discover - £98,000

- Assessing potential biomarkers and long term symptoms
- Published the initial findings in August which showed 74% of the patients experienced persistent symptoms at 12 weeks post admission.
- Ongoing to explore long COVID symptoms in more detail

Aerator - £432,000

- In partnership with the UoB and UHBW the study aims to identify the amount and type of aerosol generated when medical procedures are performed, and how infectious this aerosol is.
- It is hoped this will enable more accurate assessment of the risks to staff and patients and inform national guidance on how to safely manage the infection control procedures

North Bristol NHS Trust

Report To:	Trust Board		
Date of Meeting:	26 November 2020		
Report Title:	Integrated Performance Report		
Report Author & Job Title	Lisa Whitlow, Associate Director of Performance		
Executive/Non-executive Sponsor (presenting)	Executive Team		
Purpose:	**Approval**	**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.

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NHS North Bristol NHS Trust

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

November 2020 (presenting October 2020 data)

Exceptional healthcare, personally delivered

CONTENTS

North Bristol Integrated Performance Report

Domain	Description	National Standard	Current Month Trajectory (RAG)	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Trend	Benchmarking (in arrears except A&E & Cancer as per reporting month)		
																		National Performance	Rank	Quartile
Responsive	A&E 4 Hour - Type 1 Performance	95.00%	81.08%	80.04%	80.18%	74.64%	78.33%	72.43%	80.16%	96.00%	95.47%	94.74%	93.47%	86.90%	87.76%	82.07%		87.98%	37/114	
	A&E 12 Hour Trolley Breaches	0	0	4	9	2	38	48	2	0	0	0	0	0	0	12		0 - 49	1/16	
	Ambulance Handover < 15 mins (%)	100%	94.92%	94.09%	94.34%	92.65%	92.71%	91.06%	95.41%	94.72%	97.38%	98.50%	98.07%	98.01%	76.69%	68.07%				
	Ambulance Handover < 30 mins (%)	100%	99.20%	99.19%	99.14%	99.22%	98.72%	98.15%	99.37%	99.53%	99.56%	99.96%	99.76%	99.83%	96.04%	93.50%				
	Ambulance Handover > 60 mins	0	0	0	1	0	2	2	1	0	0	0	0	0	4	33				
	Stranded Patients (>21 days) - month end			138	128	127	160	156	120	58	57	72	83	96	114	117				
	Bed Occupancy Rate		93.00%	96.51%	96.29%	96.96%	98.96%	98.87%	82.25%	50.84%	58.18%	77.11%	82.97%	87.93%	94.75%	96.57%				
	Diagnostic 6 Week Wait Performance	1.00%	26.26%	9.09%	8.87%	12.56%	11.00%	5.60%	10.25%	61.24%	65.94%	46.56%	28.98%	32.36%	29.58%	27.47%		47.82%	112/248	
	Diagnostic 13+ Week Breaches	0	0	239	63	147	258	113	114	402	2292	3161	1886	1979	1998	1697			105/228	
	Diagnostic Backlog Clearance Time (in weeks)			0.2	0.2	0.3	0.3	0.1	0.2	1.2	2.7	2.0	1.0	1.0	0.9	0.9				
	RTT Incomplete 18 Week Performance	92.00%	65.59%	83.28%	82.58%	82.43%	83.62%	82.95%	80.02%	71.82%	64.51%	58.20%	58.48%	63.95%	70.46%	74.00%		53.52%	140/387	
	RTT 52+ Week Breaches	0	1381	13	14	14	9	17	43	130	275	454	648	797	1001	1092		0	165/227	
	Total Waiting List		31539	29118	28351	28078	29672	29552	28516	25877	25518	25265	27512	28810	29387	30214				
	RTT Backlog Clearance Time (in weeks)			3.1	3.0	3.0	3.2	3.0	3.2	4.4	6.9	10.3	9.5	7.6	6.4	5.4				
	Cancer 2 Week Wait	93.00%	88.92%	87.23%	90.21%	81.94%	78.21%	89.94%	91.25%	76.35%	93.17%	97.30%	88.13%	78.12%	76.35%	-		87.76%	119/139	
	Cancer 2 Week Wait - Breast Symptoms	93.00%	96.04%	98.61%	92.00%	81.08%	70.27%	89.63%	81.82%	76.47%	98.28%	96.62%	96.05%	75.18%	54.04%	-		82.28%	65/86	
	Cancer 31 Day First Treatment	96.00%	93.25%	85.76%	93.24%	96.80%	92.74%	95.36%	97.71%	93.66%	85.23%	95.35%	97.51%	95.78%	90.31%	-		94.53%	54/114	
	Cancer 31 Day Subsequent - Drug	98.00%	100%	100%	100%	100%	-	100%	100%	100%	100%	100%	100%	100%	100%	-		99.16%	1/30	
	Cancer 31 Day Subsequent - Surgery	94.00%	81.73%	69.09%	79.80%	81.54%	72.00%	70.89%	85.09%	75.76%	79.73%	86.96%	92.13%	89.86%	85.19%	-		87.31%	26/65	
	Cancer 62 Day Standard	85.00%	81.48%	66.98%	71.62%	75.53%	68.18%	61.31%	74.15%	74.34%	69.52%	70.12%	75.31%	73.10%	70.07%	-		77.94%	91/132	
	Cancer 62 Day Screening	90.00%	93.10%	77.50%	81.43%	81.13%	64.38%	67.27%	83.95%	85.92%	46.67%	28.57%	44.44%	66.67%	100.00%	-		55.87%	24/50	
	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%		84.19%	83.21%	83.16%	83.79%	82.90%	83.42%	83.25%	84.03%	85.37%	82.97%	82.55%	82.94%	83.98%				

North Bristol Integrated Performance Report

Domain	Description	National Standard	Current Month Trajectory (RAG)	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Trend
Quality Patient Safety & Effectiveness	5 minute apgar 7 rate at term		0.90%	0.9%	0.6%	0.5%	0.5%	0.7%	0.7%	1.3%	1.6%	1.0%	0.6%	0.2%	0.2%	0.6%	
	Caesarean Section Rate		28.00%	32.8%	35.3%	33.9%	38.4%	34.0%	33.4%	31.5%	33.9%	36.7%	34.6%	39.0%	35.0%	36.4%	
	Still Birth rate		0.40%	0.8%	0.2%	0.7%	0.2%	0.0%	0.4%	0.2%	0.0%	0.0%	0.4%	0.2%	0.4%	0.0%	
	Induction of Labour Rate		32.10%	38.5%	35.3%	40.2%	41.4%	41.4%	40.8%	40.6%	38.9%	34.9%	35.4%	38.6%	38.9%	36.6%	
	PPH 1000 ml rate		8.60%	13.3%	13.3%	12.2%	10.7%	9.2%	9.7%	8.7%	12.9%	11.5%	11.2%	10.7%	8.0%	10.4%	
	Never Event Occurance by month	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
	Serious Incidents			8	7	6	4	5	7	3	1	4	7	5	4	0	
	Total Incidents			1131	1121	1096	1150	1118	853	598	678	835	948	1022	1002	1064	
	Total Incidents (Rate per 1000 Bed Days)			44	45	42	43	45	39	45	43	46	47	49	47	101	
	WHO		95%	97.65%	97.78%	98.98%	99.72%	99.30%	99.30%	99.50%	99.50%	99.60%	99.70%	99.70%	99.70%	99.60%	
	Pressure Injuries Grade 2			43	43	32	34	17	29	24	16	13	8	14	13	28	
	Pressure Injuries Grade 3		0	0	0	1	0	1	1	0	0	0	0	0	1	1	
	Pressure Injuries Grade 4		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Falls per 1,000 bed days			6.72	6.32	6.11	7.04	8.54	7.34	10.14	8.84	8.09	7.10	7.71	6.69	9.31	
	#NoF - Fragile Hip Best Practice Pass Rate			83.78%	87.23%	86.11%	68.18%	60.00%	70.91%	2.13%	10.20%	9.43%	47.46%	63.64%	0.00%	-	
	Stroke - Patients Admitted			89	83	82	79	72	97	71	72	79	84	63	83	86	
	Stroke - 90% Stay on Stroke Ward		90%	93.15%	91.18%	70.97%	81.54%	87.10%	86.67%	87.10%	81.50%	86.20%	80.00%	93.20%	88.00%	-	
	Stroke - Thrombolysed <1 Hour		60%	50.00%	37.50%	41.67%	62.50%	66.67%	66.67%	50.00%	Nil	85.70%	50.00%	60.00%	69.00%	-	
	Stroke - Directly Admitted to Stroke Unit <4 Hours		60%	51.95%	62.16%	59.68%	42.65%	54.84%	58.44%	74.19%	64.80%	88.10%	73.60%	63.30%	69.10%	-	
	Stroke - Seen by Stroke Consultant within 14 Hours		90%	84.34%	81.58%	73.53%	90.28%	80.60%	80.00%	79.41%	94.34%	94.00%	91.00%	89.00%	80.00%	-	
	MRSA	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	
	E. Coli		4	7	7	7	7	4	6	2	3	2	5	7	8	0	
	C. Difficile		5	5	2	3	5	4	4	1	4	3	6	6	6	0	
	MSSA		2	2	3	1	1	2	3	1	2	1	4	2	1	0	
Quality Caring & Experience	PALS - Count of concerns			119	104	90	107	108	104	45	105	49	75	51	95	73	
	Complaints - % Overall Response Compliance		90%	87.00%	90.00%	81.00%	82.61%	88.57%	88.89%	88.46%	100.00%	98.30%	98.08%	97%	98.04%	94.44%	
	Complaints - Overdue			1	2	3	0	2	0	2	1	0	0	0	0	2	
	Complaints - Written complaints			47	41	36	57	51	26	24	27	40	59	53	46	48	
Well Led	Agency Expenditure ('000s)			836	990	868	1081	869	1112	613	386	364	555	822	687	874.7	
	Month End Vacancy Factor			8.75%	8.77%	9.21%	8.80%	7.56%	6.76%	4.91%	4.93%	5.39%	6.05%	5.14%	3.82%	3.83%	
	Turnover (Rolling 12 Months)		13.80%	14.46%	14.44%	14.47%	14.08%	13.68%	13.25%	12.80%	12.50%	12.30%	13.10%	13.40%	13.30%	12.80%	
	Sickness Absence (Rolling 12 month -In arrears)		4.20%	4.38%	4.43%	4.44%	4.45%	4.46%	4.46%	4.53%	4.56%	4.53%	4.46%	4.46%	4.44%	-	
	Trust Mandatory Training Compliance			88.89%	88.80%	88.97%	87.99%	87.95%	87.95%	87.42%	87.23%	87.07%	85.24%	86.77%	86.26%	86.45%	

EXECUTIVE SUMMARY
October 2020

Urgent Care

The Trust continued to achieve the four-hour performance trajectory of 81.08% with performance of 82.07%. Despite reduced attendance levels in October, performance continued to be significantly challenged with high levels of bed occupancy impacting flow. Significant delays were reported in month with the Trust conceding 33 ambulance handovers exceeding one hour and 12, 12-hour trolley breaches. The breaches occurred during periods of significant pressure in the Emergency Department with the Trust reporting an escalation status of Internal Critical Incident for 11 days during October. Despite challenges impacting the four-hour performance in October, the Trust continues to perform well for Type 1 performance when compared nationally.

Elective Care and Diagnostics

As part of Phase 3 planning, trajectories have been reset to more accurately reflect the planned delivery for the rest of the year. In October the Trust has reported a continued increase in the overall wait list size, impacted by increased demand. Despite the increase, the waiting list position remained less than the new trajectory. There were 1092 patients waiting greater than 52 weeks for their treatment in October against a revised trajectory of 1381. The continued increase in breaches is due predominately to cancelled operations as part of the initial COVID-19 response and the impact of the application of the Royal College of Surgeons Clinical Prioritisation guidance. Diagnostic performance improved for most test types in October but failed the revised trajectory of 26.26% with performance at 27.47%.

Cancer wait time standards

In September, the TWW standard, 31 day standard and 62-day standard failed to achieve the revised recovery trajectories. Performance has been predominantly impacted by capacity constraints and patient choice delays. TWW demand increased to levels comparable to pre-pandemic levels in September. The recovery of the 62 day trajectory remains on track for January 2021, but the second wave of COVID-19 has put this at risk. The number of patients waiting more than 104 days due to COVID-19 has remained static at 65 per week; though significant work has been carried out to ensure patients are clinically reviewed and treatment plans are in place. Any delays to treatment have been in line with national guidance to ensure safety for patients and staff.

Quality

The number of formal complaints has remained static in October, with the most common subject of complaints being Clinical Care and Treatment. Core NHS services have been re-established within the Trust with clear pathways established across the hospital for different patient areas according to level of transmission risk. There were four probable and six definite healthcare associated infections of COVID-19 and one MRSA bacteraemia reported in October. The Trust reported an increase in Grade 2 pressure injuries and one Trust attributable Grade 3 pressure injury.

Workforce

The Trust turnover continues to improve with October's position at 11.15% (excluding the impact of staff temporarily employed during the COVID-19 response). The Trust vacancy factor is static at 3.83% with ongoing focus on particularly resourcing. Temporary staffing demand has increased in October and both bank and agency use has risen as a result and is reflective of the operational pressures.

Finance

NHSI/E suspended the usual operational planning process in March 2020 and financial framework due to COVID-19 response preparations with a revised financial framework applied until the end of September. The position for the end of September showed the Trust meeting this requirement and achieving a breakeven position. From 1 October a new financial framework has been implemented where Providers are funded under a block arrangement to cover historical contract income and allowed to bill for other income in line with previous years.

RESPONSIVENESS
SRO: Chief Operating Officer
Overview

Urgent Care

The Trust achieved four-hour performance of 82.07% against a trajectory of 81.08% in a challenging month where Medicine bed capacity was the predominant cause of breaches (46.61%). Ambulance handover delays were reported in-month with 33 handovers exceeding one hour. The delays were due to a lack of offload capacity as a result of no flow out of the emergency zone and to maintain social distancing for infection prevention measures. There were 12, 12-hour trolley breaches which occurred on several days throughout the month whilst the Trust was under significant pressure, reporting an escalation status of internal critical incident. Bed occupancy averaged at 96.57% with a continued reduction in variation in October, resulting from greater consistency in bed demand. Stranded patient levels remained an area of increasing concern to system leads. This has been driven by ongoing constraints in community capacity. The recording of Delayed Transfers of Care (DToC) has now formally ceased. The Trust is now required to review patients on a daily basis on all wards to define if they meet the right to reside criteria or are optimised for discharge.

Planned Care

Referral to Treatment (RTT) – 18 week RTT performance reported an improvement at 74.00% in October, achieving the new trajectory of 65.59%; the improvement is the result of increased demand and activity, reducing the backlog by 9.49%. The number of patients exceeding 52 week waits in October was 1092 against a revised trajectory of 1381; the majority of breaches (683; 62.55%) being in Trauma and Orthopaedics. Reduced elective activity as a result of the initial COVID-19 response and the application of the Royal College of Surgeons Clinical Prioritisation guidance, leading to some of the longest waiting patients having further extended waits, has been a significant factor in the deterioration in the 52 week wait position and the 18 week RTT performance. In addition, the Trust is still experiencing some patients choosing to defer their treatment due to concerns with regards to COVID-19.

Diagnostic Waiting Times – Trust performance for diagnostic waiting times improved to 27.47% in October, but did not achieve the revised trajectory of 26.26%. Waiting list activity remained static with a 5.93% reduction in the backlog positively impacting performance. There was a significant improvement in the number of patients waiting 13 weeks or more with a 15.07% reduction from September. Nationally, the Trust positioning showed a marginal deterioration for both 6 week and 13 week performance in September.

Cancer

The Trust failed five of the seven Cancer Wait Times (CWT) standards in September and achieved the revised recovery trajectory for three of the standards. Failure to achieve the standards in September was due to backlog clearance plans in diagnostics and surgery. Some services continued to run at reduced activity due to infection prevention and control requirements and in some specialties staffing pressures and patient choice continued to be a cause of delay. The number of patients waiting more than 104 days due to COVID-19 have remained static at 65 per week. TWW demand continued to increase when compared to 2019 levels but capacity remained challenging in Breast and Skin. Significant progress was made to address the Endoscopy backlog created during the pandemic and this will continue to have an impact on the CWT standards into October and November. The recovery of the 62 day trajectory remains on track for January 2021, but the second wave of COVID-19 has put this at risk.

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 as per the Trust's response to the COVID-19 pandemic.
- The ongoing impact of COVID-19 Infection Prevention and Control guidance and Clinical Prioritisation guidance on the Trust's capacity and productivity and therefore, ability to deliver national wait times standards.

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

Improvements

PPH rates: have continued to improve in the last 3 months.

COVID-19 pathways: Core NHS services have been re-established within the Trust with clear pathways established across the hospital for different patient areas according to level of transmission risk. The Trust continues to provide a robust staff Coronavirus testing system.

Areas of Concern

Caesarean Section rate: The maternity service has seen a continued increase in emergency caesarean section (CS) rates since May 2020. An overview of CS rates has been completed and this was discussed at the September Quality & Risk Management Committee and Trust Board.

Pressure Injuries: October saw an increase in reported pressure injuries with 28 Grade 2 pressure and injury. A NBT attributable Grade 3 pressure injury to the spine on Gate 8a (Medicine) has occurred and the Nursing Intensive Support Team (NIST) has been commenced to support staff undertake identified improvements.

Infection control: There were four probable and six definite healthcare associated infections with Covid-19 in October. Post infection reviews were completed and organisational learning shared. One MRSA bacteraemia was reported in October, which is being investigated in line with protocols.

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

Corporate Objective 4: Build effective teams empowered to lead

Vacancies
The Trust vacancy factor remained at 3.83% in October with limited movement across all staff groups.

Turnover
The Trust turnover is reported as 12.8% in October. Excluding the impact of staff leaving who were on temporary contracts during the COVID-19 response the Trust turnover is 11.15%, compared to 14.46% in October 2019. All staff groups improved or remained static from the previous month's position.

Expand leadership development programme for staff
In response to organisational need there is now a increased focus on the development of band 2 and band 3 health care assistants.

Prioritise the wellbeing of our staff
The rolling 12 month sickness absence remained at 4.44% in September with limited movement across all staff groups, this includes COVID-19 related sickness. Next month will see an increase in reported absence due to the rise in COVID-19 related absence in the Trust. The October People and Digital committee had a deep dive into long term sickness absence and agreed targeted actions aimed at improving the Trust long term sickness position.

Further enhancement of the wellbeing programme to run through winter / COVID-19 surge with:
- Well for winter campaign focussing on physical health – rollout of free online exercise videos for staff
- Daily wellbeing message in the Operational Update
- Secured charity funding for staff 'Calm Rooms'

Continue to reduce reliance on agency and temporary staffing

Overall temporary staffing demand increased in October compared to September. Greatest increase was in registered nursing and midwifery for 'additional capacity' and 'enhanced care' booking reasons. Bank use increased by 38 wte in October compared with September and fill rates increased to 71% (from 69% in September) with bank responding to the increase in demand.

Overall agency use increased in October compared with September, predominantly in registered nursing with 6 additional wte used compared with September, 50% of this increase was for registered mental health nurses. Theatres, NMSK and Care of the Elderly and ICU continue to be areas with highest registered nursing agency use.

Increased temporary staff recruitment is in progress with focus on key areas, allied health professionals, specialist nurses including registered mental health, ICU, theatres and NICU.

FINANCE
SRO: Director of Finance
Overview

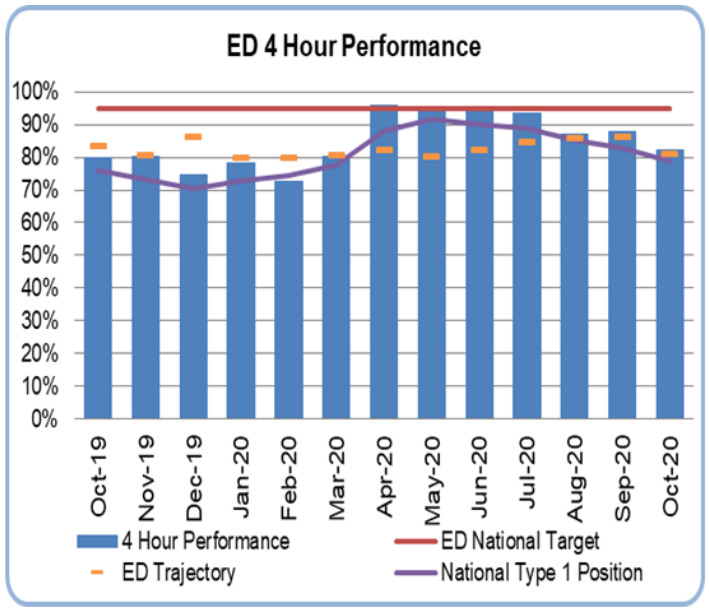
On 17 March 2020, the Trust received a letter from Simon Stevens and Amanda Pritchard which suspended the operational planning process for 2020/21 and gave details of an alternative financial framework initially for the first four months of the year that was then extended to cover the first half of the year. This first half year framework required the Trust to breakeven against an NHSI/E calculated income level and to recover any additional costs incurred in dealing with the COVID-19 pandemic; net of any savings from reduced or cancelled elective activity, in line with national guidance. The position for the end of September shows the Trust meeting this requirement and achieving a breakeven position (top ups due to the trust for April to August have been finalised and agreed while the £7.6m due for September is still to be audited and confirmed).

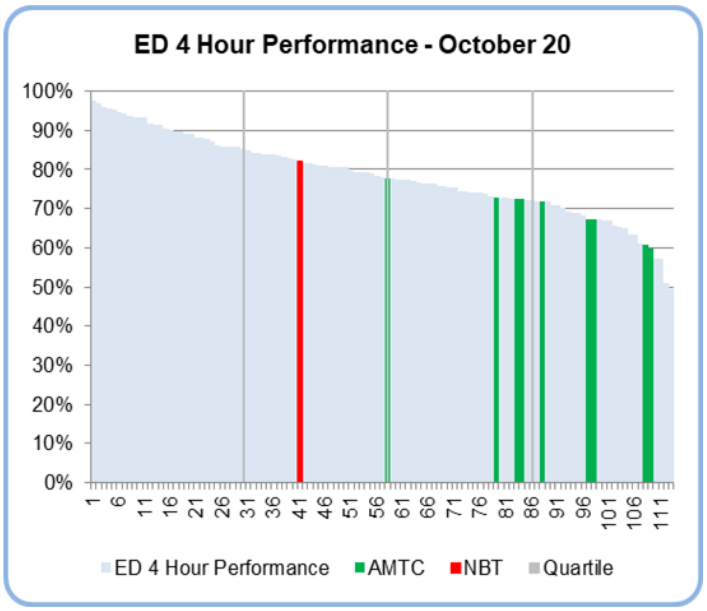
From 1 October a new financial framework has been implemented where Providers are funded under a block arrangement to cover historical contract income and allowed to bill for other income in line with previous years. Separately each System (either Sustainability and Transformation Partnership [STP] or Integrated Care System [ICS]) has received an allocation to cover the required top-up income, COVID-19 costs and growth that has been calculated as being needed to bring the System into an overall breakeven position.

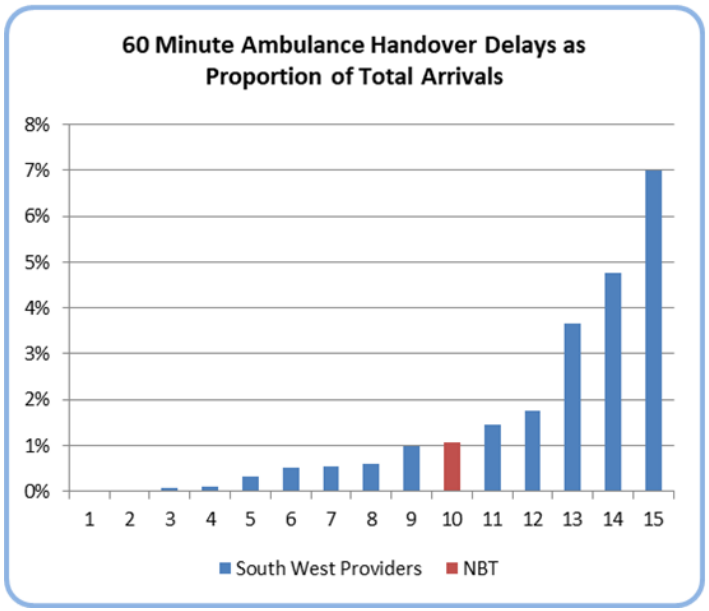
Due to errors in calculating the levels of achievable Other income NBT and the System are currently forecasting deficit positions for the full year. This gap in funding is being discussed with Regional and National teams to identify the reasons for the gaps and identify potential routes to secure funding. In the event that the additional funding is not received the Trust is still forecasting maintaining a cash balance throughout the year that will enable it to operate effectively including the full delivery of its capital plan.

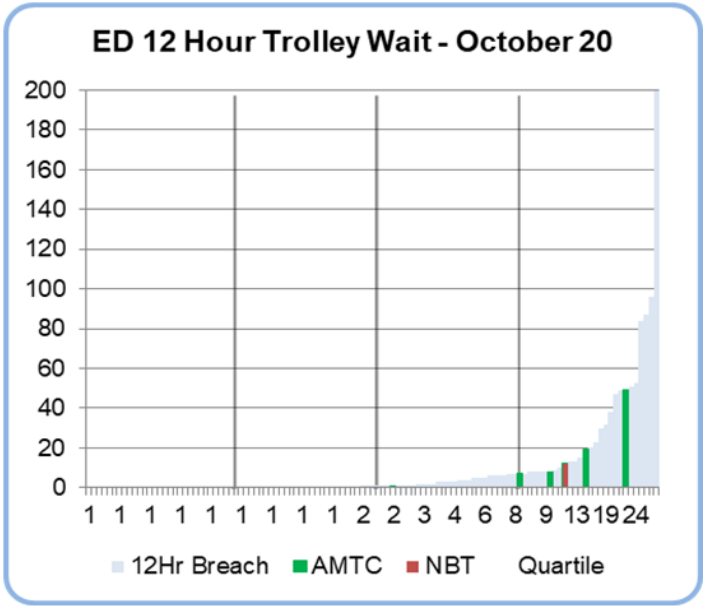
Responsiveness

Board Sponsor: Chief Operating Officer and Deputy Chief Executive
Evelyn Barker









Urgent Care

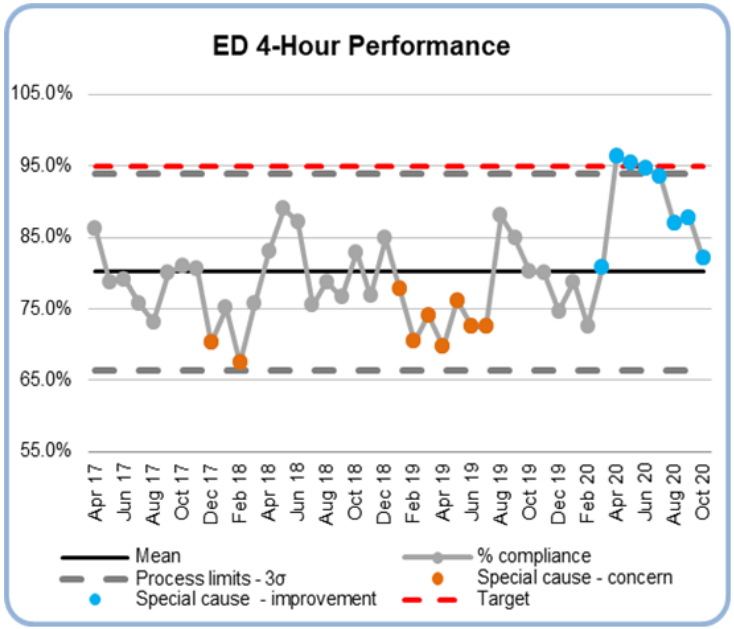
The Trust continued to exceed the four-hour performance trajectory of 81.08% in October with performance of 82.07%. The Trust conceded 33 ambulance delays exceeding one hour in October and 12, 12-hour trolley breaches. The breaches occurred on several days throughout October whilst the Trust was under significant pressure, reporting an escalation status of internal critical incident.

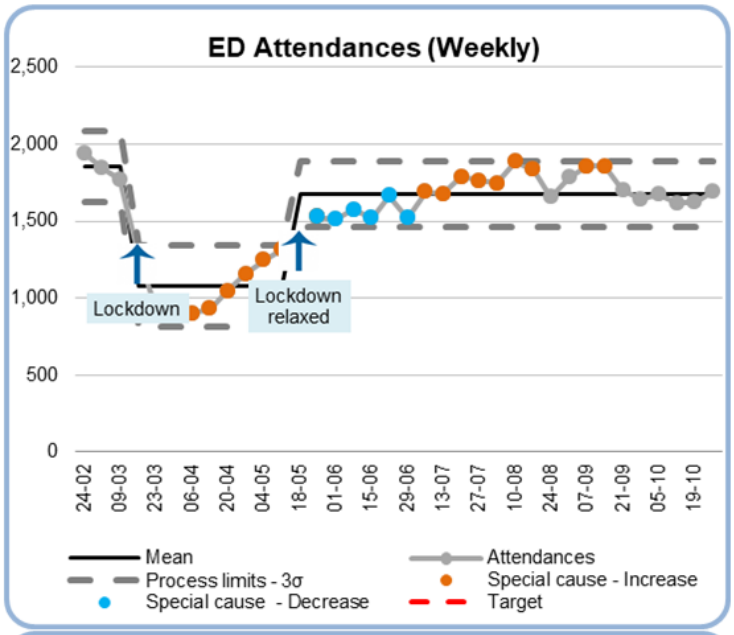
Performance was significantly challenged in October with continued high levels of bed occupancy. Majors performance continued to be negatively impacted by significant bed pressures within the Medicine division. Despite the challenges in October, minors performance improved to 97.76%.

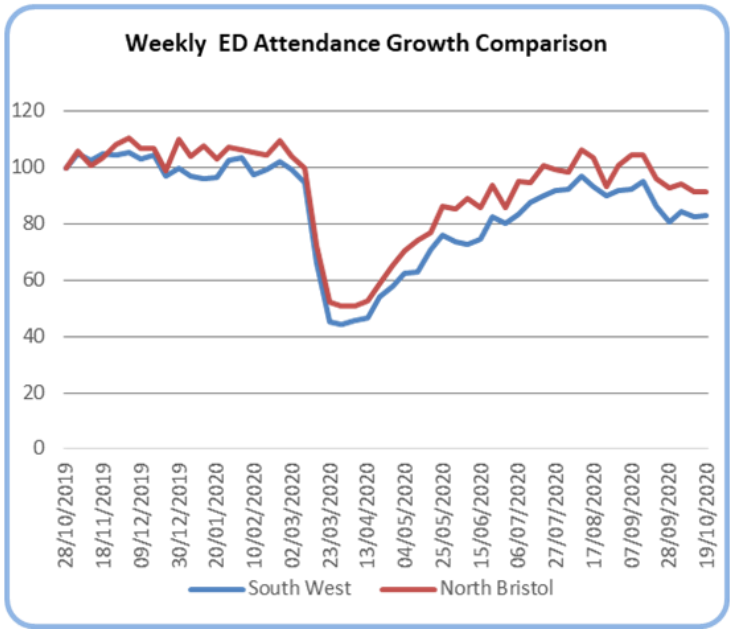
At 7238, ED attendances were at 86.68% of 2019/20 levels. Emergency admissions were at 87.59% of 2019/20 levels and elective admissions were at 78.11% of 2019/20 levels. For October the Trust ranked 57 out of 140 providers for year to date emergency admission difference.

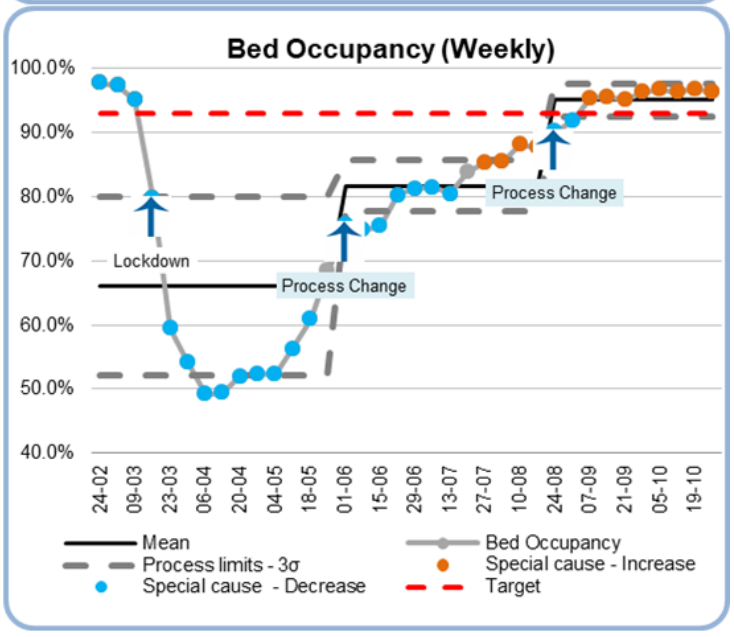
Despite a challenging month impacting four-hour performance in October, the Trust continued to perform well for Type 1 performance when compared nationally.

ED performance for the NBT Footprint stands at 85.57% and the total STP performance was 84.88% for October.









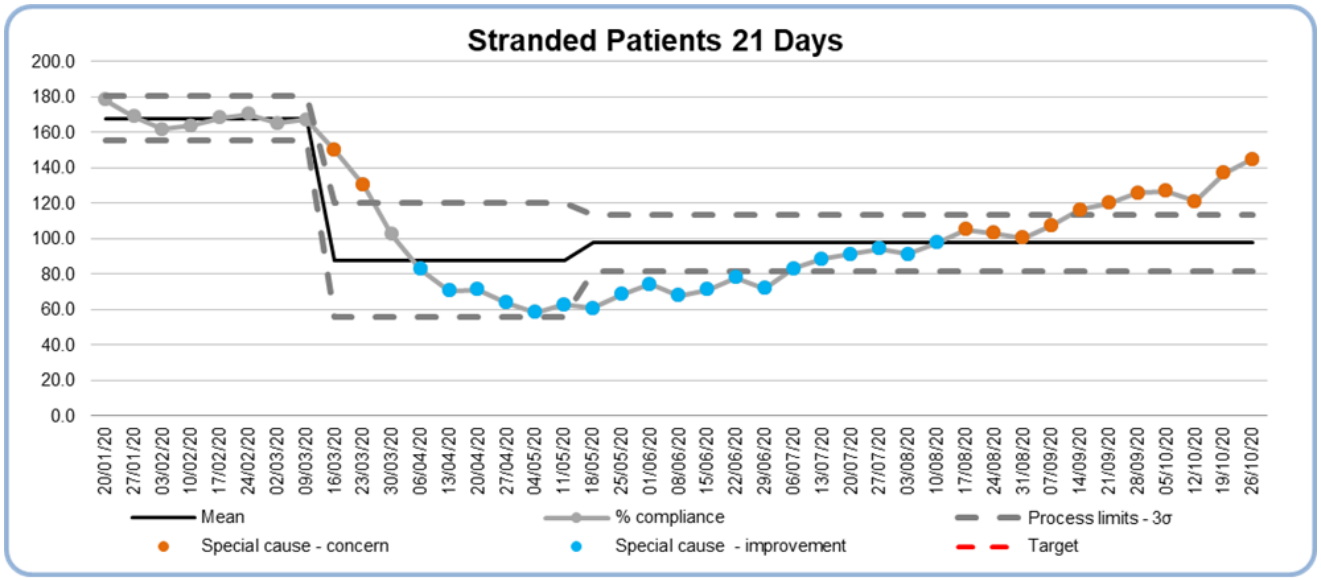
4-Hour Performance
Of the breaches in ED in October, 46.61% were a result of waiting for a medical bed and 14.79% of delays resulted from waits for assessment. Medicine bed capacity has been the predominant cause of breaches for the second consecutive month, increasing from 25.45% in September.

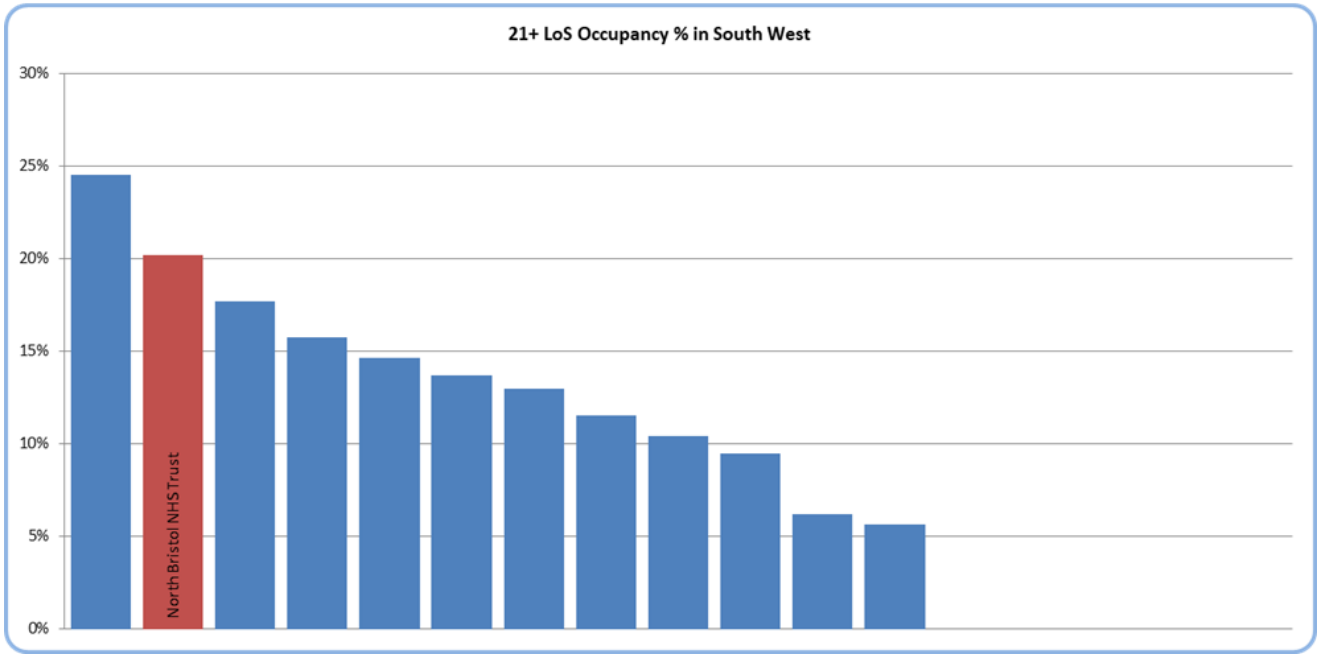
Attendances reduced in October but when compared to the South West rate of growth, attendance levels averaged at c.11% more. The comparison suggests that whilst following the same trend, Trust attendance growth has been consistently greater than that of the Region.

Variation in bed occupancy continued to be reduced in October resulting from greater consistency in bed demand. Bed occupancy varied between 93.58% and 100.64%, breaching the 93% trajectory every day in the month. There were 25 days that breached the 93% trajectory in September.

Internal bed modelling and current occupancy levels suggest high levels of bed occupancy will continue through November which will result in challenged 4-hour performance. Bed mitigations formulated through the Winter Planning process are being monitored via the COVID-19 Command and Control structures.

NB: The method for calculating bed occupancy changed in June and September due to reductions in the overall bed base resulting from the implementation of IPC measures. Weekly attendance growth comparison graph applies the NBT and South West week on week percentage difference to a baseline of 100 for comparability.





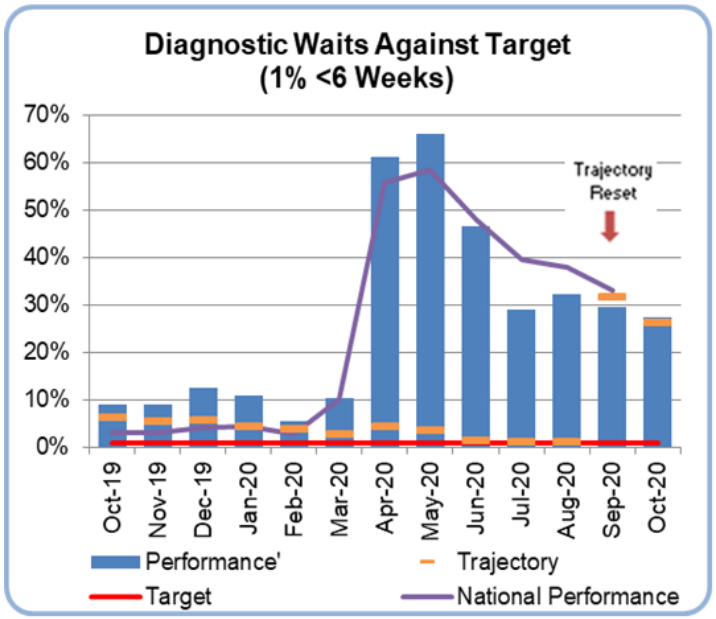
DToCs and Stranded Patients

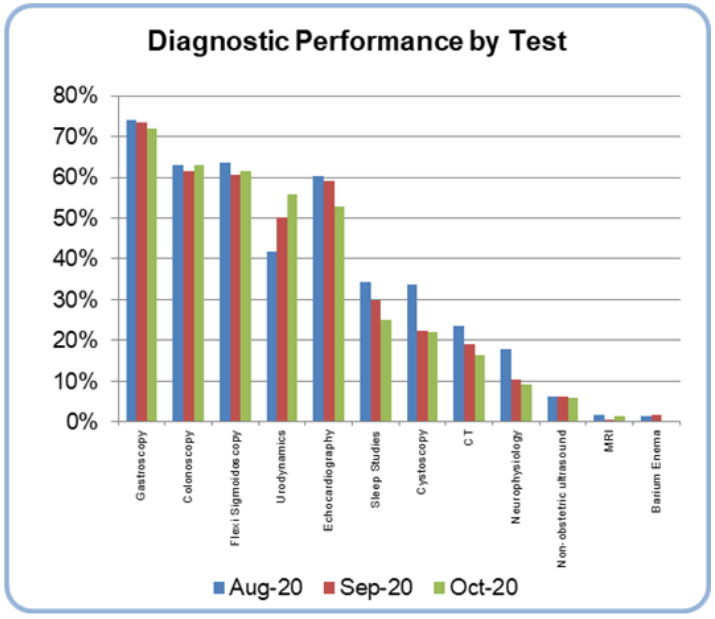
The levels of Stranded Patients over 21 days has remained an area of increasing concern to system leads. This has been driven by ongoing constraints in capacity in the community, linked to lack of flow in Pathway 3 beds and complex reablement packages not being available for Pathway 1. The situation has remained challenged with an increasing number of Care Providers restricting access as there are further outbreaks in Care Homes.

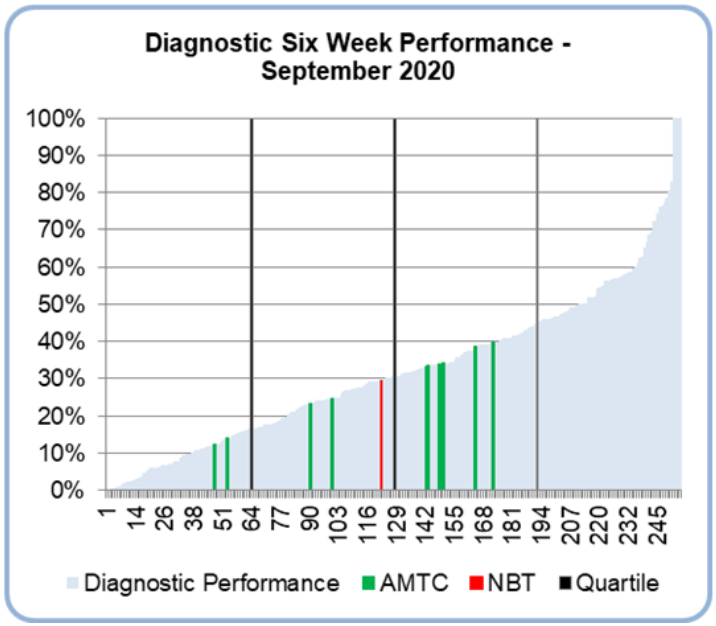
BNSSG Phase 3 plans have prioritised recurrent funding in staffing (Homefirst) and bedded community capacity (Discharge to Assess) to match the LOS improvements achieved during the lockdown period. However, the recruitment lead in time will extend into December. Temporary staffing options are being explored, but the inability to meet the resourcing, as per the D2A business case, remains a risk to the overall Trust bed model.

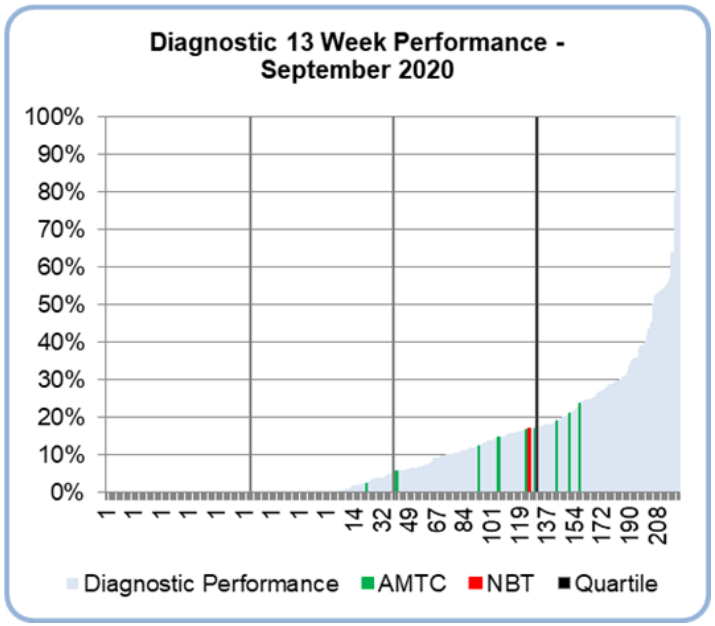
The recording of Delayed Transfers of Care (DToC) has now formally been ceased. The Trust is now required to review patients on a daily basis on all wards to define if they meet the right to reside criteria or are optimised for discharge. In addition, there will be a weekly review of all stranded patients for those waiting for 14 days+ and 21 days+ and do not meet the Criteria to Reside that will be reported on a weekly basis to NHSE/I.

The monthly report is in development and will provide the reasons why the patient is not able to leave the Hospital and the number of days linked to those not meeting the criteria to reside remaining in the Trust









Diagnostic Waiting Times

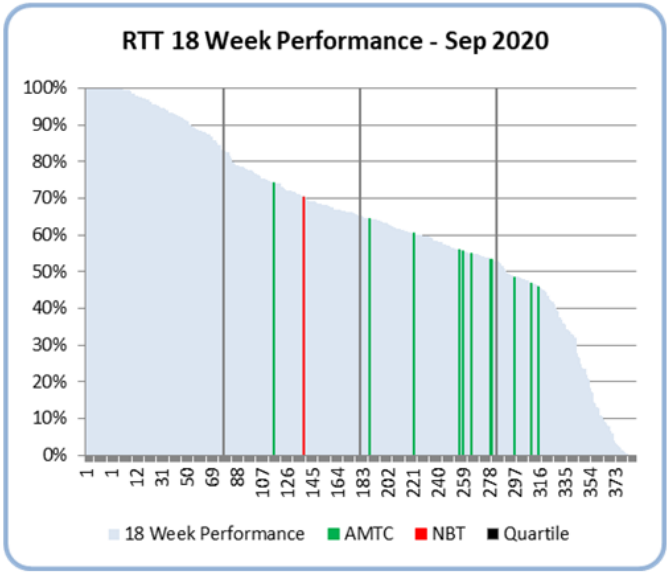
Diagnostic performance improved to 27.47% in October but failed to achieve the revised trajectory of 26.26%. Improvement has been reported for most test types in month.

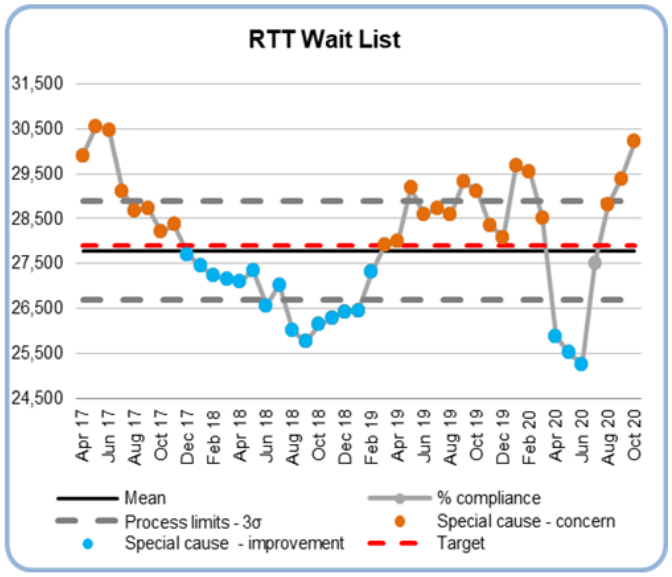
In October, waiting list activity levels remained static, reporting at 85.92% of 2019 levels. The overall waiting list increased by 1.28% with a backlog reduction of 5.93%.

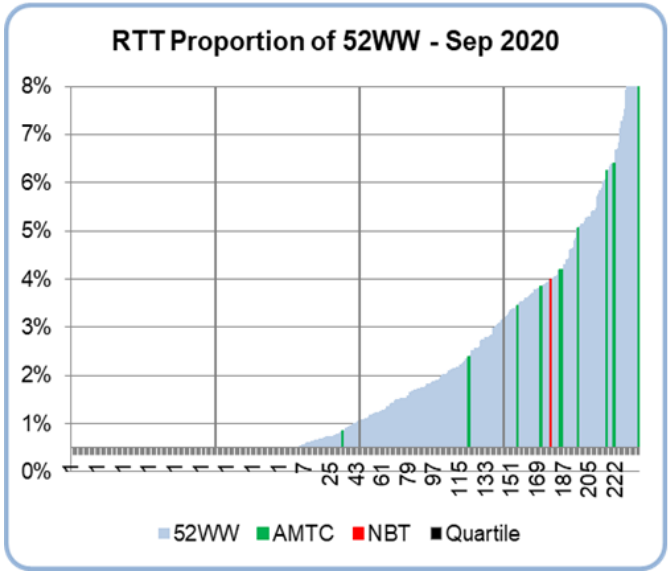
There was a significant improvement in the number of patients waiting 13 weeks or more in October, with a 15.07% reduction from September. A high level review continues to be completed for patients exceeding 13 weeks to ensure no harm has resulted from the extended wait times.

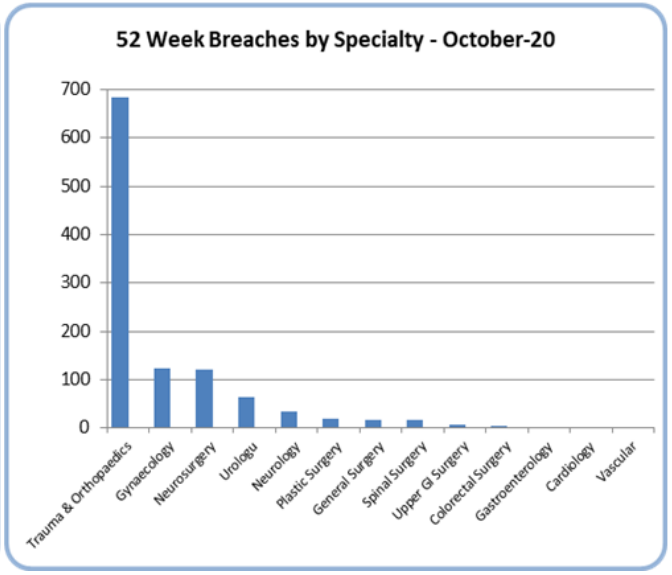
Performance in Urodynamics continued to deteriorate in October. Despite the deterioration, a significant increase in activity has had a positive impact on the wait list ; the number of patients waiting more than 13 weeks reduced by 29.63% and the overall wait list reduced by 12.98%. Comparatively, the backlog only reduced by 3.18%, which has negatively impacted performance for October.

Nationally, the Trust positioning deteriorated slightly for both 6 week and 13 week performance in September. Despite the deterioration, the Trust remained in the second and third quartiles respectively for these indicators.









Referral to Treatment (RTT)

The Trust continues to report an improved RTT performance position in October at 74.00%. resulting from a 2.81% increase in the wait list and a 9.49% improvement in the backlog.

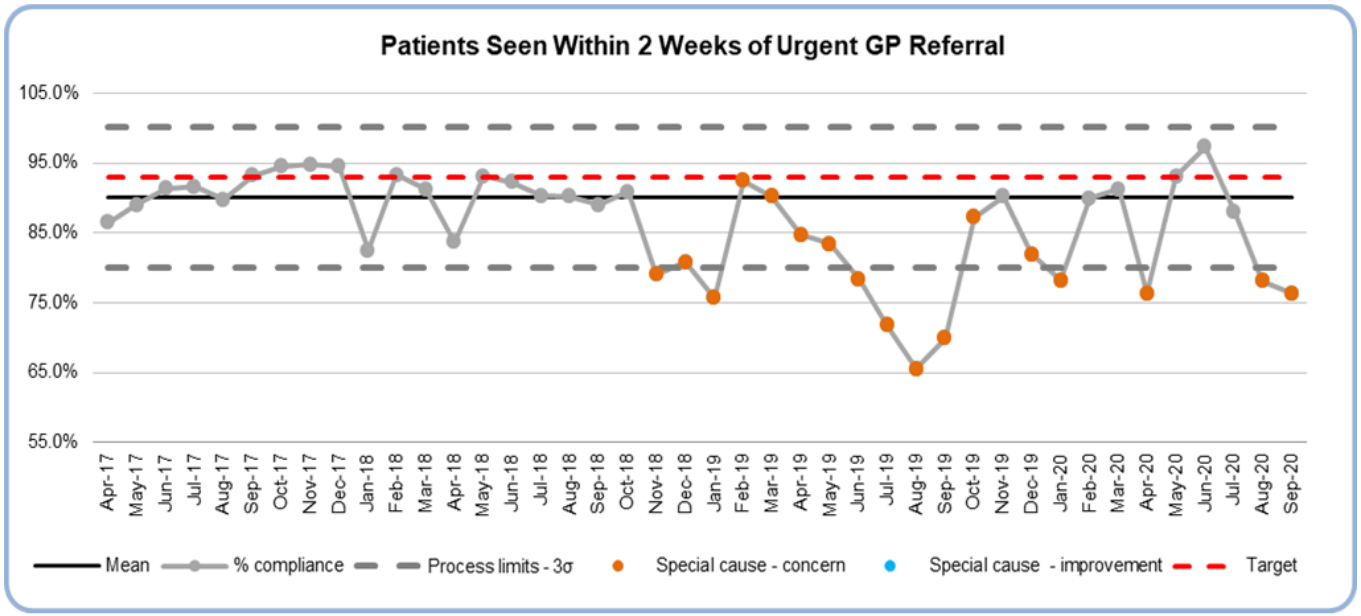
The waiting list increased to 30214 in October, reporting under the new trajectory of 31539. The waiting list increase is the result of demand growth in October, however the demand increase was less than planned resulting in the waiting list being lower than trajectory.

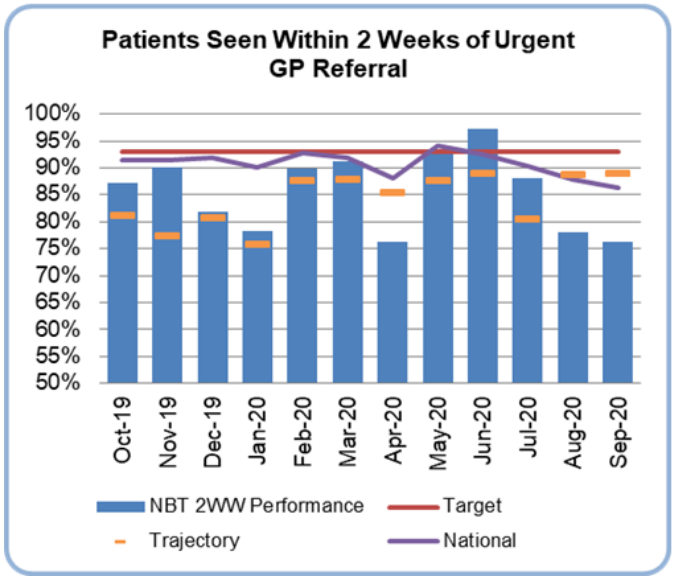
Admitted and non-admitted clock stops increased by 4.51% in October supporting the backlog and 18 week performance improvement. There was a 50.00% increase in clock stops for patients waiting more than 52 weeks.

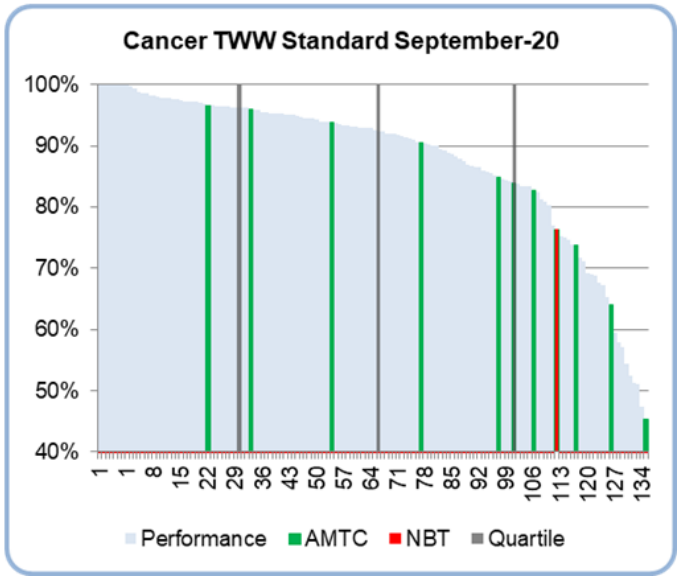
At month end, there were 1092 patients waiting greater than 52 weeks for their treatment against a refreshed trajectory of 1381; the majority of breaches (683; 62.55%) being in Trauma and Orthopaedics.

The continued increase in breaches is due predominately to cancelled operations as part of the initial COVID-19 response and the impact of the application of the Royal College of Surgeons Clinical Prioritisation guidance. In addition, the Trust is still experiencing some patients choosing to defer their treatment due to concerns with regards to COVID-19.

Nationally the Trust's 18 week positioning remained static in September, remaining in the second quartile. The positioning of the 52WW breaches as a proportion of the overall wait list has also been static, remaining in the lower quartile.







Cancer: Two Week Wait (TWW)

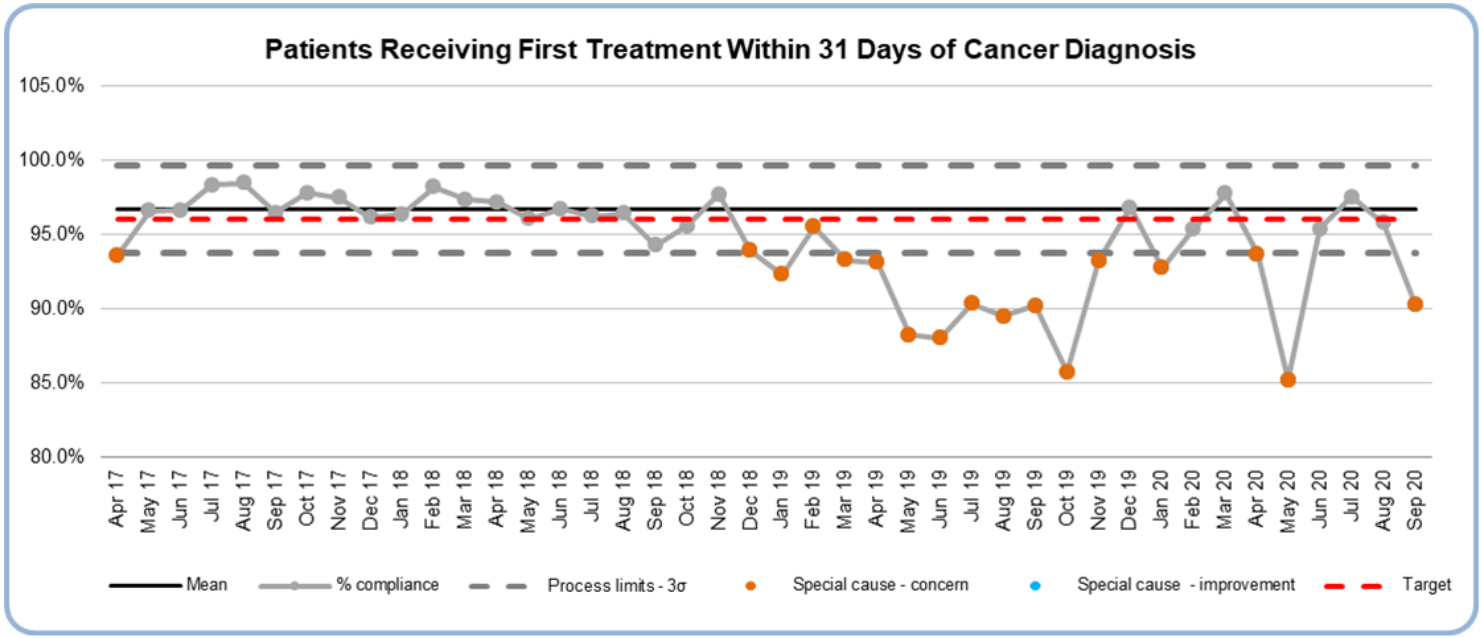
The Trust failed to achieve the recovery trajectory and the national TWW standard with performance of 76.35% in September. Referrals increased in September to levels similar to that seen before the pandemic.

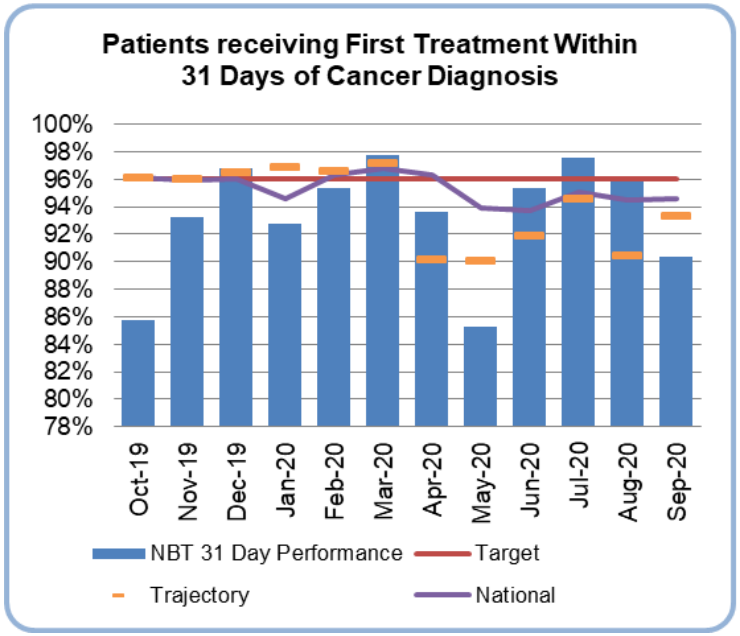
Out of the 2080 TWW patients seen in September, 492 breached; 72 related to Colorectal, 85 in Upper GI pathways and 243 in Breast.

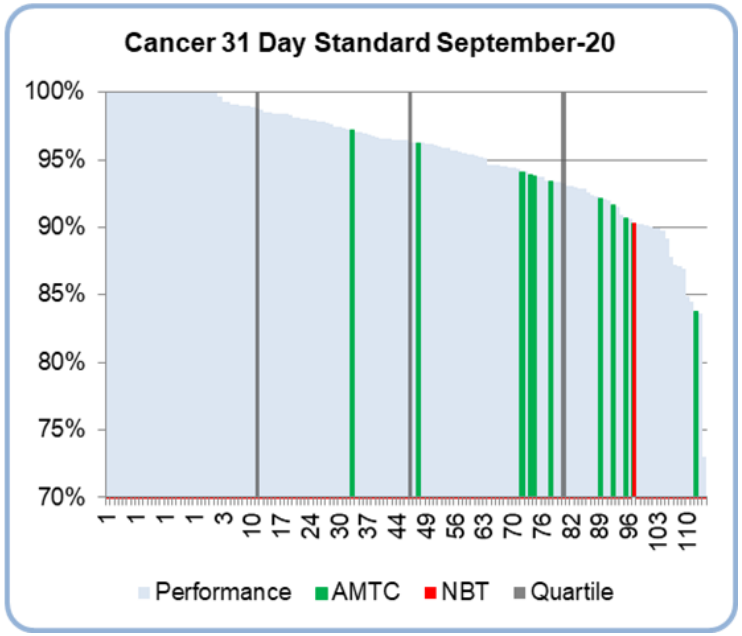
Colorectal services failed the standard for September, at 61.49%. They received 187 referrals and had 72 breaches. In September, the backlog clearance plans were well established using both independent sector and internal capacity. In September, out of the 72 colorectal breaches, 4 were for direct to test CT Colonoscopy procedures.

Upper GI failed the standard this month, at 47.53%; they received 162 referrals with 85 breaches. With the introduction of the new IPC guidelines, endoscopy were able to increase the Gastroscopy list by 4 patients to be able to see 10 per list. Skin services received 484 referrals in September and just missed the standard at 87.98%.

Breast services received 753 referrals in September with 243 breaches. The service put on additional TWW clinics throughout September and were still without two Radiographers due to shielding. The volume of referrals and the capacity constraints will continue to impact on the capacity for one stop clinics well into October and November.







Cancer: 31-Day Standard

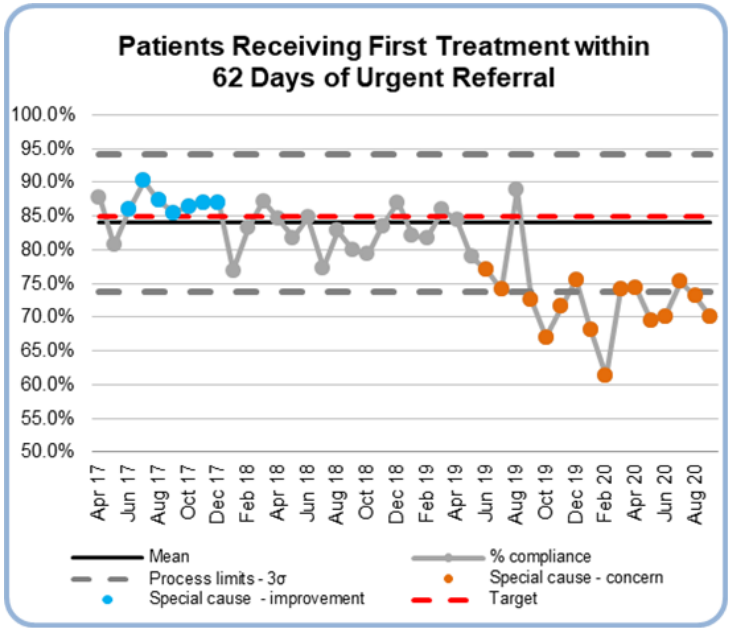
The Trust failed the 31 day first treatment national standard of 96% with performance of 90.31% and failed the revised trajectory of 93.25%.

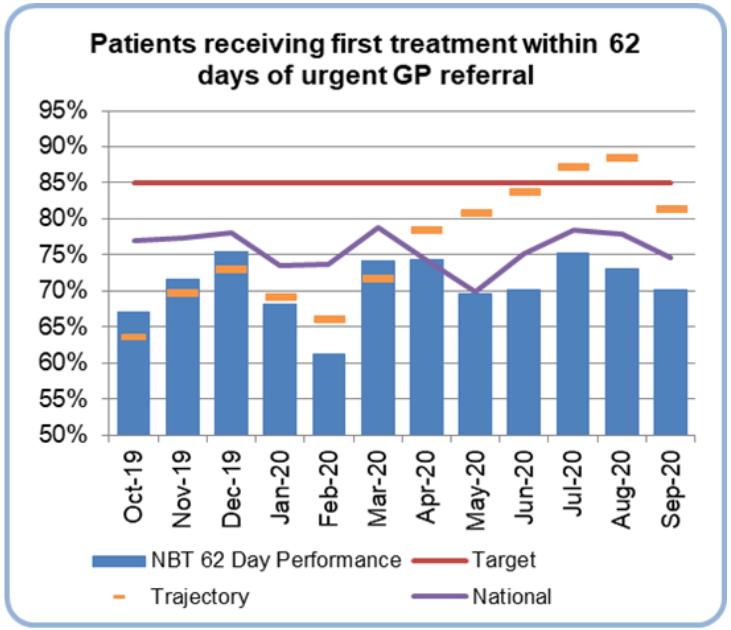
The Trust was able to treat 227 patients in September, with 22 breaches. 18 patients breached in Skin due to capacity and staffing pressures.

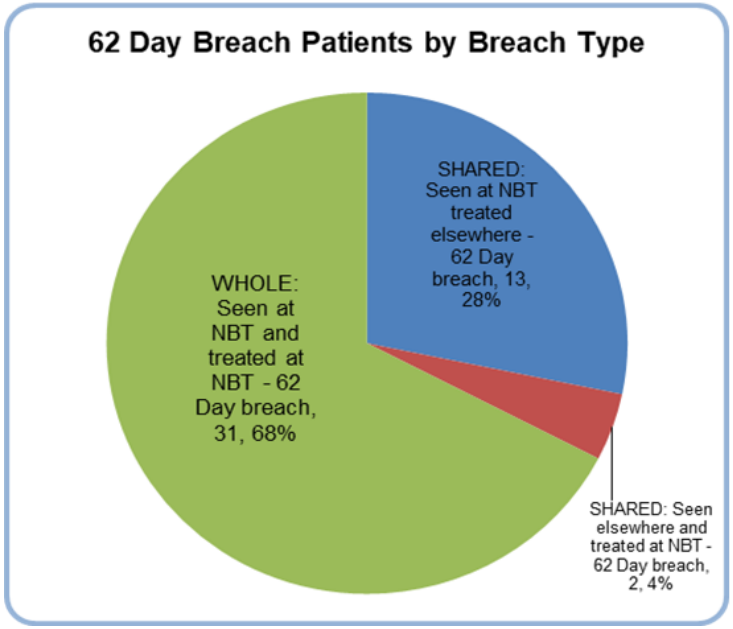
The Trust passed the 31 day subsequent surgery treatment trajectory of 81.73%, performing at 85.19%. The Trust treated 108 patients with 16 breaches in Breast and Skin.

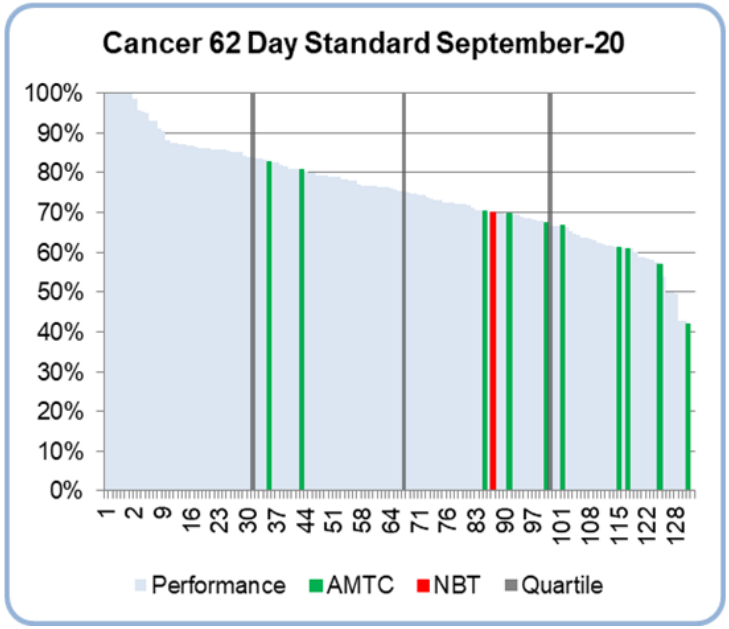
There were 7 ,104 day treated breaches in September that required Datix harm reviews; 5 within Urology and 2 in Colorectal.

Of the 7 patients that required Datix harm reviews ,4 were due to hospital COVID-19 delays, 2 were patient choice and 1 was a complex pathway. No harm has been identified as a result of the delay.









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

The Trust failed the 62 day cancer trajectory and the national standard in September, reporting a position of 70.07% against a revised trajectory of 81.48%.

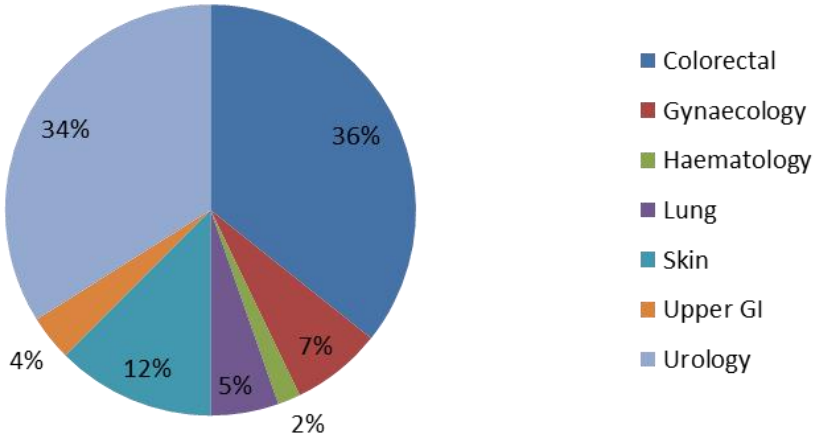
142 patients were treated with 42.5 breaches. All of the breaches in August were as a result of clinical deferral due to COVID-19 within the diagnostic and treatment pathway.

Urology's September performance of 58.89% with 49 breaches failed to achieve both CWT and post COVID-19 revised trajectory of 92.20%. This is an improvement on the previous month's position of 56.06%.

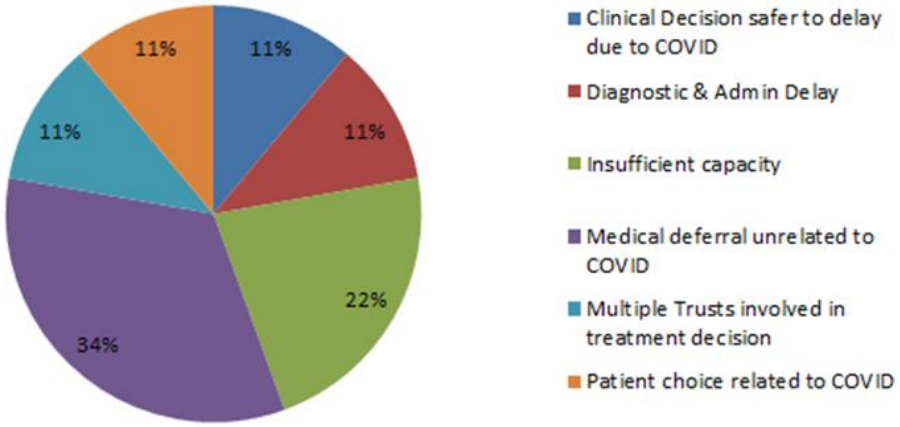
The majority of the Urology breaches were due to clinically deferred template biopsy procedures backlog clearance, plus the delay in self-isolation rules. We are unlikely to see any effect on 62 day performance until the early part of 2021.

Colorectal failed to achieve the standard with 27.27%, they treated 11 patients with 10 breaches wholly due to delays in endoscopy during the COVID-19 period.

104 Day Waiters on PTL without DTT



104 Delay reasons with DTT



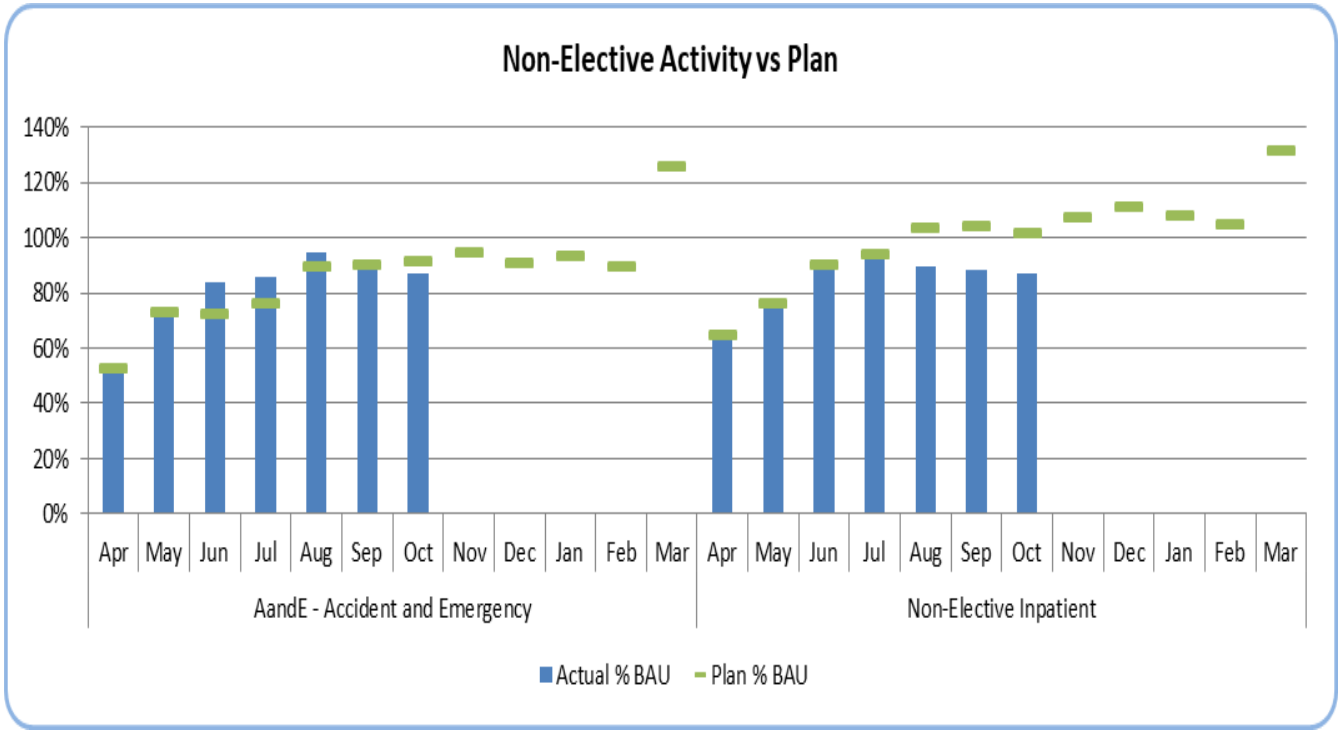
Cancer
104 Day Patients Live PTL Snapshot
October 2020

The Trust has 65 patients on the live cancer PTL as of 13 October waiting over 104 days. The report is split into two sections; patients with or without a Decision to Treat (DTT) for cancer treatment.

The Trust has 56 patients waiting >104 days without a DTT. 20 of them are in colorectal, 1 in Haematology,3 in Lung, 7 in Skin, 2 in Upper GI and 19 in Urology.

There were 9 patients with a DTT >104 days with a confirmed cancer diagnosis. 8 of these are Urology patients, due to COVID-19 Cancer treatment protocols; 1 in Breast. All have received clinical review.

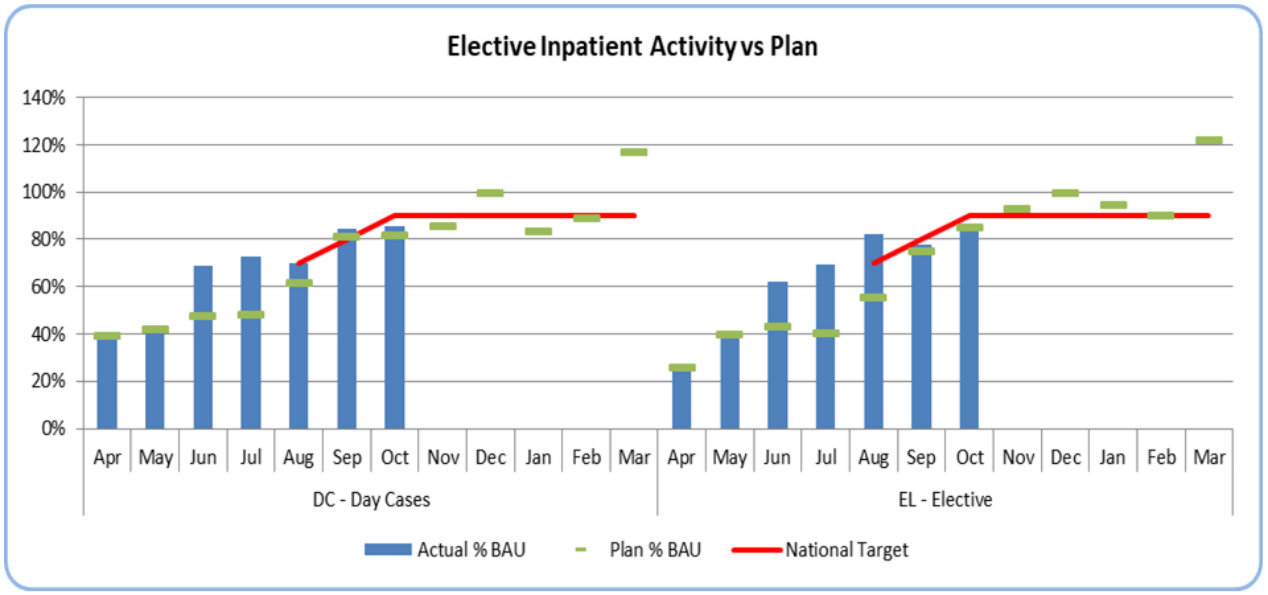
Significant work has been carried out by the specialties to ensure all patients waiting over 104 days are clinically reviewed and treatment plans are in place. There has been an overall reduction in the number of 104 day breaches since August's highest position of 106 patients.

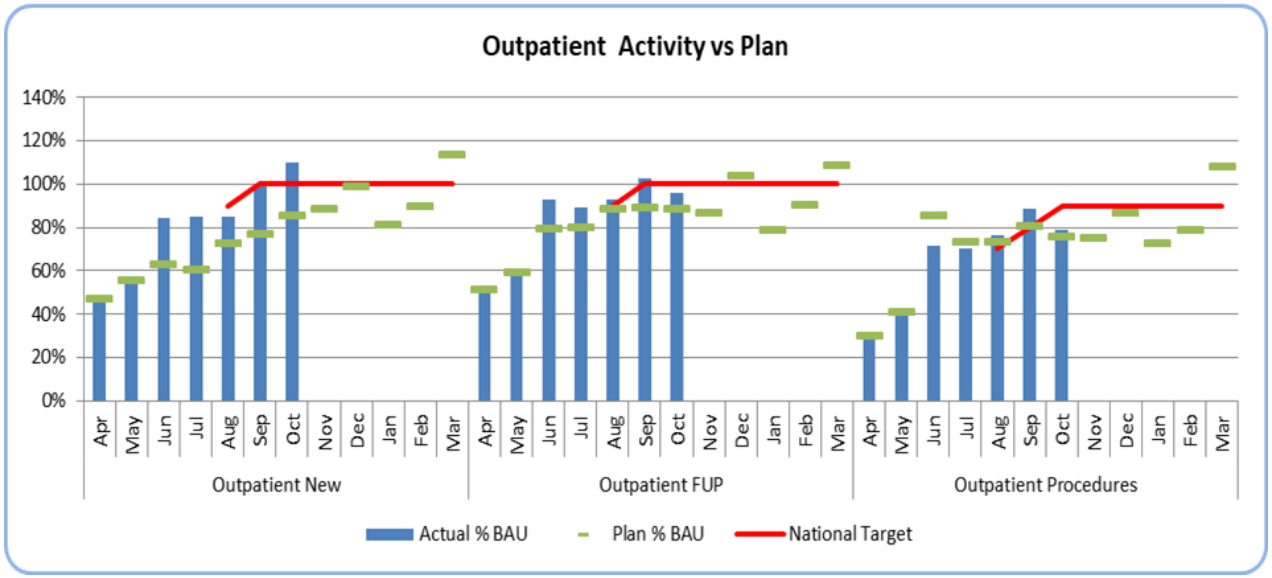


Non-Elective Activity vs Plan

- **ED attendances** have been above plan in every period with the exception of October 2020.
- **Non-Elective** activity has been below plan since July 2020.

NB: March 2021 plan is above 100% due to March 2020 actuals being partially impacted by COVID-19.

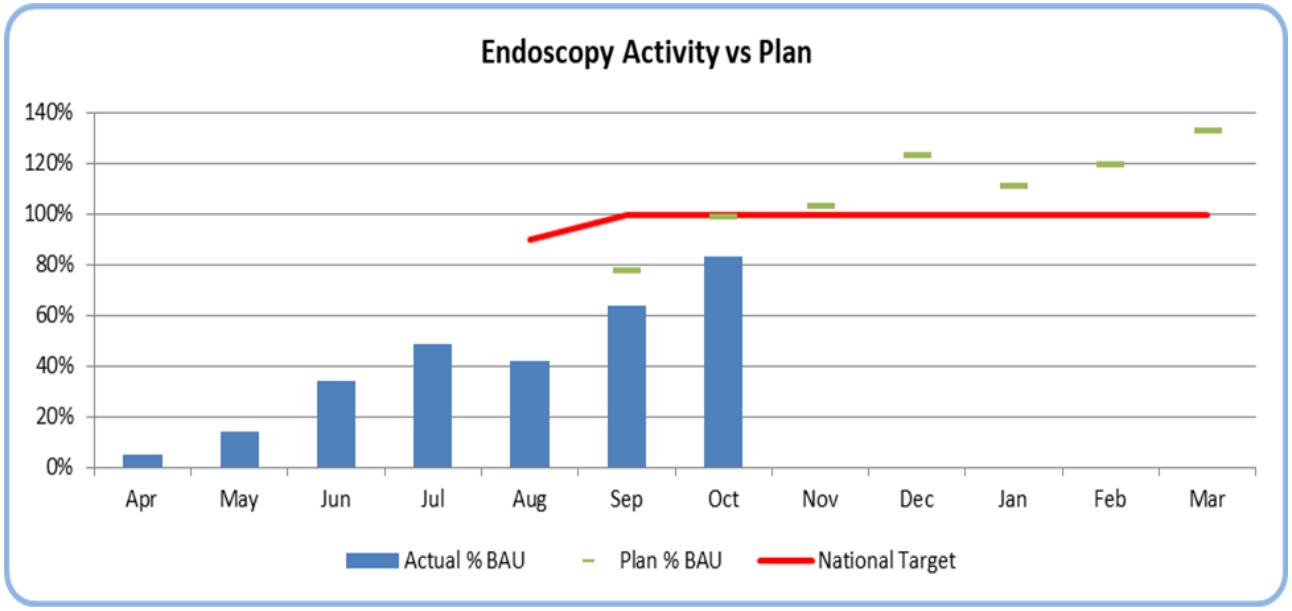


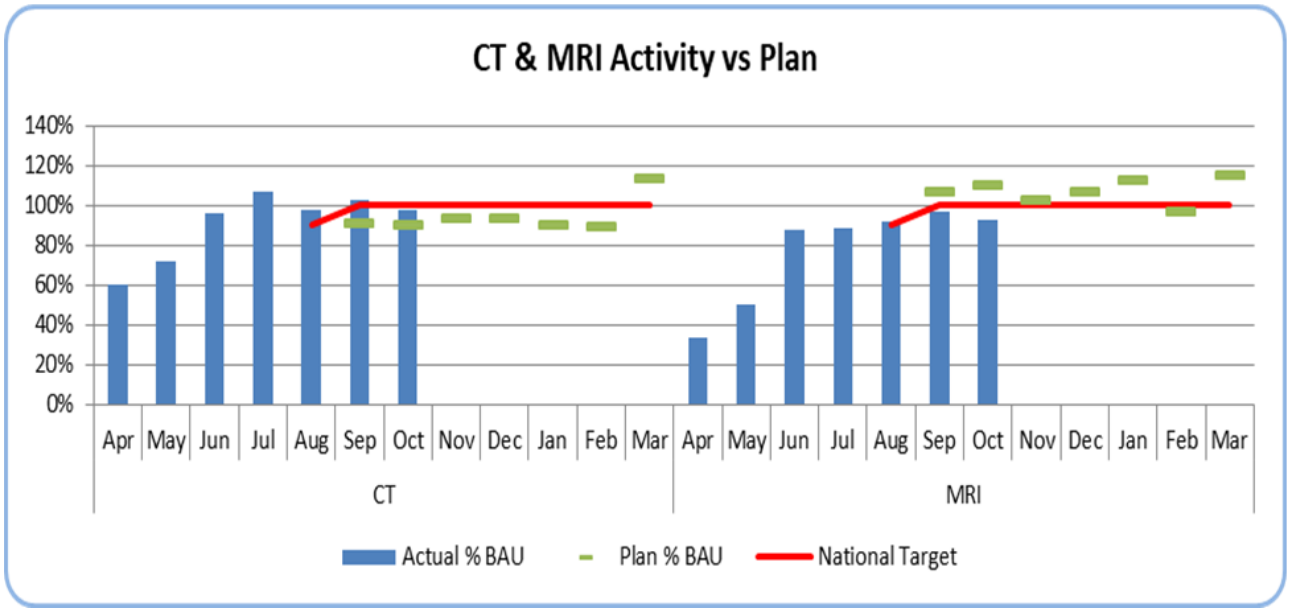


Elective Activity vs Plan

- **Day case and overnight admissions** have achieved plan in every period. Targets were not achieved in October.
- **Outpatient first attendances** have been above plan in every period but did not achieve the 90% target in August with activity at 85%.
- **Outpatient follow up** attendances have been above plan for every period and achieved the target in August and September.
- **Outpatient procedures** have been above plan in every period with the exception of June. The targets were achieved for August and September.

NB: March 2021 plan is above 100% due to March 2020 actuals being partially impacted by COVID-19. Data includes activity undertaken in the Independent Sector on behalf of the Trust.





Diagnostic Activity vs Plan

- **Endoscopy activity** reports below plan for September and below target for August, September and October. This relates to the under-reporting of activity due to a coding lag. Delivery of target is anticipated for October.
- **CT activity** has achieved plan for September and October.
- **MRI activity** did not achieve the target or plan in October. National 6 week wait performance was achieved in September but reported a slight deterioration to 1.42% in October.

NB: March 2021 plan is above 100% due to March 2020 actuals being partially impacted by COVID-19.

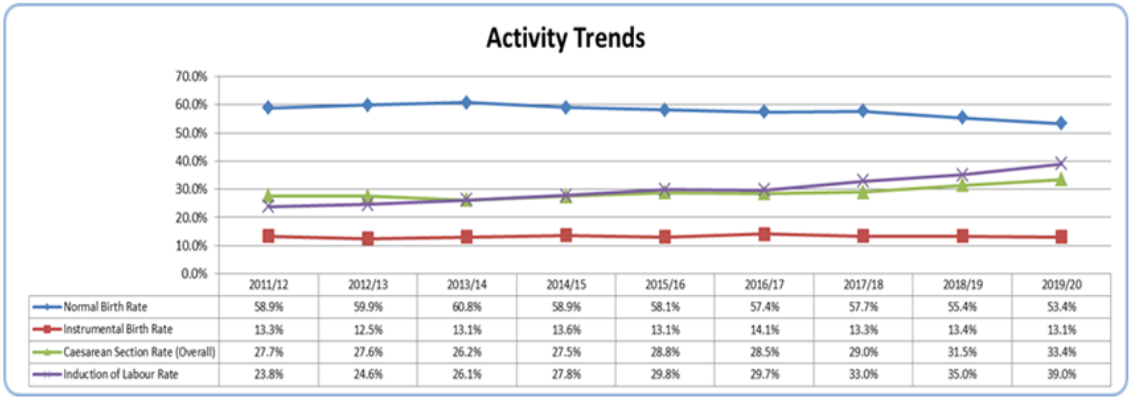
Safety and Effectiveness

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

NBT Maternity Dashboard

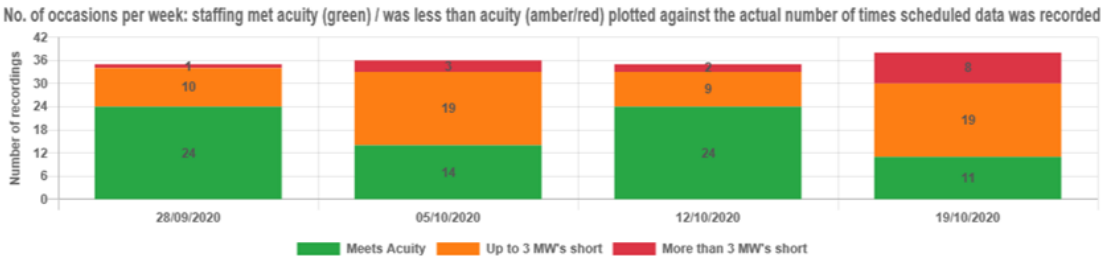
	Target	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
Caesarean section rate (overall)	28.0%	32.8%	35.3%	33.9%	38.3%	34.0%	33.4%	31.5%	33.9%	36.8%	34.6%	39.0%	38.7%	36.4%
Elective CS rate (as % of all birth episodes)		16.6%	19.2%	13.7%	16.5%	14.4%	15.6%	12.0%	14.0%	15.4%	15.4%	16.8%	17.2%	16.1%
Emergency CS rate (as % of all birth episodes)		16.2%	16.1%	20.2%	21.8%	19.7%	17.8%	19.5%	19.9%	21.4%	19.2%	22.2%	21.4%	20.3%
Induction of labour rate	32.1%	38.5%	35.3%	40.2%	41.5%	41.4%	40.8%	40.6%	38.9%	34.8%	35.4%	38.6%	38.9%	36.6%
3rd&4th degree tear rate as % of vaginal births	3.3%	3.9%	6.5%	5.5%	3.3%	2.5%	4.0%	3.8%	4.2%	2.8%	2.8%	3.4%	2.1%	3.2%
3rd&4th degree tear rate in unassisted births	2.5%	3.4%	6.2%	1.8%	2.8%	1.7%	3.4%	2.1%	2.4%	1.3%	2.3%	2.5%	1.3%	3.0%
PPH >=1000 ml rate	8.6%	13.3%	13.3%	12.2%	10.8%	9.2%	9.7%	8.7%	12.9%	11.5%	11.2%	10.7%	8.0%	10.4%
PPH >=1500 ml rate	3.5%	5.0%	4.0%	4.9%	4.8%	3.7%	3.3%	2.8%	5.4%	3.8%	3.4%	3.9%	2.1%	3.4%
PPH >=2000 ml rate	1.5%	1.2%	1.4%	2.7%	2.5%	1.4%	0.9%	0.7%	1.9%	0.9%	1.6%	2.3%	0.8%	2.0%
5 minute apgar <7 rate at term	0.9%	0.9%	0.6%	0.5%	0.5%	0.7%	0.7%	1.3%	1.6%	1.0%	0.6%	0.2%	0.2%	0.6%
Stillbirth rate	0.4%	0.8%	0.2%	0.7%	0.2%	0.0%	0.4%	0.2%	0.0%	0.0%	0.4%	0.2%	0.4%	0.0%
Stillbirth rate at term		0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.2%	0.2%	0.0%	0.0%
Stillbirth rate <37 weeks		8.3%	3.2%	8.3%	2.9%	0.0%	4.8%	0.0%	0.0%	0.0%	2.6%	0.0%	5.3%	0.0%

**RAG is determined by a tolerance level set by the number of standard deviations away from the target a performance is.*



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Normal Birth Rate	58.9%	59.9%	60.8%	58.9%	58.1%	57.4%	57.7%	55.4%	53.4%
Instrumental Birth Rate	13.3%	12.5%	13.1%	13.6%	13.1%	14.1%	13.3%	13.4%	13.1%
Caesarean Section Rate (Overall)	27.7%	27.6%	26.2%	27.5%	28.8%	28.5%	29.0%	31.5%	33.4%
Induction of Labour Rate	23.8%	24.6%	26.1%	27.8%	29.8%	29.7%	33.0%	35.0%	39.0%

The slide below shows the impact of the increasing acuity based on an assessment of Midwife/nurse time to meet the complex needs of the woman



COVID-19 Maternity

The division has installed additional screens across the division to improve infection control within multiple occupancy bays and which helps restore some capacity.

Options for access and use of maternity and gynae has been completed. The agreed changes to date will;

- Increase capacity for recovery and HDU in light of increasing numbers of women requiring Level 1 and 2 care
- Prevent delays for women requiring induction of labour
- Reduce current risk and improve patient experience
- Improve efficiency of staffing

Visiting arrangements within maternity have been under nationwide discussion. Our current restrictions are informed by national guidance and in place to protect women, babies and the staff in the face of an ongoing rise in COVID-19 cases across BNSSG.

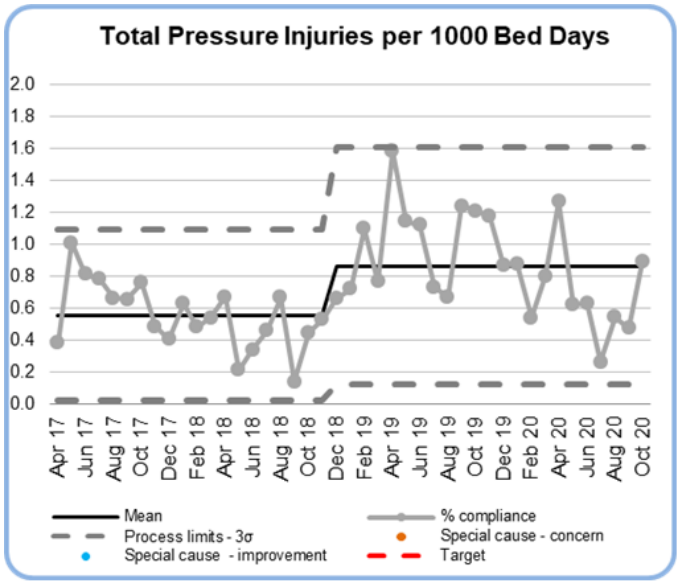
Clinical

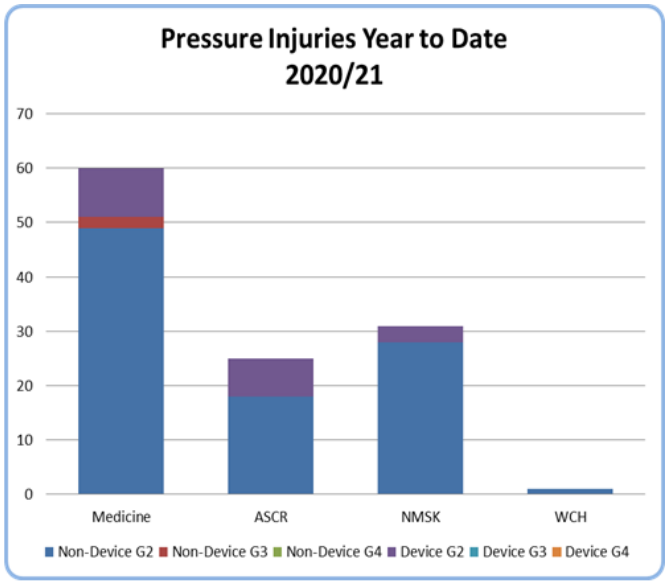
Both Elective and Emergency CS rates remain high with an average rate for the year at 35.4% and higher for the last 6 months at 36.38%. Births have increased over the last three months and in line with complexity trends the acuity on CDS remains high.

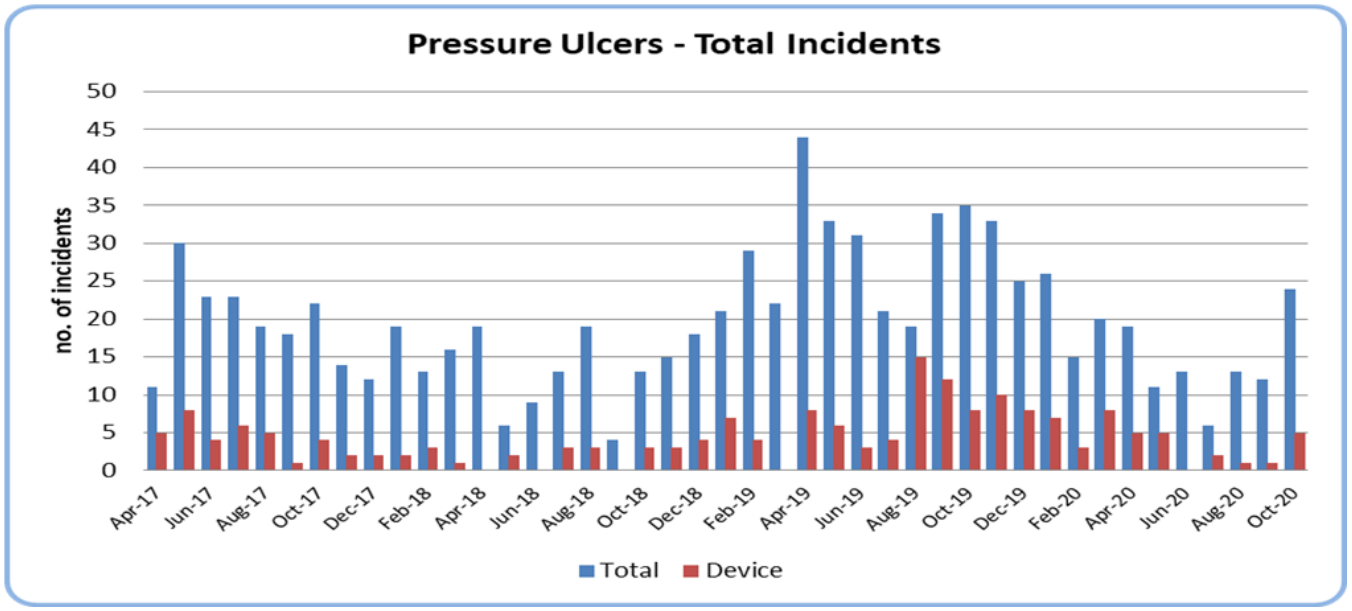
Better Births NHSE

NBT is working towards meeting the national target of 35% of women being on a continuity of carer pathway by March 2021 as part of the national ambition to reduce stillbirths by 50% by 2024. The same must be in place for BaME women across the service and data assessment against this is being completed. This mandated requirement needs to be achieved as an LMS and will be reported as such – however for CNST and commissioning purposes the expectation will be by individual trust.

QP2







Pressure Injuries (PIs)

The Trust ambition for 2020/21 is:

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

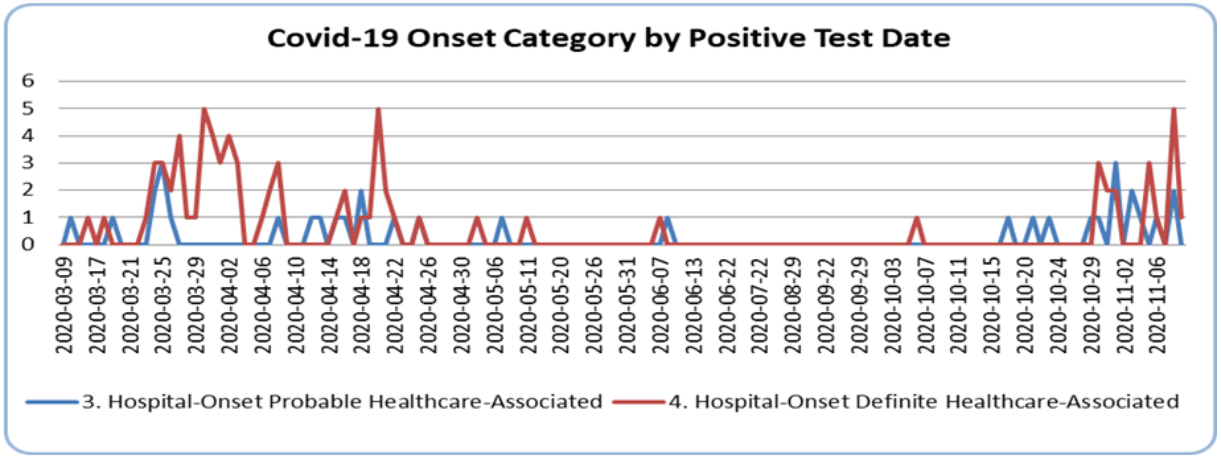
There have been no reported Grade 4 pressure injuries in October. There has been 1 Grade 3 pressure injury reported within medicine division, Gate 8a.

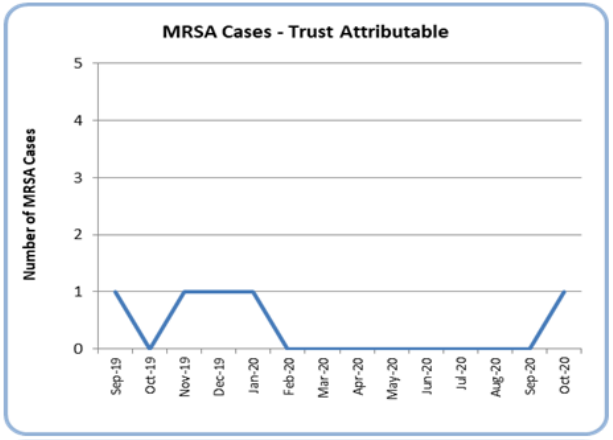
In October we saw an increase of Grade 2 pressure injuries reported (28). This included 5 device related injury.
The incidence summary for October is as follows:
Medical Devices: 17%
Heels: 23%
Coccyx/ Natal Cleft: 13%
Buttock/ Sacrum: 23%
Elbow/ Spine/ Ankle: 17%
Ear/ Toe: 7%

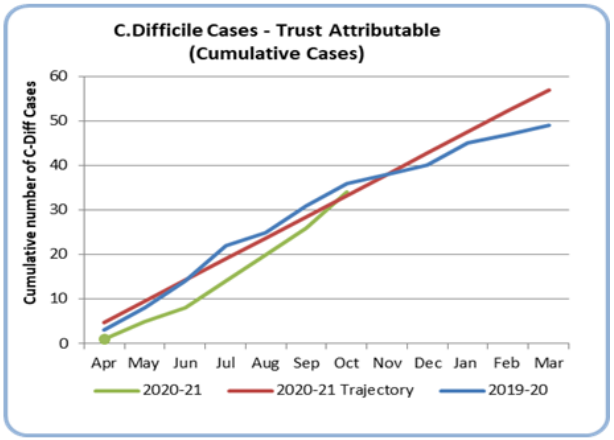
The NIST approach continues on Gate 8a following validation of a second hospital acquired grade 3 pressure injury to the coccyx. Quality Improvement team working alongside teams to establish themes and trends and to embed learning using the QI methodology.

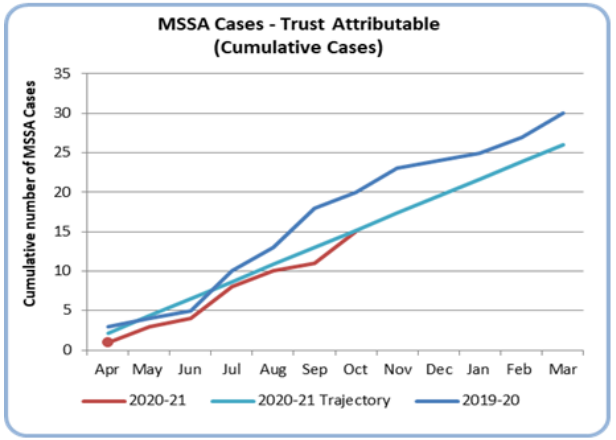
The Trust Wide themes and trends and subsequent actions and learning are monitored and shared through the Trust's pressure injury incident meeting.

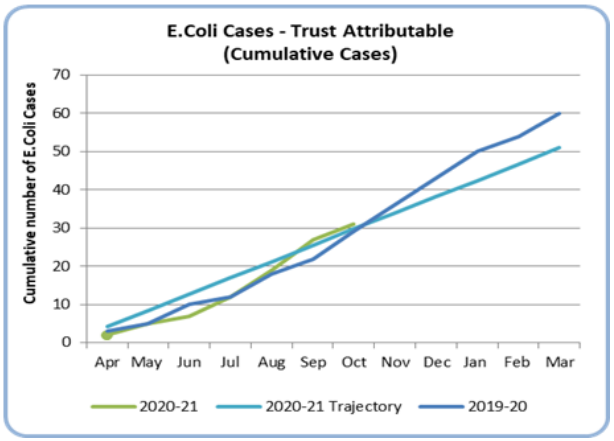
QP4











COVID- 19 (Coronavirus)
The infection control effort and resources are focused on managing the COVID-19 pandemic and its impact on the Trust. October has seen a rise in community transmission of the virus.

After several months with no hospital onset cases October saw four probable and six definite healthcare associated infections with COVID-19. As shown in the graph this has continued in early November with a number of localised outbreaks in the hospital. Post infection reviews are completed for each individual case. Where outbreaks occur Management meetings are convened including external parties from public health.

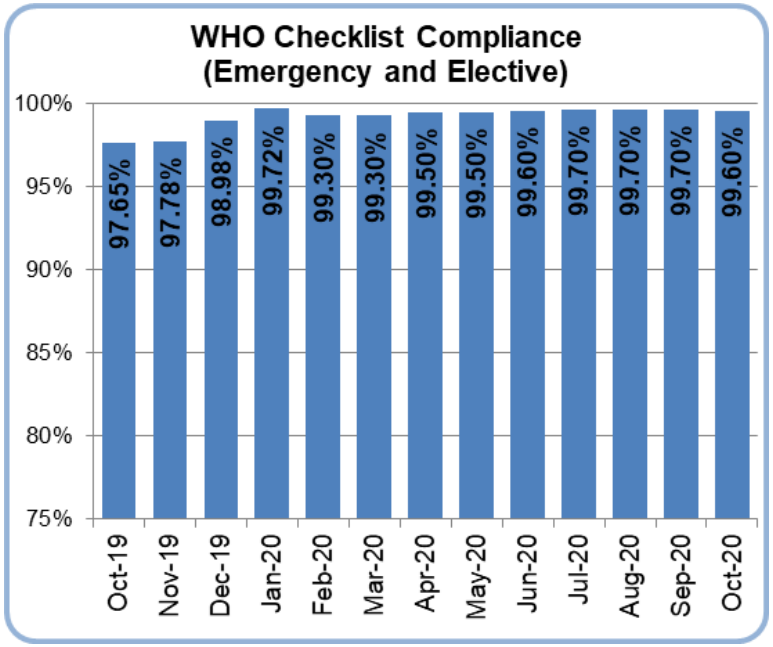
Transmission within ward bay areas has been a common theme and the learning included a review of the perspex screens between bed spaces which have been purchased for all bays. We have also reviewed guidance for patients on wearing of face mask in bays and when staff enter single rooms.

The Trust has reviewed signage in public areas emphasising the key messages of hand hygiene, wearing of face masks and maintaining social distancing. We will repeat our self assessment against the board assurance framework in the next month.

MRSA
There has been one reported case of MRSA bacteraemia for October which is under investigation.

C. Difficile
Seven Trust cases have been reported which is higher than the expected trajectory. Late sampling is a major reason in some recent cases so that community onset symptoms are being attributed to the trust.

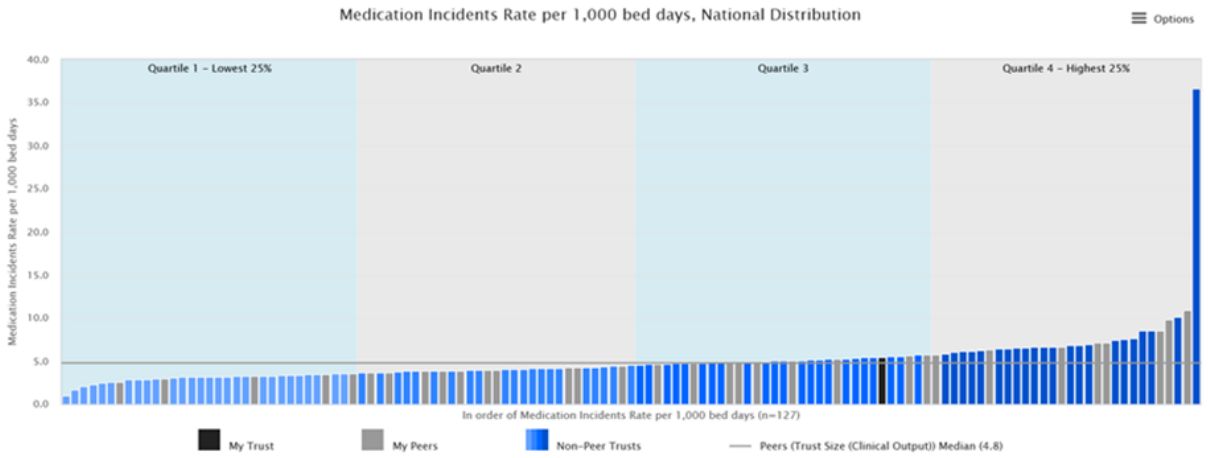
QP2

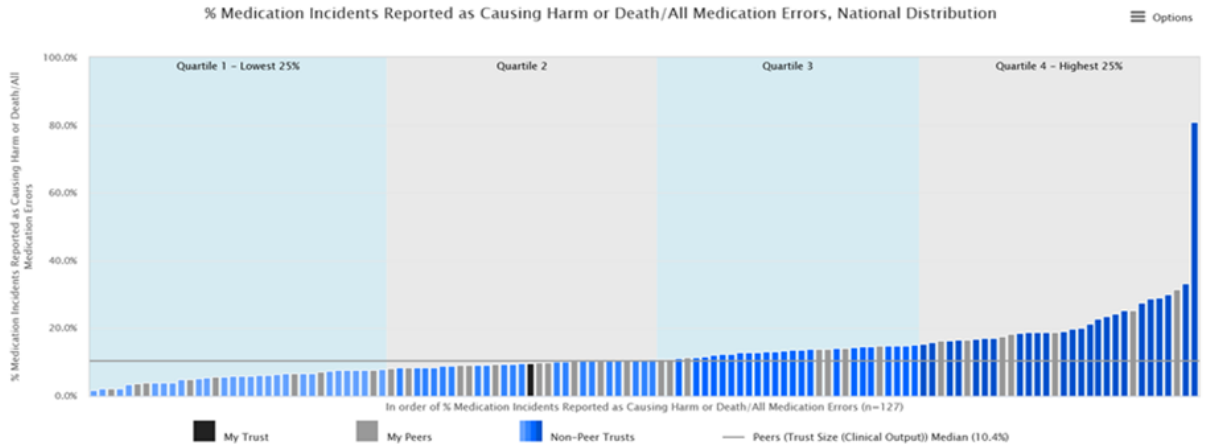


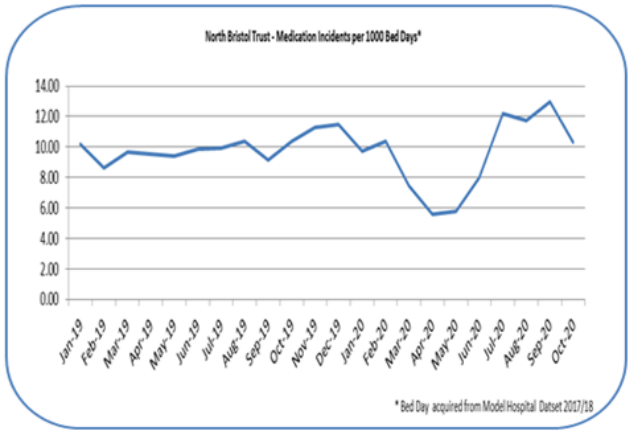
WHO Checklist Compliance

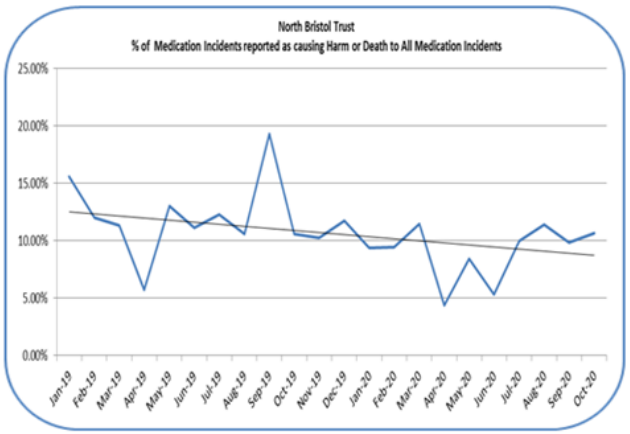
The Board expects that a WHO surgical safety checklist will be completed and documented prior to each operation in theatres.

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.









Medicines Management National Benchmarking
These metrics are a measure of medicines safety and governance. *Data source: National Reporting & Learning System (NRLS) March 2020.*

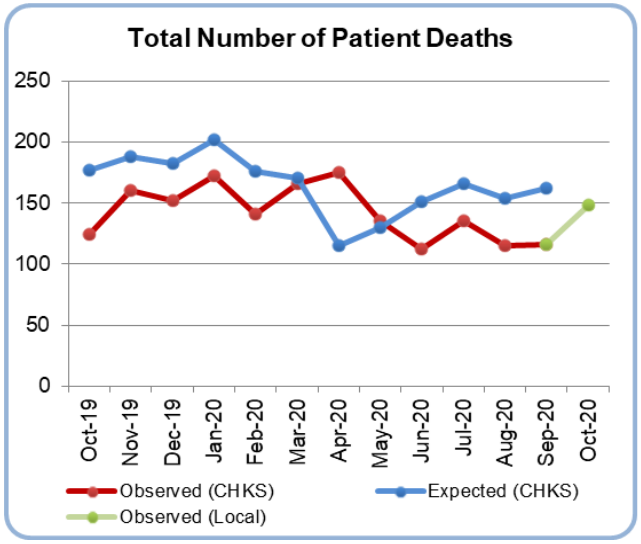
Medication Incident Rate per 1000 Bed Days. North Bristol Trust has a rate of 5.5 incidents per 1000 bed days which is above the median for its peer group (4.8) and above the National median (4.5).High levels of reporting are considered an indicator of a strong safety culture.

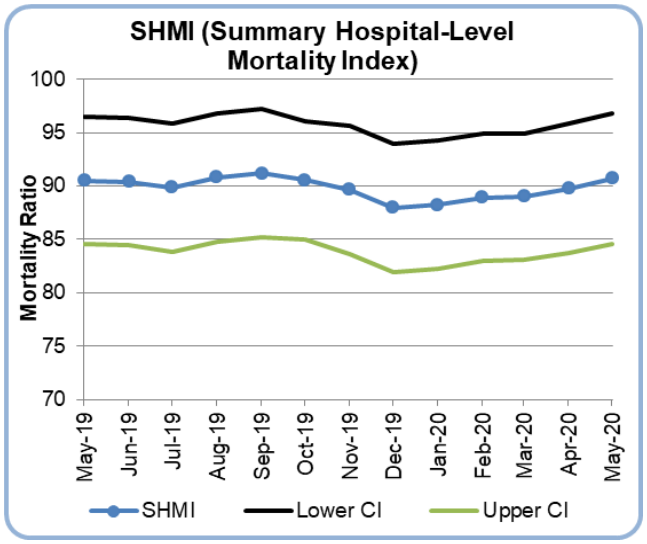
Percentage of Medication incidents reported as causing Harm or Death. 9.7% of incidents reported from NBT have caused harm which below the median for its peers (10.4%) and below the National median (10.8%). A lower number demonstrates safer medication practice.

North Bristol Trust Medication Incident Reporting (October 2020).
Organisations where staff believe reporting incidents is worthwhile are likely to report a higher proportion of "no harm" incidents. No harm incidents are 89% of NBT reported incidents and the percentage of harm incidents is declining over time.

NBT has a medicines governance process overseen by the Drugs and Therapeutics committee which reports to Quality and Risk Management Committee.

Mortality Outcome Data





Mortality Review Completion

Aug 19 – June 20	Completed	Required	% Complete
Screened and excluded	1107*		
High priority cases	264		
Other cases reviewed	251		
Total reviewed cases	1622	1821	89.1%

Overall Score	1=very poor	2	3	4	5= Excellent
Care received	0.0%	3.3%	17.8%	49.0%	29.9%

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

Date of Death	Jul 19 – June 20
In progress	2
Reviewed not SIRI	12
Reported as SIRI	1
Total score 1 or 2	15

*171 (non high priority) cases were excluded from any form of review between January and April 2020 to aid with clearing a backlog of cases worsened by the COVID-19 pandemic mortality review suspension.

All high priority cases are still being reviewed.

Overall Mortality

Mortality outcome data has remained within the expected statistical range.

Mortality Review Completion

The current data captures completed reviews from 01 Aug 19 to 31 Jul 20. In this time period 89.1% of all deaths had a completed review. Of all "High Priority" cases, 93.9% completed Mortality Case Reviews (MCR), including 23 of the 23 deceased patients with Learning Disability and 30 of the 31 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 96.7% (score 3-5). There have been 15 mortality reviews with a score of 1 or 2 indicating potentially poor, or very poor care which are reviewed as potential Serious Incidents through Divisional governance processes and the Patient Safety Group.

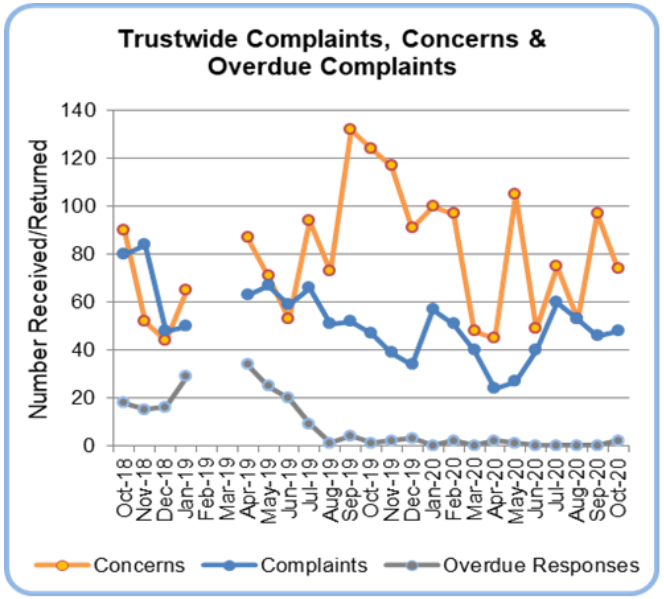
Medical Examiner service

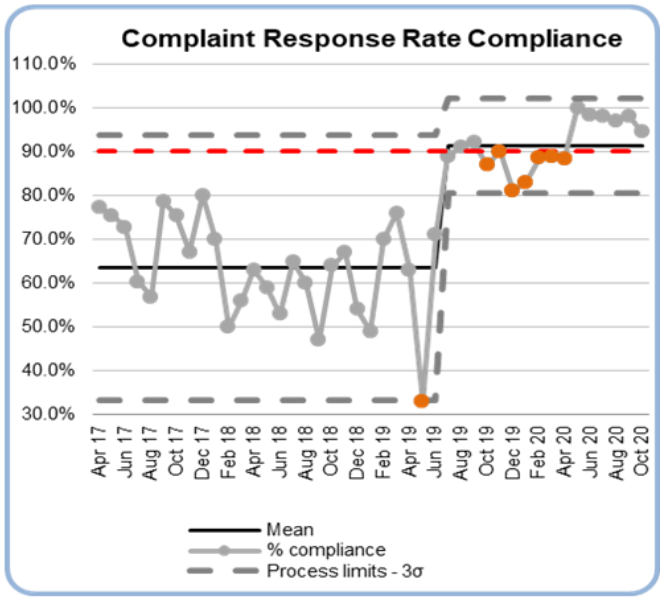
The project to implement a Medical Examiner service jointly with UHBW FT is progressing well with the regional October implementation target met.

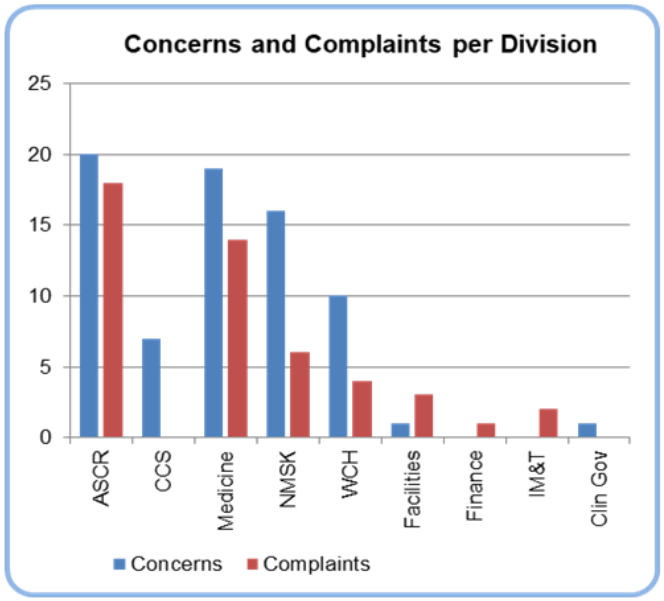
As the project completes by March 2021 there will be revision of the policies with respect to mortality reviews to ensure that reviews are focussed on those cases with the greatest likelihood of significant learning.

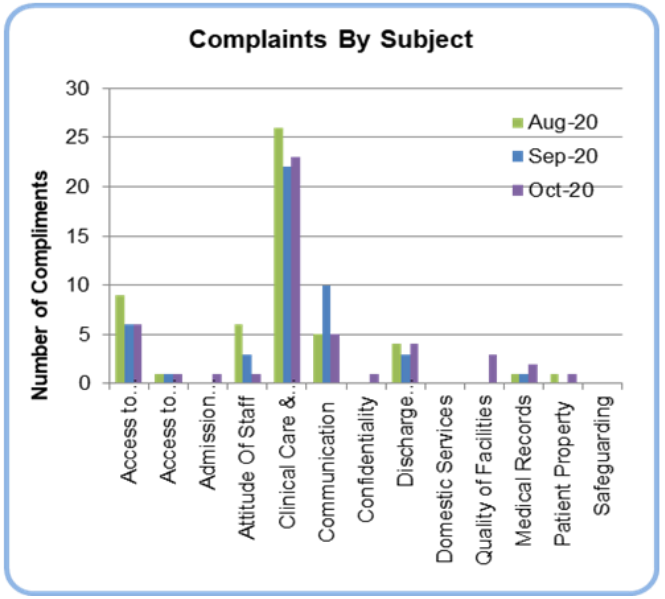
Patient Experience

Board Sponsor: Director of Nursing and Quality
Helen Blanchard









N.B. Feb-19 and Mar-19 data has been removed for complaints, concerns and overdue complaints owing to data quality issues. From June-19 Enquiries have **not** been included in the 'concerns' data.

Complaints and Concerns

In October 2020, the Trust received 48 formal complaints.

For the fourth consecutive month the most common subject of complaints is Clinical Care and Treatment. 3 complaints were received regarding Quality of Facilities. Prior to this, this has not been the subject of any complaints this year.

The 48 formal complaints can be broken down by division: (the previous month total is shown in brackets)

ASCR	18 (13)	CCS	0 (1)
Medicine	14 (12)	NMSK	6 (9)
WCH	4 (8)	Facilities	3 (0)
IM&T	2 (1)	Finance	1(0)

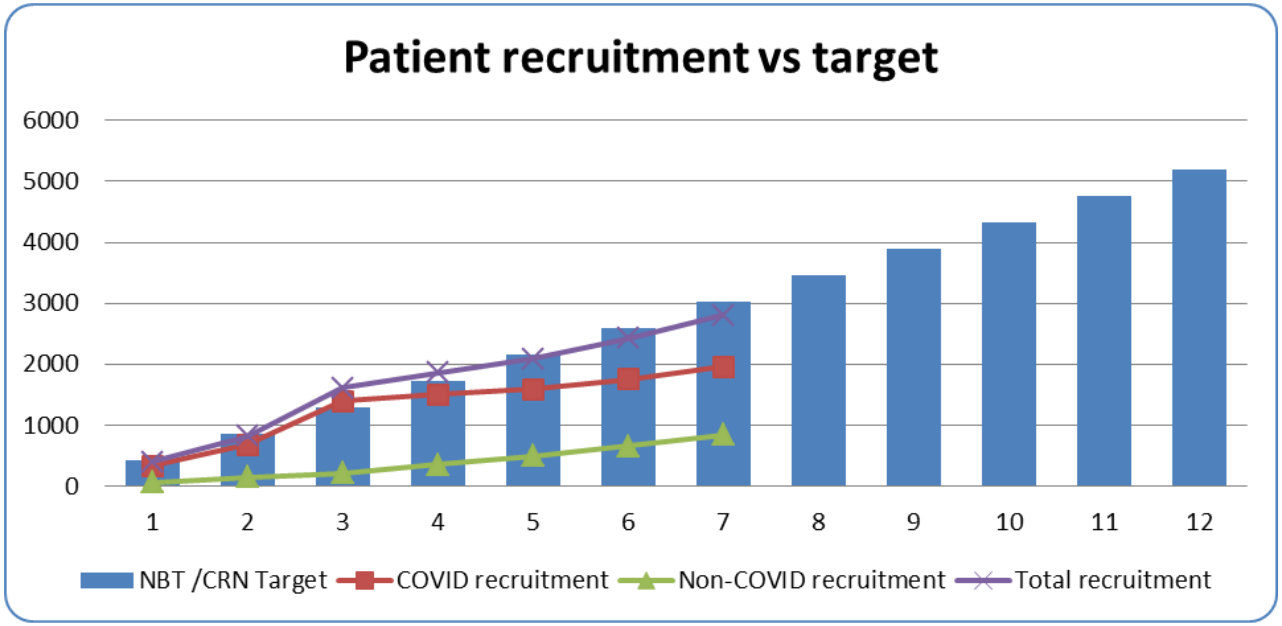
Enquiries and PALS concerns are recorded and reported separately. In October 2020, a total of 20 enquiries were received by the Patient Experience Team. 74 PALS concerns were received. This is a decrease of activity on the previous month.

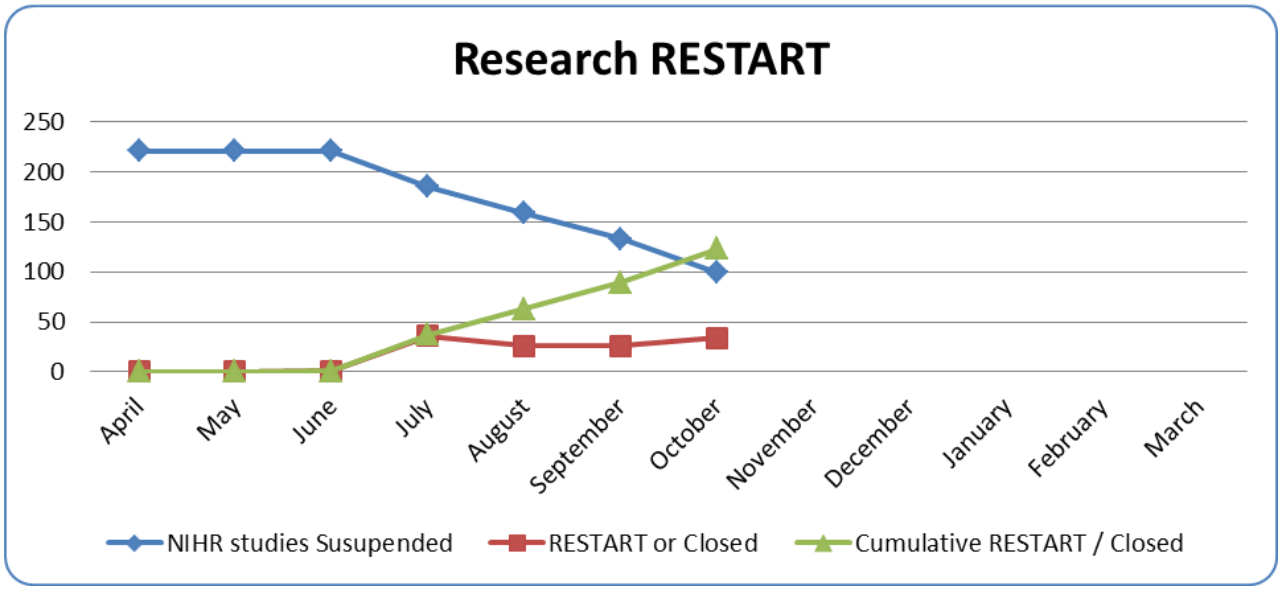
Compliance Response Rate Compliance

The chart demonstrates sustained improvement in responding to complaints within agreed timescales. In October, 94% of complaints were closed on time. That is of the 72 complaints due to be closed in October, 68 were responded to on or before the due date. 2 remain open and 2 were responded to after the agreed timescale.

Overdue complaints

There are 2 overdue complaints. These are in ASCR and due to the complainant awaiting notes from their Local Resolution Meeting in order to close the case. These delays have been due to a team administrator vacancy, that has now been filled.





The recruitment target was set before the COVID-19 outbreak. Recruitment has remained on target as RESTART offered recruitment opportunities between COVID-19 waves. All the research teams are working hard to balance COVID-19 and Non-COVID-19 studies as pressures permit.

NBT suspended 221 studies during the epidemic. 140 studies have been re-started / closed.

With the rise in COVID-19 positive inpatients research delivery staff are now supporting the COVID-19 Urgent Public Health studies, which is reducing capacity to recruit to non-COVID-19 studies.

NBT leads 53 research grants (NIHR, charity, industry and other) to a total value of £22.2m, and is a partner on 47 grants to a total value of £9m. This includes the COVID-19 focused NIHR grant, AERATOR, led by Prof Nick Maskell (Aerosolisation And Transmission Of SARS-CoV-2 in Healthcare Settings, award value £432k) which, following a review by the DHSC, is expected to be expanded to include additional sites and clinical areas.

R&I are accepting applications from NBT staff to undertake COVID-19 focused research projects, up to £20k per project, funded by the SHC Research Fund. Applications are reviewed each month by a funding panel, comprising the R&I Senior Team, SHC representative, Research Design Service and members of the public. To date we have awarded:

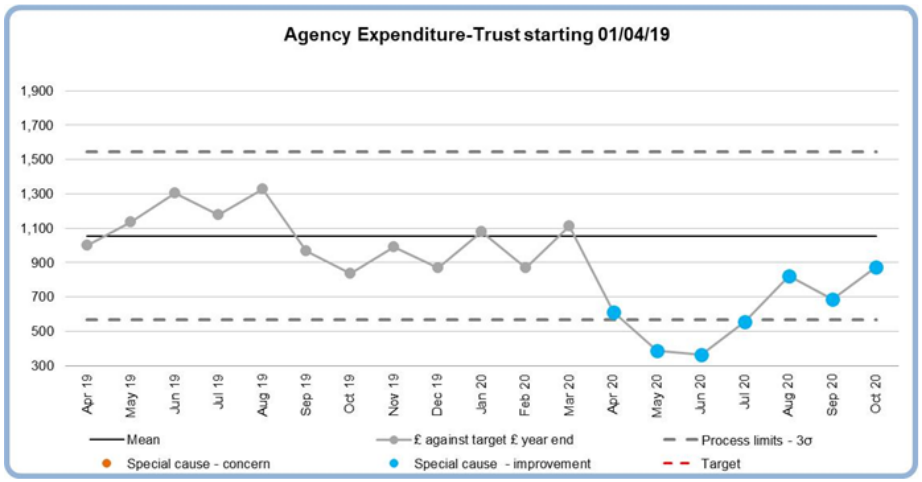
- Jo Daniels £19,757: COVID-19 clinicians cohort (CoCCo) study: trauma needs and preferences
- James Dodd £20,000: Remote teaching of home spirometry in patients with respiratory symptoms

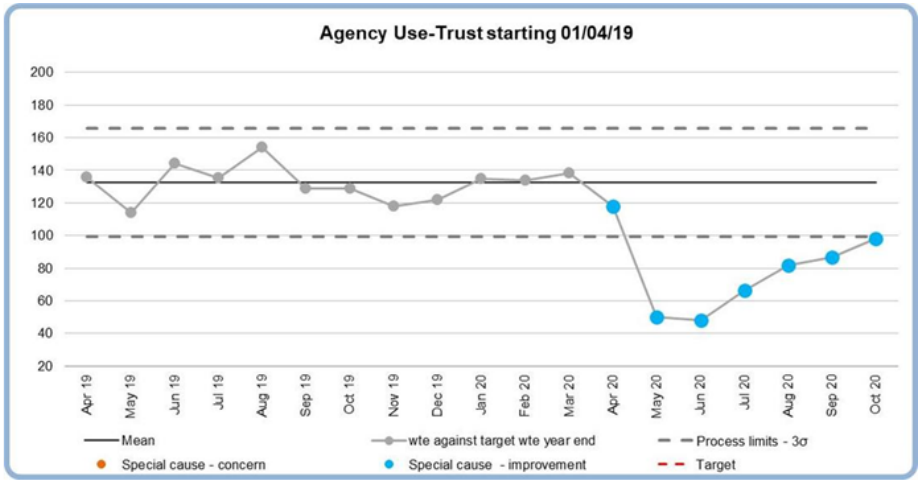
INVESTORS IN PEOPLE | Silver

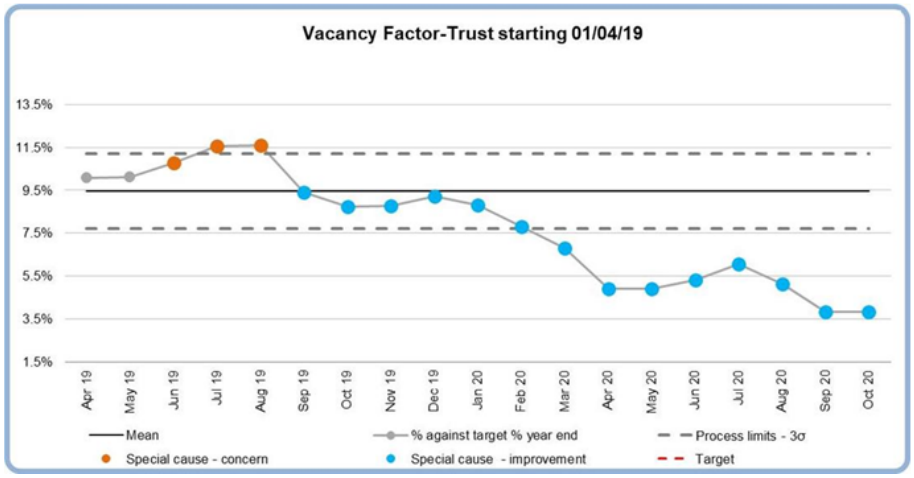
Well Led

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

Workforce







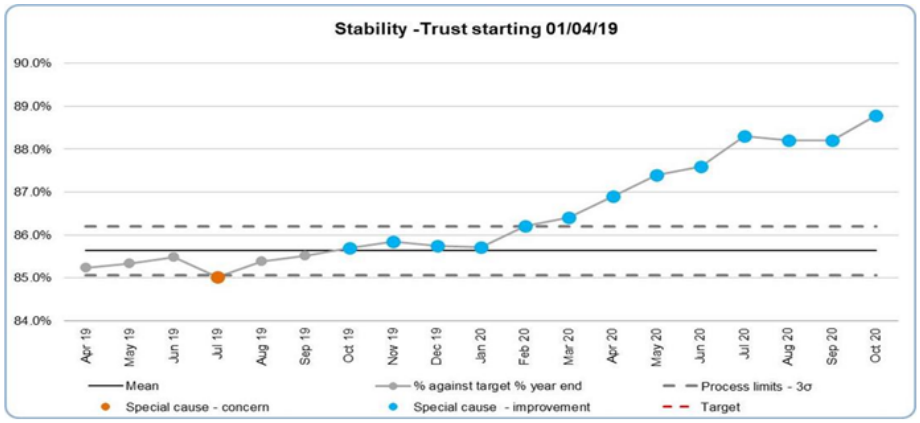
Resourcing

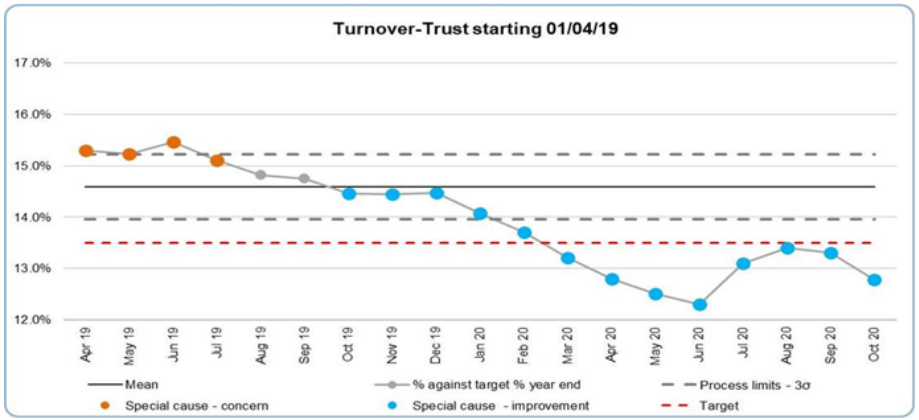
An increase in agency usage in October has been seen as services are being maintained whilst both substantive and bank capacity is affected by increases in absence levels. There have also been a large number of short notice requirements for registered mental health nurses where framework agencies have been unable to support so high cost non framework usage has been required.

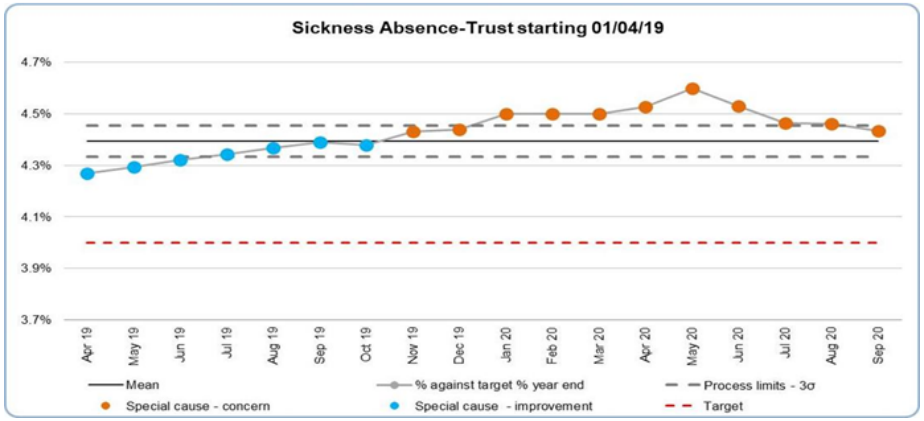
Substantive recruitment saw 32.59 new starters on the Band 4 and 5 Nursing line and the Trust made 55 further offers to band 5 Nursing and Midwifery staff in October. HCA Recruitment remains a priority with increased recruitment activity whilst ensuring quality is not diluted.

The Current Vacancy factor for Band 5 is 8.4% (109 vacancies) which is the lowest the vacancy factor has been since December 2017.
The HCA vacancy factor is now 9.4%, which was 14% this month last year.

Engagement and Wellbeing







Turnover and Stability

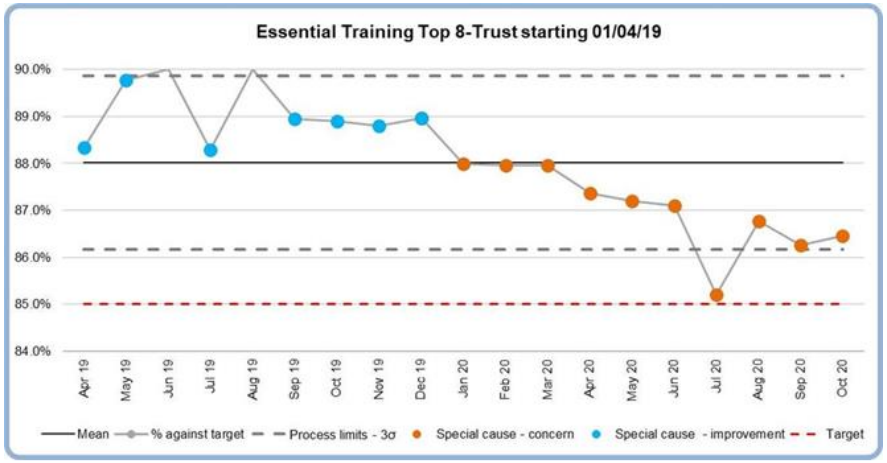
Turnover continues to improve across all staff groups. Registered nursing has seen some of the greatest ongoing improvement largely driven by band 5 nursing. 137 wte band 5 nurses left between April and October 19/20, 84 wte have left in the same period this year.

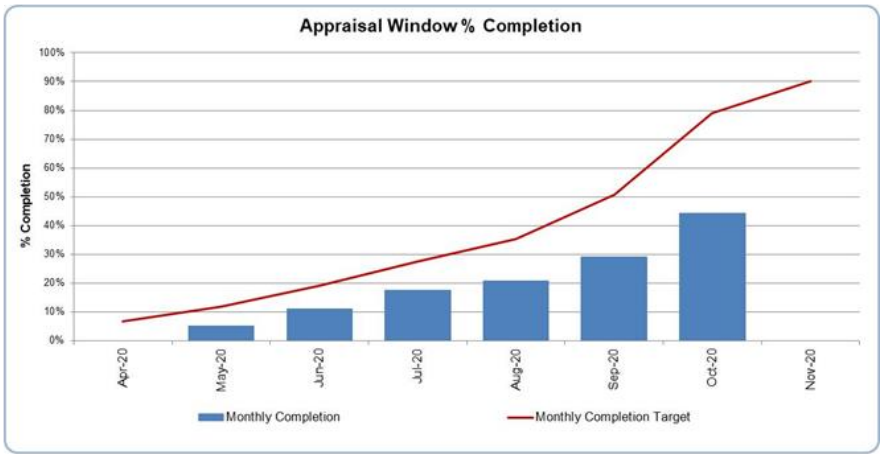
Sickness and Health and Wellbeing

Initial data analysis earlier this year identified that the increase has been driven by long-term sickness. A deep dive into long-term sickness causes and drivers which was paused due to COVID-19 has now taken place with actions agreed at the People and Digital committee on 20/10/20.

Work undertaken to help improve sickness absence includes:

- Absence project in ASCR targeting absence hot spot areas
- Continued development of guidance and support for staff off sick with COVID-19 related sickness absence
- Incorporating COVID-19 health risk assessments into the new starter process to support safe working at NBT for everyone, in conjunction with Occupational Health
- Partnership working with the Psychology Team, People Team, Unions and People Partners to help understand better how to manage and support staff with high absence levels
- Introduction of a high level case review process for the ‘top 30’ LTS cases commencing later this month, to provide a ‘fresh pair of eyes’ and support to help determine the best way forward
- Work-related stress ‘bitesize’ toolkit being rolled out in November via LINK





Training Topic	Variance	Sep-20	Oct-20
Child Protection	-0.2%	86.0%	85.8%
Adult Protection	-0.1%	88.3%	88.2%
Equality & Diversity	0.5%	90.6%	91.1%
Fire Safety	0.2%	85.7%	85.9%
Health &Safety	-0.3%	89.6%	89.3%
Infection Control	0.2%	91.2%	91.4%
Information Governance	0.2%	81.5%	81.7%
Manual Handling	0.9%	76.3%	77.2%
Waste	0.3%	87.2%	87.6%
Total	**0.2%**	**86.26%**	**86.45%**

Appraisal

Messaging around non-medical appraisal is continuing and numbers are steadily increasing. Appraisal training has recommenced and appraisal resources on LINK are receiving a large volume of 'hits'.

Essential Training

No statistically significant change in compliance with the top eight essential training requirements. Wherever feasible, content continues to be made available online through MLE (Managed Learning Environment). Supply of places on practical classroom based sessions continues to be limited by social distancing requirements. Some clinically trained staff are being released for operational duties.

Leadership & Management Development

To maximise resource availability for operational duties, all non-essential learning events (online and practical) have been postponed until after February 2021. Although content directly related to staff wellbeing or use of eRostering will continue to be made available. Activities focused on getting Band 2 and 3 healthcare assistants qualified will also be prioritised in order to support Trust resourcing requirements.

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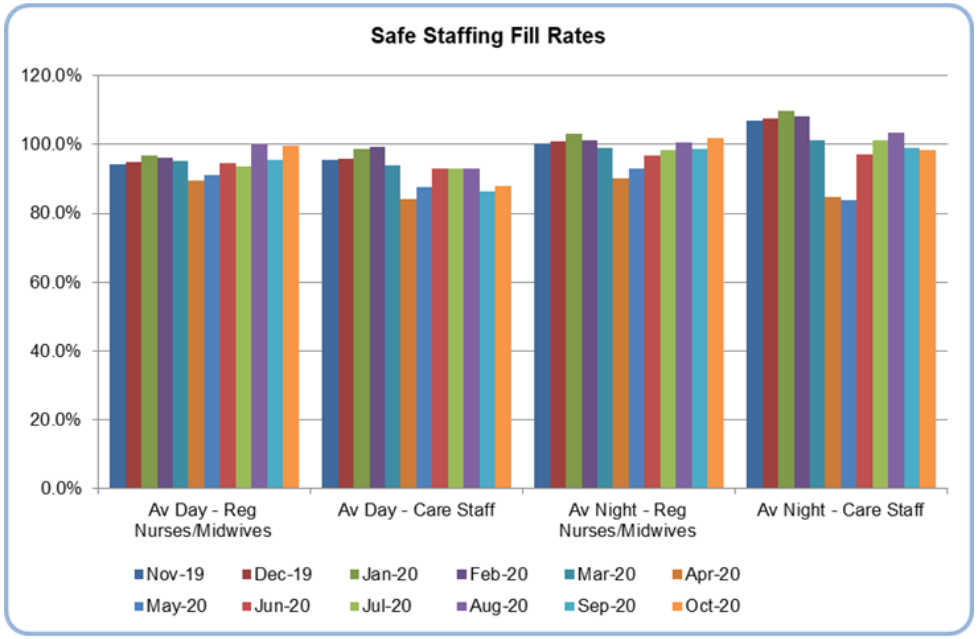


Oct-20	Day shift		Night Shift	
	RN/RM	CA Fill	RN/RM	CA Fill
Southmead	99.7%	87.9%	101.9%	98.4%

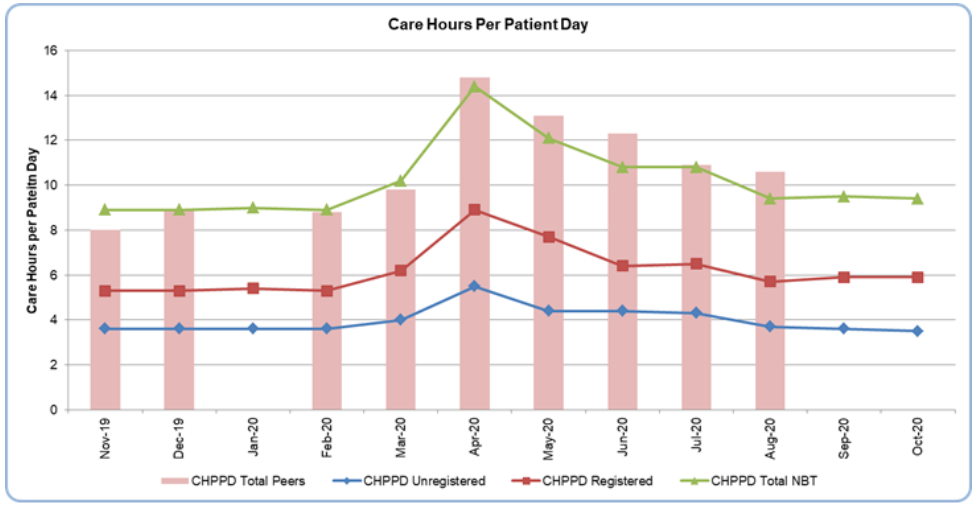
The numbers of hours Registered Nurses (RN) / Registered Midwives (RM) and Care Assistants (CA), planned and actual, on both day and night shifts are collated. CHPPD for Southmead Hospital includes ICU, NICU and the Birth Suite where 1:1 care is required. This data is uploaded on UNIFY for NHS Choices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

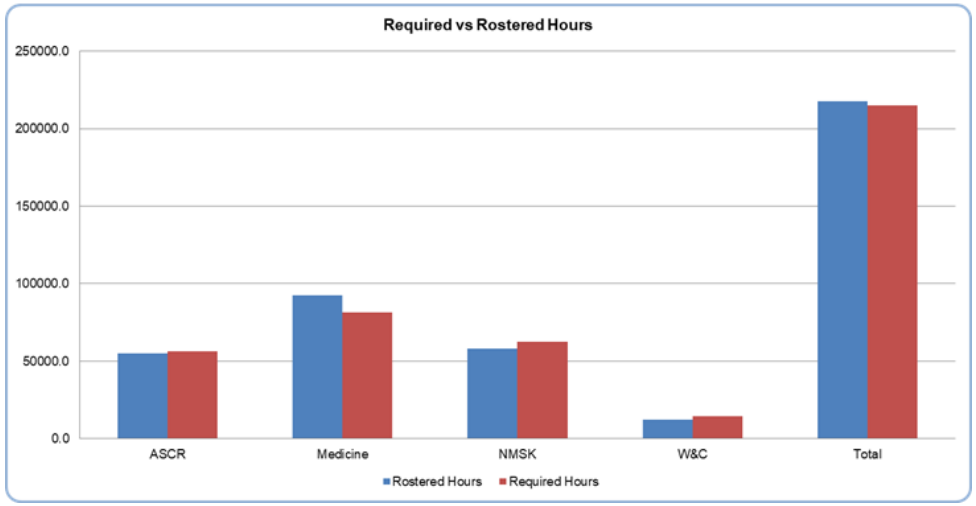
The safe staffing report now requires the wards to identify Nursing Associates including Trainees and AHP staff employed in an inpatient area. There are however ongoing issues with the reporting and this has been escalated to Allocate the roster provider. We will be back reporting as soon as it is possible.
The organisation's overall occupancy remains reduced and the elective activity programme is in restoration phase with reduced elective care beds available. Elgar 1 & 2 staff was merged manually as this one team is providing patient care in the open Elgar ward. The other ward remains closed and the staff redeployed as in previous months.

Wards below 80% fill rate for Registered Staff:
7A (76.5% Days 73.3% Nights) This is a green ward which is running below full occupancy so planned staffing has been reduced accord to the dependency on the ward on a daily basis.
Cotswold Ward (65.7% Days) : Reduced number of beds open and staffing reduced accordingly to match capacity and patient acuity.

Wards below 80% fill rate for Care Staff:
Cotswold Ward: The is no change to the current plan for Cotswold Ward with no Care Assistants planned in staffing numbers
AMU: (75.3% Nights) Planned reduction due to change in dependency with the AFU direct admissions. Template change expected
ICU (22.5% days 37.1% nights) Unregistered staff vacancies
8b: (62.4 days) Unregistered staff vacancies
7A (68.7%% Days) This is a green ward which is running below full occupancy so planned staffing has been reduced accord to the dependency on the ward on a daily basis.
NICU (73.9% Days 69.2% Nights) Unregistered staff vacant shifts, safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required.
9A: (79.8% Days) Unregistered staff vacancies
Quantock (72% Night) Unregistered staff vacancies Registered staff allocated to support.

Wards over 150% fill rate:
6b (181.1% night) additional patients requiring enhanced care support with RMN and colocation of tracheostomy patients into this area.
25b (158.1% Nights) additional patients requiring enhanced care support
Rosa Burden (150% Day 152% Nights) additional patients requiring enhanced care support





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).

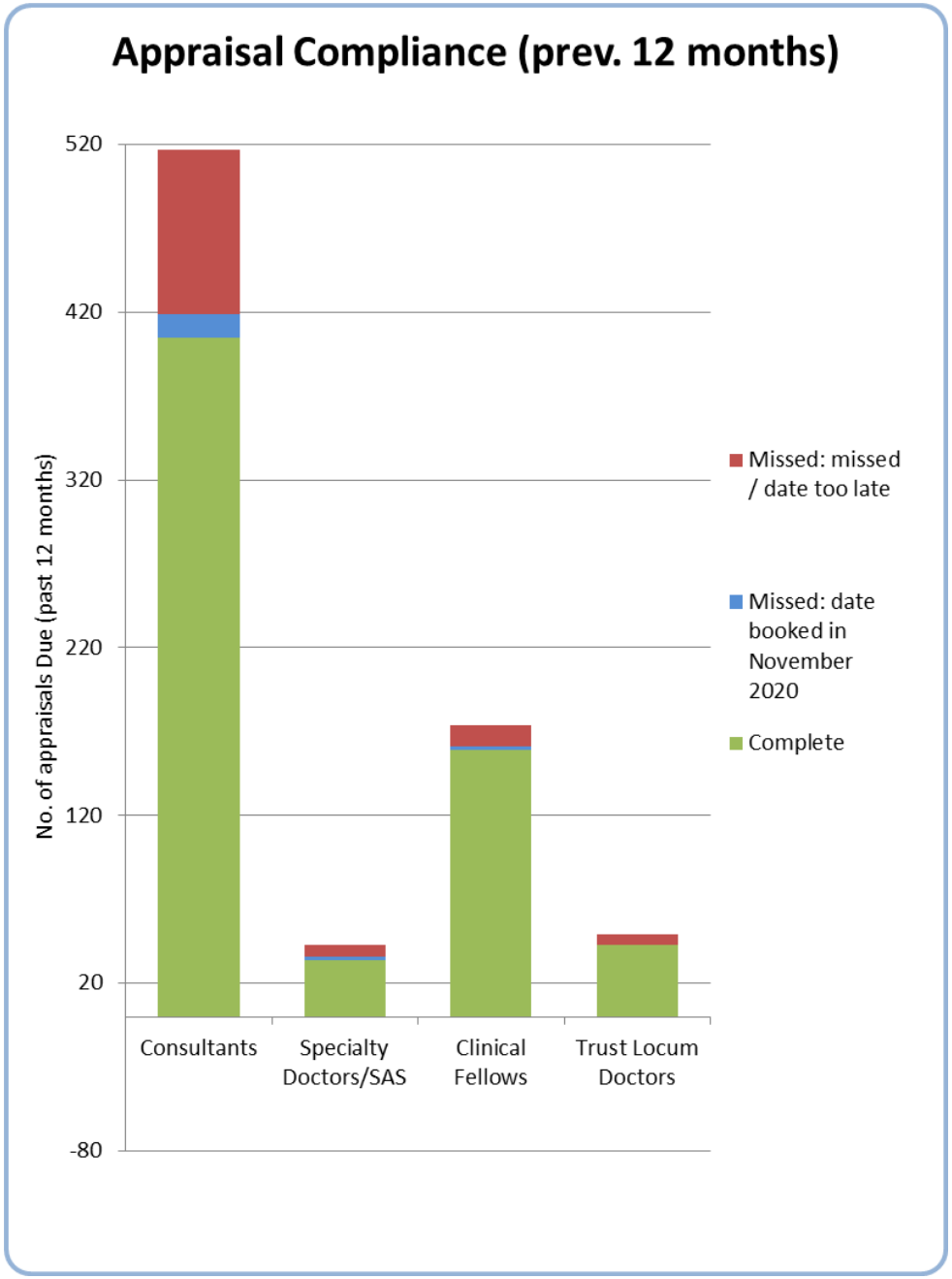
CHPPD are consistent with last month, rostered hours overall are above the required hours due to the decreased patient census and reduced lists.

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

In March 2020 the appraisal process was suspended by NHSE due to COVID-19. The process resumed in June 2020. NHSE have stated that appraisals suspended during this period should be considered cancelled and not postponed. This applied to 109 appraisals, (included as complete appraisals in this data). The revalidation team have advised all doctors that appraisals can now take a 'light touch' approach to appraisal preparation. This means that appraisal portfolios can contain reduced evidence of CPD, QIA and written reflection. These will now be captured in the appraisal discussion and the focus of the appraisal will be on wellbeing and personal development.

On the 17th March 2020 all revalidations due prior to the end of September 2020 were automatically deferred for 12 months by the GMC due to COVID-19. In June 2020 the GMC automatically deferred all remaining revalidations due prior to the 16th March 2021 for 12 months. The next revalidations due at NBT will be in March 2021. Due to these automatic deferrals, the number of revalidations due in 2021/22 has increased significantly. Where possible, the revalidation team will be making revalidation recommendations for those doctors who were automatically deferred in order to reduce the burden in 2021/22.

Finance

Board Sponsor: Director of Finance
Catherine Phillips

Year to Date Position at 31st October 2020

2020/21 I&E	Position as at 31 October 2020				
£m	Apr - Sep Actual	Oct Actual	YTD Actual	Oct Forecast	V Forecast
Contract Income	273.3	52.4	**325.6**	52.6	-0.3
Other Income	83	5.4	**88.4**	4.4	1.1
Total Income	**356.3**	**57.8**	**414.1**	**57**	**0.8**
Pay	-205.3	-34.7	**-240**	-35.1	0.4
Non-Pay	-115.3	-18.8	**-134.1**	-17.6	-1.2
Financing	-35.7	-5.6	**-41.3**	-5.8	0.2
Total Expenditure	**-356.3**	**-59.1**	**-415.4**	**-58.5**	**-0.6**
Surplus/ (Deficit)	**0.0**	**-1.3**	**-1.3**	**-1.5**	**0.2**

Statement of Comprehensive Income

Assurances

The financial position at the end of October shows a year to date deficit of £1.3m compared to a forecast of £1.5m

The trust achieved breakeven in months 1 to 6 under the cost recovery regime implemented to support service delivery under COVID-19 and a deficit of £1.3m when operating within the new financial envelope.

Income for the month includes a retrospective claim of £0.6m for Nightingale Hospital running costs.

There are no further key issues to report.

Balance Sheet (£m)	Mar-20	Sep-20	Oct-20	In-month change	YTD change
Property plant and equipment (PFI)	367.4	363.3	362.6	-0.7	-4.8
Property plant and equipment (non-PFI)	192.6	198.0	199.5	1.5	6.9
Intangible Assets	12.0	10.8	10.6	-0.2	-1.4
Non-current debtors	4.0	4.0	4.0	0.0	0.0
Total non-current assets	**576.0**	**576.1**	**576.7**	**0.6**	**0.7**
Inventory	13.1	12.3	12.2	-0.1	-0.9
NHS debtors	50.5	34.1	28.7	-5.3	-21.7
Non NHS Debtors and Prepayments	22.1	30.5	32.9	2.5	10.8
Cash and cash equivalents	10.7	90.2	92.7	2.6	82.0
Total current assets	**96.4**	**167.0**	**166.7**	**-0.3**	**70.2**
NHS creditors	-11.1	-10.1	-10.9	-0.8	0.2
Non NHS Creditors and Accruals < 1 year	-61.3	-137.3	-137.1	0.2	-75.8
Loans and Finance lease commitments < 1 year	-189.0	-17.4	-17.6	-0.2	171.4
Total current liabilities	**-261.4**	**-164.8**	**-165.5**	**-0.7**	**95.9**
Provisions and deferred income	-7.2	-6.4	-6.5	-0.1	0.7
PFI liability	-377.8	-372.9	-372.2	0.7	5.6
Loans and Finance lease commitments > 1 year	-10.7	-4.8	-6.2	-1.4	4.5
Total non-current liabilities	**-395.7**	**-384.1**	**-384.9**	**-0.8**	**10.8**
Total net assets	**15.3**	**194.1**	**192.9**	**-1.2**	**177.6**
Public Dividend Capital	248.5	427.5	427.5	0.0	178.9
Revaluation reserve	149.1	150.2	150.2	0.0	1.0
In-year Income and Expenditure	-3.8	-0.2	-1.4	-1.2	2.4
Retained earnings	-378.5	-383.4	-383.4	0.0	-4.8
Total net assets	**15.3**	**194.1**	**192.9**	**-1.2**	**177.6**

Statement of Financial Position

Assurances

DHSC loans of £178.5m were replaced by PDC during September which created a significant change on the balance sheet when it was transacted. The improved cash position of £92.7m (£82.0m up since March) is a result of the current financial regime of advance payment arrangements presently in place for all NHS Trusts.

Key Issues

The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for the year to date in 2020/21 of 89.4% by value compared to an average of 85.8% for 2019/20.

Financial Risk Ratings , Capital Expenditure and Cash Forecast

Capital expenditure for the first 7 months of the year is £15.5m which compares to a year to date plan of £14.2m.

Financial Risk Rating

The new financial framework means that a Financial risk rating is no longer calculated or reported to NHSI.

Rolling Cash forecast

The high level cashflow below is in line with NBT's element of the forecast submitted to NHSI on 22nd October. This shows that the Trust has will end the year with a circa. £34m cash balance after the unwinding of the month in hand advance payment in March 2021.

£m	Nov-20 (Forecast)	Dec-20 (Forecast)	Jan-21 (Forecast)	Feb-21 (Forecast)	Mar-21 (Forecast)
Cash brought forward	**92.7**	**108.2**	**102.6**	**96.1**	**93.0**
Total I&E cash flows	-3.8	-0.9	-1.9	-1.8	-3.8
Total Other cash flows	19.3	-4.7	-4.6	-1.3	-55.3
Total in-month cash movement	**15.5**	**-5.6**	**-6.5**	**-3.1**	**-59.1**
Cumulative cash balance	**108.2**	**102.6**	**96.1**	**93.0**	**33.9**

Regulatory

Board Sponsor: Chief Executive
Andrea Young

Monitor Provider Licence Compliance Statements at October 2020
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 on all Executive Directors and no issues have been identified.
G5	Having regard to monitor Guidance	Yes	The Trust Board has regard to NHS Improvement guidance where this is applicable.
G7	Registration with the Care Quality Commission	Yes	CQC registration in place. The Trust received a rating of Good from its inspection reported in September 2019. A number of mandatory actions were identified which are being addressed through an action plan. The Trust will receive updates on these actions via its Quality and Risk Management Committee.
G8	Patient eligibility and selection criteria	Yes	Trust Board has considered the assurances in place and considers them sufficient.
P1	Recording of information	Yes	A range of measures and controls are in place to provide internal assurance on data quality. Further developments to pull this together into an overall assurance framework are planned through strengthened Information Governance Assurance Group.
P2	Provision of information	Yes	The trust submits information to NHS Improvement as required.
P3	Assurance report on submissions to Monitor	Yes	Scrutiny and oversight of assurance reports to regulators is provided by Trust's Audit Committee and other Committee structures.
P4	Compliance with the National Tariff	Yes	NBT complies with national tariff prices. Scrutiny by CCGs, NHS England and NHS Improvement provides external assurance that tariff is being applied correctly. It should be noted that NBT is currently receiving income via a block arrangement in line with national COVID-19 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 COVID-19 financial arrangements.
C1	The right of patients to make choices	Yes	Trust Board has considered the assurances in place and considers them sufficient. It should be noted that the Trust is currently implementing national COVID-19 restoration guidance which involves staged standing back up elements of activity previously reduced as part of the COVID-19 operational response.
C2	Competition oversight	Yes	Trust Board has considered the assurances in place and considers them sufficient.
IC1	Provision of integrated care	Yes	Range of engagement internally and externally. No indication of any actions being taken detrimental to care integration for the delivery of Licence objectives.

Appendix 1: Glossary of Terms

Unless noted on each graph, all data shown is for period up to, and including, 31 October 2020.

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

Target lines

Improvement trajectories

National Performance

Upper Quartile

Lower Quartile

NBT Quality Priorities 2020/21

QP1 Enhance the experience of patients with Learning Disabilities and / or Autism by making reasonable adjustments which are personal to the individual

QP2 Being outstanding for safety – at the forefront nationally of implementing the NHS Patient Safety Strategy within a 'just' safety culture.

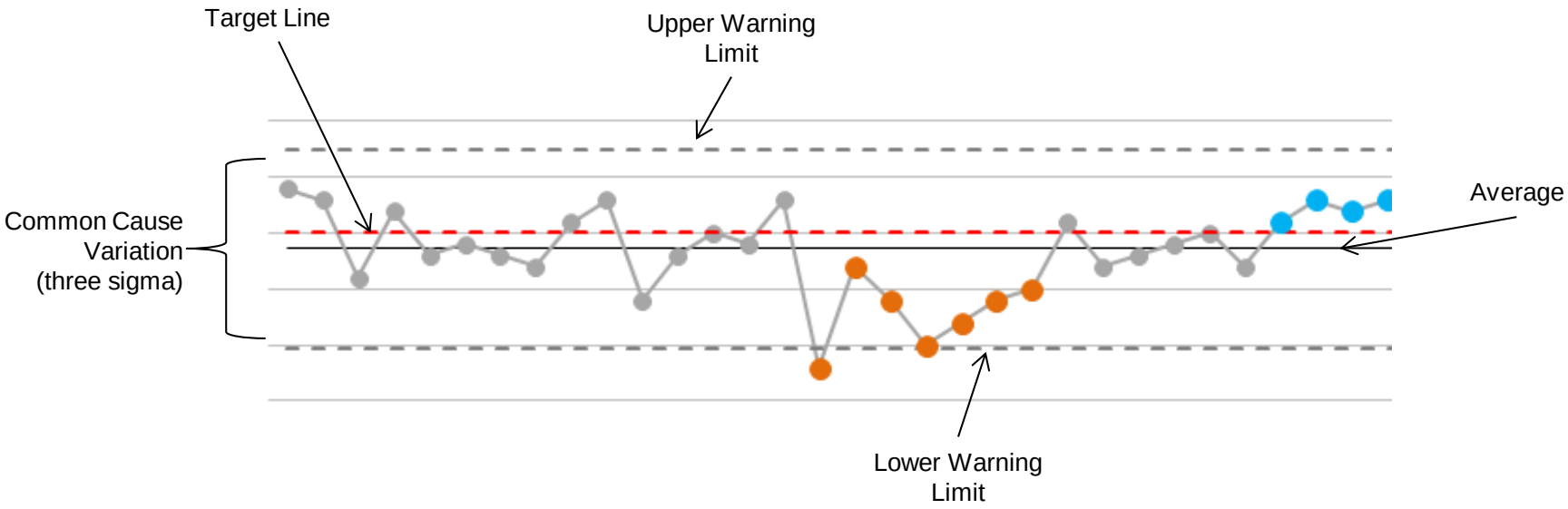
QP3 Ensuring excellence in our maternity services, delivering safer maternity care.

QP4 Ensuring excellence in Infection Prevention and Control to support delivery of safe care across all clinical services

Abbreviation Glossary

AMTC	Adult Major Trauma Centre
ASCR	Anaesthetics, Surgery, Critical Care and Renal
ASI	Appointment Slot Issue
CCS	Core Clinical Services
CEO	Chief Executive
Clin Gov	Clinical Governance
CT	Computerised Tomography
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
RAP	Remedial Action Plan
RAS	Referral Assessment Service
RCA	Root Cause Analysis
SI	Serious Incident
TWW	Two Week Wait
WCH	Women and Children's Health
WTE	Whole Time Equivalent

Appendix 2: Statistical Process Charts (SPC) Guidance



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

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

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

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

Report To:	Trust Board		
Date of Meeting:	26 November 2020		
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		**X**
Recommendation:	The Trust Board is recommended to receive the report for assurance and to: • Note the Learning Disability & Autism Annual Report (Appendix 1); • Ratify proposed amendments to the Terms of Reference (Appendix 2);		
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 January 2021 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 18 November 2020.	
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:	*Appendix 1 – Learning Disability & Autism Annual Report* *Appendix 2 – Amended Terms of Reference*

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 18 November 2020.

2. Background

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

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

3. Key Assurances & items discussed

3.1 Patient story:

The Committee heard, via pre-recorded video, about a gentleman with learning disabilities who received a late diagnosis of cancer and then sadly died. The patient's family had been very appreciative of the care he had received from the Trust and the

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

Committee noted that planning for his care had involved good communication between the Trust, his family, the community healthcare team and the staff at the care home at which the patient was resident.

Key learning points had included the need to increase awareness amongst clinicians that people with learning disabilities and autism might present differently with clinical symptoms and that this awareness should lead to appropriate decisions on care and intervention being made at the earliest opportunity. In addition, the Committee heard that people with learning disabilities and autism generally live healthy and active lives and it is therefore also important that clinicians are mindful in planning care that staff in these settings may not have the same levels of nursing skills as those who work in a care home setting for older people.

3.2 Learning Disability & Autism Annual Report

The Committee welcomed the Learning Disability & Autism Annual Report (Appendix 1) and noted that whilst the progress set out in the Report was very positive there is some further work for the Trust to do, including around consideration of reasonable adjustments, and in developing knowledge and behaviours of Trust staff.

3.3 Communication Projects Update

An update was received on two patient experience communications projects:

- Enabling virtual visits for patients and their loved ones and seeking to establish a sustainable service.
- Further developing and embedding clinical communication – providing proactive updates on the patient clinical condition to families when visiting is not possible.

The Committee heard that both projects are progressing well and agreed the importance of establishing universality of access to virtual visits for patients across the Trust. The Committee were also assured that unlike in the first wave of Covid-19, the Trust's visiting arrangements now include provision for face to face visits for patients who are at the end of life, or who lack capacity.

3.4 Non-Emergency Patient Transport

The Committee received an update on non-emergency patient transport and noted that the transport contract is held by the CCG. A survey has been drafted based on reported patient experience, and options for delivery, analysis and reporting are currently being explored with the Renal Dialysis and Facilities teams; timelines will be confirmed later this month.

3.5 Patient Experience Risk Report

A report was provided on Patient Experience Trust Level Risks, with no new risks being identified requiring the Trust Board's attention.

3.6 Patient Experience Committee Terms of Reference

The Committee approved minor amendments to the Terms of Reference had been discussed and agreed at the September 20 meeting (Appendix 2). Trust Board is asked to ratify these amendments.

This document could be made public under the Freedom of Information Act 2000.
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3.7 Additional updates received on:

- Patient Experience Group report
- IPR – Quality section

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:

- Note the Learning Disability & Autism Annual Report (Appendix 1);
- Ratify proposed amendments to the Terms of Reference (Appendix 2).

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North Bristol NHS Trust

Learning Disability and Autism Annual Report:

September 2019 – August 2020

North Bristol NHS Trust (NBT) Learning Disability and Autism Vision

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

Executive Summary

One NBTs quality priorities for 2019/20 was to improve the care of people of all ages with a learning disability, autism or both who attend the trust for care and treatment. The Learning Disability and Autism Steering Group was established April 2019 and reports to the board via the patient and carer experience committee.

This annual report covers the priorities set out in the strategic plan for year one, our achievements and learning throughout the course of the year. The challenge of Covid 19 resulted in a successful bid to increase the liaison service to a wider 7 day service including Autism.

Workshops to review the year and set priorities for 2020/21 were delivered face to face and virtual, working with the Quality and Safety Improvement team using co-production.

Introduction

The Trusts Learning Disability and Autism strategic plan sets out our vision and objectives over a 3 year period. The plan was confirmed using co-production involving steering group members, champions and carers and was signed off by the Trust Board January 2020. The Director of Nursing and Quality leads this work and chairs the Learning Disability and Autism Steering Group. The strategic plan and vision sets out to improve the quality of care for patients with learning disability or autism whilst supporting staff to deliver person-centred care. The steering group provides governance and leadership for the programme of work and is represented by all divisions and professional groups.

The first year of the North Bristol NHS Trust learning Disability and Autism Plan has been a success. Our staff have fully embraced the plan

and sought to go further and deliver more, and supported our work to implement the plan. We now have over 100 champions from a wide range of roles and grades. Our champions received regular workshops and communication from the liaison team and development and have been key to improvements in care.

The liaison team, employed by Sirona, have also risen to the increase in demand, the team has doubled in size to meet the needs of our patients during the Covid pandemic, and now provide a 7 day service over longer working hours, including patients with Autism and no longer restricting the service to those only eligible to the Community Learning Disability Teams. During the last 12 months we have submitted further data including patient and staff surveys to NHS benchmarking, BNSSG has published its LeDeR annual report, the national LeDeR programme has published its 2019 report, and we have responded to x1 MAR (Multi Agency Review).

We have participated in the AHSN (academic health science network) workshops and presented at the regional health science network.

Achievements

During the pandemic every patient was reviewed every day. This ensured families and carers were kept informed, clinical teams had advice and guidance and patients individual needs were met. This was especially important when there was no or very little visiting, and for patients with behaviours that challenge.

Following rapid reviews of four Covid deaths it became apparent that the liaison team was not always informed of patient's admissions. Business Intelligence now send out a daily list of all patients with a flag on Lorenzo, and the team document care needs on Careflow connect, Flow and contemporaneously in the medical records. A pilot is being trialed where a summary of care needs is written on yellow paper as an initial assessment, and a sticker is added to the notes each time the patient is reviewed by the team. This provides more visibility of recommendations and reasonable adjustments required.

The team has continued to embrace change and develop organisational learning. A wide range of resources are now available on the website, and these resources will also be provided in a yellow box file for every ward and clinical area. Champions will keep the file up to date. The resource box includes communication books, MCA and best interest's paper work.

The team have received training from Bristol Autism Specialist Service (BASS) and also invited NBTs Mental Health Liaison team to join this training.

BNSSG Programme Board received the following update on the results of our increase service:

ACHIEVEMENTS (phase 1)

Sirona liaison service increased at North Bristol to provide a lead post, enable 7/7 working and the inclusion of Autism-only patients

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Supported staff with MCA and best interest decisions, making reasonable adjustments / care for patients with learning disability, autism or both during isolation

Delivered COVID Hospital Passport page, implemented by NBT and Sirona & adopted BNSSG wide

PHASES 2&3

Continue support for clinical teams, alongside preparing for an increase in planned activity and outpatient support.

Proposal for Learning Disabilities Liaison Funding put forward as part of the Covid 19 response – Covid 19 funding approved for both BRI and Weston for a period of 4 months

At NBT the outcomes and accelerated learning will support the delivery of its 3 year Learning Disability and Autism plan

Funding has been extended and a bid is being submitted for ongoing Hospital Liaison funding via Sirona, across BNSSG.

First year priorities

The strategic plan for year one focused on:

- An improved training plan for learning Disability and Autism ✓
- Improved early recognition and treatment of deterioration, recognising soft signs of illness and the use of NEWS2. ✓
- Promote the language of reasonable adjustments, and provide tools to support staff caring for patients with learning disability and autism. ✓
  - Reasonable adjustments toolkit
  - Reasonable adjustments checklist
- Improving written communication with patients by improving our library of accessible information and using video on our website. ✓
  - Website and resource box

We also successfully registered our changing places toilet and encourage its use. ✓

Further work is needed to:
Develop forums for people with learning disability or autism to quality assess our services using experience based design for improvement.
Early plans are in place for HUG group (Hospital user group).

Review how we manage people with Profound and Multiple Learning Difficulties (PMLD) and people with learning disabilities and autism who also have long term conditions.

In summary we have:

- Increased the liaison team to include weekend working, lowered eligibility for service, included autism
- Developed Covid ways of working, Covid passport adopted across BNSSG and Following Rapid Reviews of Covid deaths

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improved notification to Liaison team with BI daily report

- Established communication with clinical teams using all electronic forms (care flow and flow)
- Delivered quality improvement projects – record keeping for liaison team (stickers in notes) and reasonable adjustments resource file website and hard copy.
- Received support form Southmead hospital Charity to purchase sensory equipment and make up our own calm bags to suit individual patients

- Established Positive Behaviour Management Group – multi professional membership
- Started work on Transitions seeking to support patients coming from Children's Hospital, Lifetime, Jesse May and Children's Hospice South West
- Developing a Pathway from Pre-op to Medirooms & Theatres with Anaesthetists
- Completing a Pathway/Careplan, for Patients who refuse Fluid and lack capacity.
- Input into NBT Continence Group – Poo Matters campaign, and also obtaining Urine samples
- LD & Autism Champions – 100+, Quarterly training sessions & 1 day masterclasses planned (revised due to Covid)
- Tailored Training for Learning Disability Team /ED Staff & Mental Health Liaison team from Bristol Autism Service (BASS) & Liaising with Plymouth Autism Service (Derriford) re their Autism Team
- NBT has signed up to Hidden Disabilities, the launch includes awareness raising and organisational sign up.

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Preparing for year 2

In order to refresh our priorities two workshops were held, one face to face and one virtual with the support of the Quality and Safety Improvement Team QSIT. Participants were updated on plan, our work so far and reviewed our priorities as well as BNSSG LeDeR priorities and recommendations from the August 2020 National LeDeR report.

Virtual workshop 'today I pledge to'…

Additional considerations from National LeDeR:

The National LeDeR report includes, to make MCA / Best interests more person centred, Improve aspiration pneumonia care, better training about epilepsy and review medication including sodium valproate prescriptions, better recognition and prevention of DVT, improve communication and transition for 16-24 year olds. There is also a recommendation to consider introducing specialist physician for people with learning disability, this is included in our plan beyond year 2 and comes from the NHSE standards for acute Trusts, this role would benefit the delivery of our quality improvement work.

Additions from BNSSG LeDeR:

Continue our pathway work on Poo Matters and food and fluids, continue to improve communication with GPs and making reasonable adjustments work.

NBT plan beyond year 2 includes:

Sensory / safe space and quiet hour in CT / XRay

1-2 PAs to provide leadership for clinical teams and support quality improvement

Ongoing work using a QI (quality improvement) approach:

- A bespoke training plan, now a different requirement post Covid
- A library of easy read resources
- Continue to promote the language of reasonable adjustments

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Year 2 Plan

- Provide training and development for our champions, keep them engaged and help them to lead in their area
- Continue to develop support for patients with behaviours that challenge use of PBS and the behaviour forum
- Improve Autism knowledge and resources including Autism passport, reasonable adjustments request form and national autism training
- Update and revise our training plan
- Access expertise for epilepsy management and medication reviews
- Continue improvement pathways including Poo Matters, dysphagia, food and fluids, and the theatre pathway
- Set up a HUG group and actively use their feedback
- Plan an improvement approach for Profound and Multiple Learning Disabilities
- Improve the safety of the pathway for prospective parents
- Ongoing communication and reasonable adjustment support / improvement
- Support complex patients to access our services and reduce admissions
- Improve easy read resources

Continuing to Deliver our vision and plan

The Learning Disability and Autism Steering Group will continue to oversee the work of our strategic plan and will work to ensure outcomes and improvements are visible and shared across BNSSG, working together with Hospital Liaison and CLDTs.

."Thank you so much for coordinating plans for today. This has been an amazing example of inter-agency and MDT working at its very best.
I'm so pleased to hear her daughter will be so well supported when she's told the news…."
Consultant, Palliative Medicine

"We couldn't have done it without you. I really felt for R but didn't know how to help him; I was scared of doing the wrong thing. You really helped us to 'get it right' for this gentleman."
Staff Nurse, Emergency Department

Mum also reported that x has now read her medical notes, and has seen LD Team's recommendations, and was really pleased, as she felt like LD Team 'got her' and understood her, and felt like she had been listened to.

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Patient & Carer Experience Committee Terms of Reference

Date Approved and Adopted	
Frequency Review	Annual
Next Review	~~April~~ November 2020
Terms of Reference Drafting	Trust Secretary
Review	Patient Experience Committee
Approval and Adoption	Trust Board
Version Number	~~1~~2.0

1. Constitution

1.1. The Trust Board hereby resolves to establish a Committee to be known as the Patient Experience Committee.

1.2. The Committee is constituted as a standing committee of the Trust Board. Its constitution and terms of reference shall be as set out below; and will be subject to amendments approved by the Trust Board.

2. Authority

2.1 The Committee is authorised to seek information it requires from any employee of the Trust. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal or other independent professional advice and to secure the attendance of advisors with such expertise that it considers necessary.

2.2 The Committee is authorised by the Board to make decisions within its terms of reference, including matters specifically referred to it by the Board.

3. Membership

3.1. The Committee shall comprise:

- Three Non-Executive Directors one of whom will chair the Committee.
- The Director of Nursing and Quality
- Deputy Medical Director
- ~~Director of Facilities~~
- ~~Director of People and Transformation~~
- Two Lay members

3.2. In the absence of the appointed Committee Chair, another Non-Executive Director will chair the meeting.

4. Attendance at Meetings

4.1. The following officers (or their nominated alternates, where appropriate) are required to attend all meetings but are not members:

- Director of Corporate Governance/Trust Secretary
- Head of Patient Experience
- Head of Equality , Diversity and Inclusion

4.2. The Committee can request the attendance of any other director or senior manager if an agenda item requires it.

4.3. Attendance at meetings is essential. In exceptional circumstances when an Executive Director member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf.

5. Quorum

The quorum necessary for the transaction of business shall be ~~three~~ two members of whom ~~two~~ one must be a Non-Executive Director~~s~~ and one an Executive Director or nominated deputy.

6. Frequency of Meetings and Conduct

6.1. The Committee will meet bi-monthly and will be set in advance as part of the planning of the Trust Board and Committee meetings annual calendar of business.

6.2. Further meetings can be called at the request of the Committee Chair.

6.3. An agenda of items to be discussed and supporting papers will be forwarded to each member of the Committee and any other person required to attend, no later than five working days before the date of the meeting.

6.4. Decisions may be taken by written resolution upon the agreement of the majority of members of the Committee in attendance, subject to the rules on quorum.

7. Responsibilities

The purpose of the Committee is 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.

7.1. ***Strategy & Policy***

The Committee will ensure that an effective patient experience strategy is developed, delivered and embedded across the Trust.

7.2. ***Implementation***

The Committee will:

- Ensure a trust-wide approach to patient experience is maintained which continually reviews intelligence and drives outcome based improvements;
- Work with the Patient Experience Group to identify areas of concerns and celebrate best practice;
- Ensure the Trust is sourcing inclusive feedback from all groups which are representative of the local population;
- Ensure the Trust has a patient engagement programme which also includes interaction with patient support groups and encourages involvement in the redesign of services.

7.3. ***Performance Monitoring***

The Committee will:

- Review performance and associated outcomes against patient experience metrics and targets and ensure that action is taken to address issues arising.
- Identify good patient experience and ensure that this is shared throughout the Trust.
- Review examples of learning which have resulted from patient feedback
- Ensure that poor patient experience is understood and challenged effectively, resulting in plans to address it.

7.4. ***Review and Compliance***

The Committee will:

- Have overview of the work of the Patient Experience Group and its sub-groups, and will receive regular reports from that group setting out the business it has undertaken, decisions made and performance against that group's objectives.
- Receive and analyse patient, relative and carer feedback on services provided by the Trust;
- Review and identify issues/themes resulting from PALS, complaints, social media and all forms of patient feedback and associated improvement actions;
- Review results of all national patient surveys and ensure that appropriate action plans are developed and implemented to deliver effective outcomes. Compare and correlate with local surveys;
- Review and compare results of staff surveys to patient survey and adverse event data; support the process for joint improvements;
- Review information received from external sources such as Patient Opinion/NHS Choices, Healthwatch and ensure it is considered alongside other date to contribute to patient experience improvement activity.
- Review national guidance, initiatives and reports relating to patient experience; propose action in response.
- Review and monitor CQC Compliance Assessments relating to areas of patient experience

7.5. ***Risk Management***

The Committee will review risks to providing a high standard of patient experience and seek assurance that appropriate action is being taken to mitigate.

8. Reporting

8.1. Formal minutes of Committee meetings will be recorded.

8.2. Full minutes will be sent in confidence to all members of the Committee and shall be made available on request to NHS Improvement and the Trust's internal and external auditors.

8.3. The Committee shall report to the Trust Board on its proceedings after each meeting to provide assurance and to escalate issues as appropriate.

8.4. The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these terms of reference.

9. Monitoring and Effectiveness

9.1. The Committee shall have access to sufficient resources to carry out its duties, including access to company secretarial assistance as required.

9.2. It shall be provided with appropriate and timely training, both in the form of an induction programme for new members and an on-going basis for all members.

9.3. It will review its own performance, at least annually, review its constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

10. Administrative Support

10.1. Meetings will be supported by the Trust Secretary's office including:

- Minute taking.
- Keeping a record of matters arising and issues to be carried forward within an action log.
- Collation and distribution of papers

10.2. Head of Patient Experience has the following duties:

- Agreement of agendas with the Chair and Members.
- Advising the Committee on pertinent issues/areas.
- Provision of a highlight report of the key business undertaken to the Trust Board following each meeting.

Report To:	Trust Board		
Date of Meeting:	26 November 2020		
Report Title:	Quality & Risk Management Committee Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary/ Isobel Clements, Corporate Governance Officer		
Executive/Non-executive Sponsor (presenting)	John Iredale, Non-Executive Director and Chair of QRMC		
Purpose:	**Approval/Decision**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board should receive the report for assurance and note the activities QRMC has undertaken on behalf of the Board, in particular: • "Safe to Wait" - RTT, Diagnostics and Cancer Pathways; • Covid-19 wave 2 • Pandemic mortality reviews		
Report History:	The report is a standing item to the Trust Board following each Committee meeting.		
Next Steps:	The next report will be received at the Trust Board in January 2021.		

Executive Summary
The report provides a summary of the assurances received and items discussed and debated at the Quality and Risk Management Committee (QRMC) meeting held on 19 November 2020.

Strategic Theme/Corporate Objective Links	• Be one of the safest trusts in the UK • Treat patients as partners in their care
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 Standard Reference	CQC Standards.

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

Financial implications	No financial implications identified in the report.
Other Resource Implications	No other resource implications identified.
Legal Implications including Equality, Diversity and Inclusion Assessment	None identified.
Appendices:	None.

1. Purpose

To provide a highlight of the key assurances received, items discussed, and items for the attention of Trust Board from the QRMC meetings held on 19 November 2020.

2. Background

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

3. Meeting on 19 November 2020

3.1 Hospital Pharmacy Transformation Programme (Annual Update)

The Committee received the annual update on the above transformation programme, which was approved by NHS Improvement in March 2017. The Committee was assured that Pharmacy was making good progress on delivering against the agreed project plan.

3.2 "Safe to Wait" – RTT, Diagnostics and Cancer Pathways

The Committee received a presentation from the Chief Operating Officer on the processes used within the Trust to review RTT, diagnostic and cancer patients who have waited an extended time, to determine if they are suffering clinical harm whilst waiting.

The Trust has sought the views of regional regulatory colleagues, who support the Trust's approach and is assisting in exploring whether a regional approach to the issue can be agreed, which maximises the use of limited clinical resources.

The Committee welcomed the detailed report and the insight into the Trust's approach, which was supported. It was agreed that a further update would be brought to the Committee in March.

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

3.3 Women & Children's Health Update

The Committee received an update on the Trust's involvement in the CNST Maternity Incentive Scheme, and reviewed the data supporting the Trust's compliance/achievement with the safety action requirements. The Trust is currently confident of achieving 8 of the 10 actions, with remedial actions identified for the remaining two. Submission of our compliance has been deferred nationally until May 2021.

The 2019/20 Maternity and Neonatal Services Annual Quality Governance Report was also presented to the Committee together with the Safeguarding Governance Process for Women & Children's Health.

3.4 Preventing Pressure Injuries

The Committee received an evidence based review of the work being undertaken in the prevention of pressure injuries. The report was felt to be very useful in identifying areas of good practice and where additional focus is required. It was felt that the findings could now be used to inform some cultural improvement work to progress further improvements.

3.5 Covid-19 Wave 2 Update

The Chief Operating Officer gave an update on the operational position within the hospital, and the pressure caused by increasing Covid-19 admissions and outbreaks within the hospital. The Committee were advised that P3 and P4 surgical activity was being cancelled, but that cancer and urgent activity was being prioritised.

The Committee requested additional detail on the outbreaks within the organisation, which was provided by the Medical Director. He confirmed that the number of new cases of nosocomial infection were reducing, suggesting that the actions being taken were now having an effect.

3.6 CQC Assurance Programme

The Committee received an update on the CQC assurance programme, including a number of mock inspection outcomes in 3 key areas where "must do" actions were identified via the last CQC inspection. Areas for improvement had been identified, and the Committee were assured that the process was robust.

3.7 Pandemic Mortality Reviews

The Committee received two reports regarding mortality: Pandemic Mortality Review update on action plan and Learning Disability thematic review. The former presented an update on learning from Covid-19 wave one. The Committee was reassured by the overall positive assurance of care quality provided during the initial pandemic period and the

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progress on actions taken in response of learning identified within the Pandemic Mortality review conducted on 30 cases in the first Covid-19 phase (and previously reported to QRMC in July 2020). Two actions were rated as amber due to being complex issues to resolve such as sitting externally rather than internally within the Trust.

The Committee approved the Learning Disability Thematic Review as the final report having been scrutinised at October's Clinical Effectiveness & Audit Committee (CEAC) meeting. The Committee were assured that the outcome of the review deemed that no changes to clinical care could have prevented the outcomes but that earlier engagement with the learning disability nursing team could be of benefit. From this, it was noted that the learning disability nursing team services had been extended and the Committee received details of this within the report.

3.8 Other items:

The Committee also received updates on:

- Women & Children's Health Update
- Quality Governance Improvement Programme
- Trust Level Risk and Nightingale Hospital Risk reports
- Board Assurance Framework risks.

4. Identification of new risk & items for escalation

No significant risks or issues were identified as requiring specific escalation to Trust Board.

5. Recommendations

The Trust Board should receive the report for assurance and note the activities QRMC has undertaken on behalf of the Board, in particular in-depth review of the current and next steps for:

- "Safe to Wait" - RTT, Diagnostics and Cancer Pathways;
- Covid-19 wave 2
- Pandemic mortality reviews

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Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.

Report To:	Trust Board Meeting			
Date of Meeting:	26 November 2020			
Report Title:	Audit Committee Report			
Report Author & Job Title	Kate Debley, Deputy Trust Secretary			
Executive/Non-executive Sponsor (presenting)	Richard Gaunt, Chair of Audit Committee, Non-executive Director			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
	X		**X**	
Recommendation:	The Trust Board is recommended to receive the report for assurance and: • Ratify proposed amendments to the revised Standing Orders and Standing Financial Instructions (Appendix 1). • Ratify the withdrawal of the Standards of Business Conduct. • Ratify the Covid-19 Appendix (Appendix 2).			
Report History:	The report is a standing item to each Trust Board meeting following an Audit Committee meeting.			
Next Steps:	The next report to Trust Board will be to its meeting in February 2021.			

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 12 November 2020.	
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 out 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 **4. An anchor in our community** a. Create a health & accessible environment b. Expand charitable support & network of volunteers c. Developing in a sustainable way
Board Assurance Framework/Trust Risk Register Links	None identified.
Other Standard Reference	Links to the CQC Well Led domain and key lines of enquiry.
Financial implications	None within this report.
Other Resource Implications	No other resource implications associated with this report.
Legal Implications including Equality, Diversity and Inclusion Assessment	None identified.
Appendices:	Appendix 1 – Revised Standing Orders and Standing Financial Instructions Appendix 2- Covid-19 Appendix

1. Purpose

To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Audit Committee meeting held on 12 November 2020.

2. Background

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

3. Meeting of 12 November 2020

3.1. External Audit Progress Report:
The Committee received a progress report from the external audit team. The Committee were assured that the Trust was working closely with the external audit team to consider any risks ahead of an interim audit and that there is a mutual aspiration to come out of that process with a clear set of agreements, or paths to agreement. It was noted that there had been a considerable amount of rotation in the external audit team over a 12 month period and that this presented a risk. However, the Committee was assured that any issues arising from lack of continuity were being actively managed by both the external audit and Trust finance teams.

3.2. Internal auditor update:
The Committee received a progress report and technical update from the internal audit team. It was noted that a number of senior leaders within the Trust had questioned whether there might be any flexibility in the audit programme due to exceptional pressures faced by staff as a result of Covid-19. The Committee agreed that an assessment should be undertaken of the reviews currently on the internal audit plan for the next 18 months to establish which are essential and which might be paused without excessive risk to the organisation.

3.3. The following internal audit reports were received and reviewed by the Committee:

- Nightingale Hospital Bristol Review
  The Committee received a positive report on the Nightingale Hospital Bristol with a rating of significant assurance with minor improvement opportunities.

3.4. Updates to Standing Orders, Standing Financial Instructions & Standards of Business Conduct:
An update was received following a review of the Trust's Standing Orders, Standing Financial Instructions & Standards of Business Conduct in light of the new Declarations of Interest policy and process, and wave 2 of the Covid-19 pandemic.

Proposed amendments were agreed to the Standing Orders in relation to declarations of interest (Appendix 1). It was further agreed that the Standards of Business Conduct Policy be withdrawn as it has been largely superseded by the Declarations of Interest Policy, and its remaining content has been incorporated into the Standing Orders. In addition, the Committee asked that all references to the Trust

Chair and Directors in the Standing Orders and Standing Financial Instructions be made gender neutral.

The Committee also agreed proposed amendments to the SO/SFIs which will allow the NBT command and control structure to work effectively during the response to the wave 2 Covid-19 pandemic (Appendix 2). The financial delegations to the command and control structure reflect those agreed at Trust Board in October 2020, and the streamlined procurement/STA process mirrors the arrangements that were in place during wave 1. This will remain in force until such time as Gold Command recommends any changes, or the delegated authority is withdrawn by Trust Board.

Trust Board is recommended to ratify the changes to the Standing Orders and Standing Financial Instructions as set out above, in conjunction with the withdrawal of the Standards of Business Conduct Policy.

3.5. Single Tender Actions:
The Committee received an update on Single Tender Actions (STAs) and there was a wide-ranging discussion about the information provided in the report and how it might be better presented in order to provide assurance retrospectively that the Trust's policies and processes had been followed for all STAs.

The Committee concluded that they were unable to note the Single Tender Actions report as presented at this meeting, and it was therefore agreed that further narrative should be provided on the top five STAs in order to provide additional assurance and that this should be circulated within the following two weeks.

The Committee noted that the Director of Procurement would be attending the next meeting of the Committee and that he would present his findings and proposals in relation to the STA process. In light of these findings, the finance team will conduct a further review of the format of the Single Tender Actions report, which will also take into account feedback from the Audit Committee.

3.6. Updates were received on:

- Counter Fraud Progress Report
- Losses and Salary Overpayments; and
- The Audit Committee work-plan.

The Committee did not identify any areas of concern.

4. New risks or items for escalation

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

5. Recommendations

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

- Ratify proposed amendments to the revised Standing Orders and Standing Financial Instructions (Appendix 1).
- Ratify the withdrawal of the Standards of Business Conduct.

- Ratify the Covid-19 Appendix (Appendix 2).

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

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) Director of Finance (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:	30 January 2020
Next Review Due:	29 January 2021
Version:	8.0

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

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.

Trust Standing Orders

North Bristol NHS
NHS Trust

Contents

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Foreword to Standing Orders

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

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

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

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

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

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

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

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Introduction

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

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

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

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

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

VI. The 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 ~~her~~ them and in the case of Standing Financial Instructions by the Director of Finance.

X. The following definitions apply for this document.

Legislation definitions:

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

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

Other definitions:

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

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

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

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

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

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

Part I – Membership

1. Name and business of the Trust

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

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

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

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

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

2. Composition of the Trust Board

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

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

- 2.2.1. one appointee nominated to be the Vice-Chair
- 2.2.2. one appointee nominated to be the (shadow) Senior Independent Director.
- 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. Director of Finance, or equivalent

2.3.3. Medical Director

2.3.4. Director of Nursing, or equivalent

2.3.5. Chief Operating Officer

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

3. Appointment of the Chair and directors

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

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

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

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

4. Vice-Chair

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

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

4.3. When the Chair is unable to perform ~~his~~ their duties due to illness or absence for any reason, ~~her~~ 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 ~~contained in the Trust's "Policy Standards of Business Conduct" (the Policy Standards of Business Conduct)~~ 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 ~~she~~ they think~~s~~ fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press; to ensure that the Trust Board's business may be conducted without interruption and disruption.

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

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

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

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8.7. Nothing in these Standing Orders shall require the Trust Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Trust Board.

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

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

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

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

9. Extraordinary meetings of the Trust Board

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

9.2. A meeting may be called forthwith, by the directors who are eligible to vote, if the Chair refuses to call a meeting after such a request has been presented to ~~her~~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 ~~her~~ 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 ~~his~~ 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.

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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.

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 ~~her~~ 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 ~~her~~ the Chair's interpretation of the Standing Orders shall be final. In this interpretation ~~she~~ the Chair shall be advised by the Chief Executive and the Trust Secretary and in the case of Standing Financial Instructions ~~she~~ the Chair shall be advised by the

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Director of Finance.

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13. Voting

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

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

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

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

13.5. If a director so requests, ~~his~~ 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 ~~he~~ they ~~is~~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 proceed to the next business.

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

18.1.5. that the motion be now put

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

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

19. Right of reply

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

20. Motion to rescind a decision of the Trust Board

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

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

21. Declaration of Interests and Register of Interests

Declaration of Interests

21.1. In addition to the statutory requirements relating to pecuniary interests dealt with in Standing Order 22, the Trust's Declarations of Interest Policy ~~Standards of Business Conduct~~ requires directors to declare interests which are relevant and material to the Trust Board. All existing directors and decision-making staff ~~any senior officers who may act up into an Executive Director post~~ as set out in the Policy should declare such interests on an annual basis, or as otherwise recommended in the Policy. Any directors and ~~senior officers~~ decision-making staff appointed subsequently should declare these interests on appointment.

21.2. Interests~~, which would be regarded as "relevant and material",~~ are:

21.2.1. ~~directorships, including Non-Executive Directorships held in private companies or PLCs (with the exception of those of dormant companies).~~Financial interests, where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

21.2.2. ~~ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.~~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

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professional reputation or promoting their professional career.

21.2.3. ~~majority or controlling share-holdings in organisations likely or possibly seeking to do business with the NHS.~~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. ~~a position of authority in a charity or voluntary organisation in the field of health and social care.~~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.

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21.2.5. ~~any connection with a voluntary or other organisation contracting for NHS services.~~

21.3. Subject to the requirements stated in Standing Order 22, the interests of directors' spouses, partners, or other family members must be disclosed where these maybe in conflict with the Trust.

21.4. If directors have any doubts about the relevance of an interest, this should be discussed with the Chair of the Trust or with the Trust Secretary. Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that the potential level of influence, rather than the immediacy of the relationship is more important in assessing the relevance of an interest.

21.5. ~~Annual d~~Declarations of interests should be considered by the Trust Board and retained as part of the record of ~~the~~ 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, ~~he~~ 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 ~~he~~ they may think fit to impose, remove any disability imposed by this Standing Order, in any case where it appears to ~~him~~ 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. ~~he~~they, or a nominee of ~~his~~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. ~~he~~ they ~~is~~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 ~~his~~ their membership of a company or other body, if ~~he has~~ 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 ~~he is~~ 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. ~~He has~~ 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 ~~his~~ 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. ~~All staff must comply with the Trust's current adopted Policy Standards of Business Conduct, which reflects national guidance, including the seven principles set out by the Committee on Standards in Public Life, published by the Professional Standards Authority, November 2012. The following provisions should be read in conjunction with the Trust Policy.~~ 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;

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- 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.

~~23.1.~~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 ~~or, if the interest is acquired, or recognised~~

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~~subsequently, at that time~~ 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. ~~Such director or senior manager shall ensure that such interests are entered in a Register of Interests, kept for that purpose.~~

~~23.2.~~23.7. Officers who are involved in, have responsibility for, or are able by virtue of their role or functions to influence the expenditure of taxpayer monies, may be required by the Trust to give statements from time to time, or in connection with particular contracts, confirming that they have no relevant or material interest to declare.

~~23.3.~~23.8. If an officer becomes aware of a potential or actual contract in which ~~he has~~ they have an interest of the nature described in Standing Orders 21 and 22 and this Standing Order, ~~he~~ they shall immediately advise the Director of Finance formally in writing. This requirement applies whether or not the officer is likely to be involved in administering the proposed, or awarded contract to which ~~he has~~ they have an interest.

~~23.4.~~23.9. Gifts and hospitality shall only be accepted in accordance with the Trust's ~~Policy Standards of Business Conduct~~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.

~~23.5.~~ All gifts and hospitality, other than those that are of clearly minimal value (as determined in the Trust's Declarations of Interest Policy ~~Policy Standards of Business Conduct~~), should be declared ~~in~~via the

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23.10. ~~a Register of Gifts and Hospitality kept by the Chief Executive and Trust Secretary for that purpose~~ 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.

~~23.6.~~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 ~~his~~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 ~~she~~ they will perform personally and shall nominate officers to undertake the remaining functions for which ~~he~~ they will still retain accountability to the Trust Board.

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Schedule of Decisions Reserved for the Trust Board

24.5. The Trust Board shall adopt a Schedule of Decisions Reserved for the Trust Board setting out the matters for which approval is required by the Trust Board. The Schedule that is current at the date of adoption of these Standing Orders is contained in Appendix 1 and shall be regarded as forming part of these Standing Orders.

24.6. Subject to Standing Order 44, the Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule in Appendix 1 after each review.

24.7. The Schedule of Decisions Reserved for the Trust Board shall take precedence over any terms of reference or description of functions of any committee or sub-committee established by the Trust Board. The powers and functions of any committee or sub-committee shall be subject to and qualified by the reserved matters contained in that Schedule.

Scheme of Delegated Authorities

24.8. The Trust Board shall adopt a Scheme of Delegated Authorities setting out details of the directors and officers of the Trust to whom responsibility has been delegated for deciding particular matters; and in a director's or officer's absence, the director or officer who may act for them. The Schedule that is current at the date of adoption of these Standing Orders is contained in Appendix 3 and shall be regarded as forming part of these Standing Orders

24.9. Subject to Standing Order 44, the Trust Board shall review such Schedule at such times as it considers appropriate; and shall update such Schedule in Appendix 3 after each review.

24.10. The direct accountability, to the Trust Board, of the Director of Finance and other Executive Directors to provide information and advise the Trust Board in accordance with any statutory requirements shall not be impaired, in any way, by the delegations set out in the Scheme of Delegated Authorities.

25. Appointment of committees

25.1. Subject to Standing Order 3 and such directions as may be given by, or on behalf of, the Secretary of State for Health, the Trust may, and if directed by ~~him~~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

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Board.

Role of Remuneration and Nominations Committee

25.14. The Trust Board shall appoint a committee to undertake the role of a remuneration and nominations committee. This role shall include providing advice to the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (Regulations 17-18, Membership and Procedure Regulations), as well as advising the Trust Board on the terms of service of other senior officers, and ensuring that the policy of the Trust Board on remuneration and terms of service is applied consistently.

25.15. The Committee shall advise the Trust Board on the size, structure and membership and succession plans for the Trust Board and maintain oversight of the performance of the Chief Executive and Executive Directors.

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

Charity Committee

25.17. The Trust Board, acting as Corporate Trustee, shall appoint a Committee to be known as the Southmead Hospital Charity Committee, whose role shall be to advise the Trust on the appropriate receipt, use and security of charitable monies.

25.18. The terms of reference of the Southmead Hospital Charity Committee shall have effect as if incorporated into these Standing Orders and shall be recorded in the appropriate minutes of the Trust Board, acting as Corporate Trustee, and may be varied from time to time by resolution of the Trust Board, acting in this capacity.

Non mandatory committees

25.19. The Trust Board shall appoint such additional non-mandatory committees as it considers necessary to support the business and inform the decisions of the Trust Board (Regulations 15-16, Membership and Procedure Regulations).

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

25.21. The membership of these committees may comprise Non-Executive Directors or Executive Directors, or a combination of these. The membership and voting rights shall be set out in the terms of reference of the committee and shall be subject to approval by the Board.

25.22. The current non-mandatory committees in place are (October 2018):

- Quality and Risk Management Committee
- Finance and Performance Committee
- People and Digital Committee
- Patient and Carer Experience Committee

These are subject to change at the discretion of the Trust Board. All new or amended non-mandatory committees will have the same standing and will be subject to the same standing orders.

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26. Proceedings in committee to be confidential

26.1. There is no requirement for meetings of Trust Board committees and sub-committees to be held in public, or for agendas or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the rights conferred by the Freedom of Information Act, 2000 and there is no legal justification for non-disclosure.

26.2. Committee members should normally regard matters dealt with, or brought before the committee as being subject to disclosure, unless stated otherwise by the Chair of the committee. The Chair shall determine whether specific matters should remain confidential until they are reported to the Trust Board.

26.3. A director of the Trust or a member of a committee shall not disclose any matter reported to the Trust Board, or otherwise dealt with by the committee if the Trust Board resolves that it is confidential.

26.4. Regardless of this Standing Order 26, individual directors and officers of the Trust have a right and a duty to raise with the Trust any matter of concern they may have about health service issues concerned with the delivery of care or services.

27. Election of Chair of committee

27.1. Each committee shall appoint a Chair; and may appoint a vice-Chair from its membership. The terms of reference of the committee shall describe any specific rules regarding who the Chair should be. Meetings of the committee will not be recognised as quorate, if the Chair, or vice Chair, or other suitably qualified, nominated member of the committee is not present to undertake the role.

27.2. Each committee shall review the appointment of its Chair, as part of the annual review of the committee's role and effectiveness.

28. Special meetings of committee

28.1. The Chief Executive shall require any committee to hold a special meeting, on the request of the Chair, or on the request, in writing of any two members of that committee.

Part IV – Custody of seal and sealing of documents

29. Custody of seal

29.1. The common seal of the Trust shall be kept by the Chief Executive in a secure place.

30. Sealing of documents

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

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

31. Bearing witness to the affixing of the Seal

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

32. Register of sealing

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

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

Part V – Appointment of directors and officers of the Trust

33. Canvassing of, and recommendations by, directors

33.1. Canvassing of any director of the Trust or member of a committee of the Trust directly or indirectly for any appointment under the Trust, shall disqualify the candidate from such appointment. Where the Chair or any such director or committee member is so canvassed he shall notify the Chief Executive in writing. The purpose of this Standing Order shall be included in any form of application or otherwise brought to the attention of candidates.

33.2. No director of the Trust shall solicit for any person any appointment under the Trust or recommend any person for such appointment; but this shall not preclude a director from sharing knowledge about the availability of potential candidates prior to the commencement of recruitment, nor from giving a written testimonial of a candidate’s ability, experience or character for submission to the appropriate panel or committee of the Trust Board.

34. Relatives of directors or officers of the Trust

34.1. Candidates for any appointment under the Trust shall, when making application, disclose in writing to the Trust whether they are related to any director or senior officer of the Trust. Failure to disclose such a relationship is likely to disqualify a candidate and, if appointed, render ~~him~~ them liable to instant dismissal.

34.2. Every director and senior officer of the Trust shall disclose to the Chief Executive any relationship between ~~himself~~ 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 will develop a longer-term procurement strategy in conjunction with the Trust's procurement service supplier, Bristol and Weston Purchasing Consortium (BWPC). Click here for the BWPC website : BWPC - Home (http://nww.bwpc.nhs.uk/default.htm)

35.2. Every contract made by or on behalf of the Trust shall comply with the procedures and requirements of:

35.2.1. these Standing Orders

35.2.2. the Trust's Standing Financial Instructions

35.2.3. any direction by the Trust Board

35.3. Wherever possible and provided it protects the Trust's position adequately, contracts made will reflect the most up to date and relevant model Standard Conditions that are provided by the Department of Health. These models may be amended to develop bespoke contracts.

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

35.5. Contract procedures shall take account of the Trust's ~~Policy Standards of Business Conduct~~ 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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Part VII – Miscellaneous

39. Suspension of Standing Orders

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

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

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

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

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

40. Variation of Standing Orders

40.1. These Standing Orders shall be varied only if:

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

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

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

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

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

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

40.4. Where financial limits are varied the Director of Finance will advise the Audit Committee, and internal and external audit.

41. Availability of Standing Orders

41.1. The Trust Secretary shall make available a copy of the Standing Orders to each director of the Trust and to such other employees as the Chief Executive considers appropriate.

41.2. A copy of these Standing Orders will be held, with unrestricted access to all staff, on the Trust's intranet site.

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42. Signature of documents

42.1. Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall be signed by the Chief Executive, or by any Executive Director of the Trust duly authorised for that purpose by the Board in accordance with the Scheme of Delegated Authorities, unless any enactment otherwise requires or authorises differently.

42.2. The Chief Executive or nominated directors shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

43. Standing Financial Instructions

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

44. Review of Standing Orders

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

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

ENDS

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North Bristol NHS Trust Board

Appendix 1 – Schedule of decisions reserved to the Trust Board

Introduction

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

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

1.1. Approve, including variations to:

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

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

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

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

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

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

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

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

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

1.5.1. Appoint the Chief Executive (SO 3)

1.5.2. Appoint the Executive Directors (SO 3)

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

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

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

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

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

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

2. Determination of strategy and policy

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

2.2. Approve the Trust's strategic direction:

2.2.1. annual budget, strategy and business plans

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

2.2.3. clinical and service development strategy

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

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

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3. *Direct operational decisions*

3.1. Approve capital investment plans:

3.1.1. the annual capital programme

3.1.2. all variations to approved capital plans over £500,000 (SoDA 13f)

3.1.3. to acquire, dispose of, or change of use of land and/or buildings (SO 38,)

3.1.4. capital investment over £1 million in value, supported by a business case and in line with the approval guidance issued by the NTDA. (SoDA 13c, 13d)

3.1.5. contracts for building works, which exceed the pre-tender estimate by over 10% (minimum £100k). (SoDA 10j)

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

3.3. Approve individual contracts and commitments to pay, other than Commissioning Contracts, of a revenue nature amounting to, or likely to amount to over £1 million:

3.3.1. Tenders and quotations over the lifetime of the contract (SoDA 8a)

3.3.2. Revenue funded service developments, in line with the approval guidance issued by the NTDA (SoDA 8f)

3.3.3. Orders processed through approved supply arrangements (SoDA 10c)

3.3.4. Orders processed through non-approved supply arrangements (SoDA 10d)

3.3.5. Receipt of loans and trials equipment and materials (SoDA 10e)

3.3.6. Prepayment agreements for services received (SoDA 10g)

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

4. *Quality, financial and performance reporting*

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

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

4.2.1. The Care Quality Commission

4.2.2. NHS Improvement

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

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

4.5. Approve the Quality Account

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5. Audit arrangements

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

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

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

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

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

ENDS

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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 ~~her~~them. In the case of the Standing Financial Instructions ~~she~~ they will be advised by the Director of Finance.

1.2. The definitions applied to the Standing Orders apply also for these Standing Financial Instructions. The following additional definitions apply:

Legislation definitions:

No additional legislation

Other definitions:

- **Budget manager** is the director or employee with delegated authority to manage the finances (Income and Expenditure) and resources for a specific area of the Trust.
- **Commissioning** is the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.
- **Contracting and procuring** is the process of obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.
- **Divisional Operations Directors (Corporate Manager)** are the senior operational managers; and their formally nominated deputies, for the division or specialty, as designated by the Executive Director.
- **Procurement Service provider** is the group that manages the Trust's procurement strategy and processes. The current service provider: Bristol and Weston NHS Purchasing Consortium (BWPC) is hosted by the Trust
- **Shared Business Service (SBS)** is the NHS Shared Business Services, which is contracted by the Trust for general ledger provision and maintenance, core accounting for accounts payable and receivable and VAT processes.

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

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

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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 Director of Finance, prior to action.

2.6. The SFIs apply to all staff, including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Trust. Failure to comply with the SFIs could lead to disciplinary action, up to and including dismissal.

Compliance with these SFIs

2.7. These SFIs prevail over any division and service guidance or procedural documents. They also prevail over any guidance or instruction issued by other organisations conducting business with the Trust. All staff should notify the Director of Finance of any conflicts between the local guidance and instruction and the SFIs, if the conflict cannot be resolved satisfactorily locally.

2.8. **All staff** have a duty to disclose, as soon as possible, to the Director of Finance, any failure to comply with these SFIs. Full details of the non-compliance including an assessment of the potential impact; and any mitigating factors shall be reported by the Director of Finance to the next formal meeting of the Audit Committee for referring action or ratification.

Responsibilities and delegations

2.9. These SFIs have been compiled under the authority of the Trust Board. They are reviewed by the **Audit Committee** and approved by the Trust Board.

2.10. **The Trust Board** exercises financial supervision and control by:

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2.10.1. approving the financial strategy

2.10.2. requiring the submission and approval of budgets that deliver the financial targets set for the Trust within approved allocations and overall income

2.10.3. approving specific responsibilities placed on directors and employees as indicated in the Scheme of Delegated Authorities

2.10.4. approving the method of providing financial services.

2.11. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Schedule of Decisions Reserved to the North Bristol NHS Trust Board (appendix 1). All other powers have been delegated to the Board's appointed committees; and the directors and officers of the Trust.

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

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

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

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

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

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

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

2.14. **The Director of Finance** is responsible for:

2.14.1. maintaining and implementing the Trust's financial policies

2.14.2. maintaining an effective system of internal financial control including ensuring that adequate and effective financial procedures and systems incorporating the principles of segregation of duties and internal checks are prepared, documented and maintained

2.14.3. ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time

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2.15. **All staff**, including Board members are responsible for:

2.15.1. the security of the property of the Trust

2.15.2. avoiding loss

2.15.3. achieving economy and efficiency in the use of resources

3. Financial framework

3.1. The **Director of Finance** shall ensure that members of the Board are aware of the financial aspects of the NHS Improvement's Single Oversight Framework, within which the Trust is required to operate.

4. Business and budget plans

4.1. The **Chief Executive** shall submit to the Board and external regulators as required, strategic and operational plans, as suggested by relevant guidance, to meet the needs of the Board. These plans will include an annual Business Plan, which takes into account financial targets and forecast limits of available resources.

4.2. The plans will include:

4.2.1. description of the significant assumptions on which planning is based

4.2.2. details of major changes in workload, delivery of services or resources required to achieve the plans.

4.3. Prior to the start of each financial year, the **Director of Finance** shall prepare and submit budgets for approval by the Board. Such budgets will:

4.3.1. be in accordance with and reconcilable, at a summary level, to the aims and objectives set out in the annual Business Plan

4.3.2. reconcile to financial plans to be provided to relevant external regulators, such as the NHS Improvement (NHSI)

4.3.3. reflect resource plans, including workload and workforce plans

4.3.4. be prepared within the limits of available funds

4.3.5. show how the plans will deliver against the financial targets and obligations set externally by the Secretary of State and relevant regulatory bodies; and set internally by the Trust

4.3.6. provide a forecast of the Trust's performance over the year against key financial indicators, as determined by the Trust and by relevant regulatory bodies

4.3.7. include summary financial projections for the longer term

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4.3.8. identify and assess significant financial risks.

4.4. **All staff** who have been given delegated authority to manage and administer budgets shall be expected to contribute to the preparation of the annual budget.

5. Management of the financial resource

5.1. The **Chief Executive** shall require directors and authorised budget managers to seek to deliver the financial outturn targets set by the Trust Board within the approved annual budget plan and the adjustments to those targets reflected in the re-forecasts performed during the year.

5.2. The **Chief Executive** may change the financial outturn targets of any divisions, or services.

5.3. **Directors** and **authorised budget holders** shall seek to deliver their service responsibilities within the limits of the financial outturn targets set for them. Financial and other resources shall only be used for the purposes for which they are provided, as approved by the Chief Executive and the Board.

Setting the annual financial plan

5.4. The **Chief Executive** shall be responsible for providing the Trust Board with the annual financial plan, taking into account financial targets and forecast income and service developments. The plan will identify the significant assumptions on which it is based; and provide details of significant changes to service and workforce plans and how these will impact on the Trust's financial targets. The plan will identify how the Trust will achieve the annual efficiency savings set by the Department of Health.

5.5. The **Director of Finance** shall be responsible overall for the design and delivery of the annual integrated financial budget plan.

5.6. All **Executive Directors** shall be responsible for contributing to the integrated planning process, which shall incorporate plans for workforce, service delivery and quality, service capacity and activity, and efficiency planning.

5.7. **Budget holders** shall provide all financial, statistical and other relevant information, including service, capacity, workforce and efficiency plans, as required by the Director of Finance to enable budgets to be compiled.

5.8. All budget managers should sign up to their allocated budgets at the start of each financial year.

Managing and reporting the financial position during the year

5.9. The **Director of Finance** shall be responsible overall for the design and delivery of adequate systems of financial budgetary control. These systems will include processes for:

5.9.1. identifying the level of earned income directly attributable to each budget area

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5.9.2. identifying the target (gross or net) allowable expenditure for each budget area, that will enable each budget holder to deliver their annual financial target contribution to the overall Trust target

5.9.3. updating the forecast income and allowable expenditure, during the year, to reflect changes in contracted income, service capacity and delivery.

5.9.4. monitoring and reporting financial performance against plans and forecasts

5.9.5. delivering monthly integrated financial reports to meet the requirements of the Project Management Office, Finance and Performance Committee and the Trust Board in a form approved by the Board.

5.10. All **Executive Directors** shall be responsible for establishing monitoring and reporting systems for workforce, service delivery and quality, service capacity and activity, and efficiency planning to enable budget holders to deliver an integrated analysis of their service performance.

5.11. **All staff** to whom responsibility is delegated to incur expenditure, or generate income shall comply with the requirements of those systems.

5.12. Designated **budget holders** shall be responsible for maintaining expenditure within the limits of earned available income.

5.13. Designated budget holders shall monitor and analyse the integrated financial performance of their service during the year. This shall include assessment of:

5.13.1. progress towards delivering the required financial position for the budget area

5.13.2. the impact of resources used, including workforce, progress of service delivery and achievement of efficiency plans

5.13.3. trends and projections

5.13.4. where relevant, plans and proposals to recover adverse performance

5.14. The **Director of Finance** shall ensure that budget holders are provided with advice and support from suitably qualified finance staff, to enable them to perform their budget management role adequately.

5.15. The **Director of Finance** shall be required to compile and submit to the Board of Directors such financial estimates and forecasts, on both revenue and capital account, as may be required from time to time.

5.16. The **Director of Finance** shall keep the Trust Board informed of:

5.16.1. significant in-year variance from the business plan and advise the Board on actions to be taken to address the variance

5.16.2. financial consequences of changes in Trust policy

5.16.3. financial implications of external determinations, such as national pay awards and changes to the pricing of clinical services

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5.17. The **Director of Finance** shall:

5.17.1. ensure that budget managers receive adequate training on an on-going basis to help them comply with expectations and to manage successfully

5.17.2. issue timely, accurate and comprehensible advice and financial reports to each budget manager, covering the areas for which they are responsible

6. Annual accounts, reports and returns

6.1. The **Director of Finance** shall:

6.1.1. prepare financial returns in accordance with the accounting policies and guidance provided by the Department of Health (DHSC) and the Treasury, the Trust's accounting policies, and accounting practice as determined by the accounting bodies in the UK.

6.1.2. prepare and submit annual financial reports to the DHSC certified in accordance with current guidelines

6.1.3. submit financial returns to the DHSC for each financial year in accordance with the timetable prescribed by the DHSC

6.1.4. submit periodic monitoring and financial returns to external organisations, such as NHSI, in accordance with the timetables set by those organisations

6.2. The Trust's annual accounts must be audited by an auditor appointed by the Trust. The Trust's audited annual accounts shall be presented to a public meeting and made available to the public, within the timescales set by the DHSC.

6.3. The **Chief Executive** shall publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the current DHSC requirements and guidance.

7. Income, including contracts for the provision of healthcare, fees and charges

7.1. The **Director of Finance** is responsible for:

7.1.1. designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due

7.1.2. the prompt banking of all monies received.

7.2. Where such income matters are dealt with by the Shared Business Service, such arrangements will be incorporated in a Service Level Agreement with the Shared Business Service.

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Fees and charges for the provision of healthcare

7.3. The **Director of Finance** shall:

7.3.1. follow the up to date Department of Health's guidance and regulations for setting prices for providing NHS services

7.3.2. approve and regularly review the level of all fees and charges set, other than those determined by the DHSC or by statutory regulation

7.3.3. take independent professional advice on matters of valuation, as necessary.

7.4. The **Director of Finance** shall approve all property and non-clinical equipment leases, property rentals and tenancy agreements. The **Director of Facilities** shall advise on these arrangements.

7.5. **All employees** shall inform the **Director of Finance** promptly of money due to the Trust arising from transactions which they initiate, or deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

NHS service agreements for the provision of services

7.6. The **Chief Executive** is responsible for ensuring that the Trust enters into suitable Commissioning Contracts with service commissioners for the provision of NHS services to patients, in accordance with the business plans; and for establishing the arrangements for providing extra-contractual services.

7.7. The **Director of Finance** shall provide up to date advice on:

7.7.1. Standard NHS contractual terms and conditions, issued by the DHSC

7.7.2. costing and pricing of services

7.7.3. payment terms and conditions

7.7.4. amendments to contracts, SLAs and extra-contractual arrangements

7.8. The **Director of Finance** shall ensure that SLAs and other contractual and extra- contractual arrangements:

7.8.1. are devised so as to limit the risk to the Trust, whilst enabling opportunities to generate income

7.8.2. are financially sound; and that any contractual arrangement pricing at marginal cost are approved by the Director of Finance and reported to the Trust Board

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7.9. The **Director of Finance** is responsible for ensuring that systems and processes are in place to record patient activity, raise invoices and collect monies due under the agreements for the provision of healthcare services.

7.10. The **Director of Finance** shall produce regular reports, to the Trust Board or its committees detailing the Trust's forecast financial performance.

7.11. **Budget holders** with responsibilities for managing delivery against service agreements must ensure they understand and use the contract monitoring information for the financial management of their service areas.

Research and development

7.12. All applications for research funding shall be considered and approved by the Research and Innovation department. This applies to applications to NHS institutions such as grant requests to the National Institute for Health Research, and non-NHS organisations, including commercial sponsorship organisations, charitable bodies and research councils.

Sponsorship and concession agreements

7.13. The **Director of Finance**, or a nominated deputy shall maintain a register of sponsorship received by the Trust.

7.14. Sponsorship arrangements may be entered into subject to the limits set out in the Scheme of Delegated Authorities. Where sponsorship income (including items in kind such as clinical goods or loans of equipment) is considered the most recent NHS guidance on managing conflicts of interest and sponsorship should be followed.

7.15. The **Director of Facilities** shall review and propose plans for all concession agreements proposed for the Trust, including arrangements that do not incur an immediate direct cost for the Trust, but can expose it indirectly to significant liability. The Director of Finance shall authorise all concession agreements entered into by the Trust.

8. Procurement, tendering and contracting procedure

8.1. The Trust may enter into contracts within the statutory powers delegated to it. The procedure for setting contracts shall comply with those powers and these SFIs. Delegated powers of authorisation are granted to Trust officers according to the Scheme of Delegated Authorities. A contractual arrangement must be in place for all goods and services procured by the Trust. The nature of the contract or agreement will depend on the goods, services or works being provided. The Director of Finance is responsible for signing all contracts and agreements with delegated responsibilities given within the scheme of delegation (see Appendix 3)

8.2. All contracts made shall ensure best value for money using the Trust's procurement service provider (BWPC) and processes established by the Director

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of Finance. For each contract a Trust Officer shall be nominated and hence responsible for overseeing and managing the contract on behalf of the Trust.

European Union and Government directives regarding public procurement

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

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

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

Competitive tendering and quotations

8.6. The **Director of Finance** shall advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved, the thresholds shall be incorporated in Standing Orders through the Scheme of Delegated Authorities; and shall be reviewed regularly.

8.7. The **Trust Board** shall ensure that, wherever possible, competitive tenders, or quotations are invited, in line with the thresholds set out in the Scheme of Delegated Authorities, for:

8.6.1. the supply of goods, materials and manufactured articles

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

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

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

8.7.1. the estimated contract value is not reasonably expected to exceed £25,000 over the anticipated term of the contract and will be determined through formal quotations

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

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

8.7.4. the supply is a measured term contract which has been put in place following a

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formal tendering process carried out by its procurement services provider.

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

- the **Chief Executive** decides that formal tendering procedures would not be practicable
- the supply requirement is covered by an existing contract
- NHS or Government procurement agreements are in place and their use, in accordance with the Trust's Procurement Strategy, has been approved by the Board
- a consortium arrangement is in place and a member organisation has been appointed to carry out tendering activity on behalf of the consortium members
- available timescales genuinely mean that competitive tendering is not a realistic option. Failure to plan the work properly should not be regarded as a justification for waiving tendering procedures
- specialist expertise, goods and services are required and available from only one source. Evidence of the unique status will be required to support any exemption.
- the task is essential to complete the project, and arises as a consequence of an existing or recently completed assignment; and engaging different suppliers for the new task would be counter-productive
- there is a clear benefit to be gained from maintaining continuity with an earlier supply. In such cases, the benefits of such continuity must outweigh any potential advantage to be gained from competitive tendering

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

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

8.11. The **Director of Finance** shall ensure that:

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

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

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

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Audit Committee and be recorded in an appropriate Trust record

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

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

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

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

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

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

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

Tendering procedure

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

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

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

8.17.1. record of issue of invitations to tender

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

8.17.3. process and record of opening tenders

8.17.4. evaluation of tenders (inc. completeness, accuracy, compliance with prescribed format etc)

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

8.17.6. reasons behind decision to award the contract

Quotations: competitive and non-competitive

8.18. The **Trust Board** shall approve the value range whereby formal tendering procedures are not adopted, but quotations will be required. This range is currently for intended expenditure that is reasonably expected to exceed £25,000.

8.19. The **Director of Finance** shall determine the procedures to be followed in respect of competitive and non-competitive quotations. These will include:

8.20.1. types of service or supply to be sought through quotations

8.20.2. minimum number of competitive quotes to seek, currently set at three

8.20.3. requirement for written quotations

8.20.4. retention of records

8.20.5. treating all records of the process as confidential

8.20.6. recording the decision to go to contract

Temporary suspension of procedures in exceptional circumstances

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8.20. The **Trust Board** shall allow the SFIs to be suspended temporarily in exceptional circumstances, where the circumstance is:

8.21.1. a Trust wide problem, rather than a directorate specific issue.

8.21.2. of sufficient scale that failure to act quickly and decisively would put the Trust at significant financial and reputational risk

8.21.3. unforeseen and rapidly developing

8.21.4. such that following normal procedures would hinder the recovery of the situation

8.21. The **Director of Finance** shall identify specific procedures to be followed in the instance of a recognised event of exceptional circumstance.

9. Contracts and purchasing

9.1. The **Trust Board** shall only enter into contracts on behalf of the Trust that are within the statutory powers delegated to it by the Secretary of State and shall comply with:

9.1.1. the Trust's Standing Orders and Standing Financial Instructions

9.1.2. EU Procurement Directives and other statutory provisions

9.1.3. any relevant directions issued, or recognised by the DH

9.1.4. such of the NHS standard contract conditions as are applicable

9.2. In all contracts made by the Trust, the Trust Board shall:

9.2.1. seek to obtain best value for money

9.2.2. for contracts subjected to tendering, or quotation, ensure that the contracts contain the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.3. The **Chief Executive** and **Executive Directors** shall nominate managers to oversee and manage each contract on behalf of the Trust

9.4. The Procurement Service shall maintain a record of the details of all requisitions and orders placed. No requisition or order shall be placed for items for which there is no provision in an authorised budget.

Longer term commitments

9.5. All contracts, leases, tenancy agreements and other commitments, which might result in a long-term liability, must be notified to; and authorised, in accordance with the limits set out in the Scheme of Delegated Authorities, in advance of any commitment being made.

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Healthcare Service Agreements

9.6. The **Director of Finance** shall ensure that SLAs and extra-contractual arrangements agreed with other NHS trusts, for provision of services to the Trust, are agreed in accordance with the current guidance set out by the DH.

In-house services

9.7. The **Trust Board** shall determine which in-house services should be market tested by competitive tendering; and the frequency with which this should be done. In instances where competitive tendering is required, the Board shall nominate suitably qualified staff to administer the process and ensure that EU procurement and competition laws, legislation and DHSC guidance are applied correctly, including:

9.7.1. setting clearly defined specifications for the service

9.7.2. clear separation between the in-house service provider tender team and the Trust's commissioning team

9.7.3. independent evaluation process

9.8. The **Chief Executive** shall ensure that best value for money can be demonstrated for all services provided on an in-house basis and shall nominate officers to oversee and manage the contract on behalf of the Trust, separate from those that are providing the service.

10. Non-pay expenditure

10.1. Requisitions and orders are subject to the delegations and limits set out in SFI 8 and SFI 9.

10.2. The **Director of Finance** shall:

10.2.1. maintain the list of managers who are authorised to place requisitions and orders for the supply of goods and services

10.2.2. set the maximum value of each requisition or order and the system for authorisation above that level

10.2.3. set out procedures for seeking of professional advice regarding the supply of goods and services

10.3. These delegation limits are maintained in the Scheme of Delegated Authorities.

Requisitioning and ordering goods and services

10.4. The **Director of Finance** shall maintain adequate systems and procedures for the ordering (including requisitions) of goods and services. These shall include:

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10.4.1. procedural instructions and guidance on the obtaining of goods, works and services incorporating the thresholds identified in the Scheme of Delegated Authorities

10.4.2. recognition of the Trust's approved supply arrangements, including, but not limited to the following:

- recognised Trust wide procurement systems, (EROS and NHS Supply Chain) which incorporate automatic system controls to ensure adherence to approval and authorisation requirements
- other recognised controlled ordering systems for specific service areas (Pharmacy, Estates, Catering, Disablement Services) providing that they can evidence a secure audit trail
- framework agreements made by the Trust, or by the Procurement Service, including approved suppliers of temporary, locum and interim staff placements; and contractual arrangements for on-going ad-hoc support from chosen service suppliers (eg emergency maintenance and repair services for medical equipment)

10.5. **Employees** responsible for placing requisitions and orders; and **managers** responsible for authorising the orders shall ensure that:

10.5.1. approval is obtained in advance from the Director of Finance for any contractual arrangement that may involve taking on an ongoing obligation, or legal responsibility.

10.5.2. sufficient budget exists to pay for the item ordered, or if insufficient budget is available, the **Director of Finance** has authorised the purchase

10.5.3. a Purchase Order is raised on an approved electronic ordering system prior to the goods or services being received.

10.5.4. orders are not split, or otherwise manipulated to circumvent authorisation and delegation limits

10.5.5. goods and equipment are not accepted on trial, or on loan, where there is an associated risk or commitment to current or future expenditure, unless specifically approved by the **Director of Finance** as advised by BWPC.

10.6. Employees shall use the Trust's approved supply arrangements wherever possible.

10.7. Where the service is provided by or maintained by the Shared Business Service, the arrangements shall be set out in the SLA.

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Ordering and purchasing using non-approved supply arrangements

10.8. The **Director of Finance**, or their nominated deputy shall maintain adequate systems and controls; and procedural rules for commitments and purchases made outside of the Trust's approved supply arrangements.

10.9. **Employees** should seek to minimise the use of non-approved supply arrangements. Where this is unavoidable, they should ensure that any expenditure incurred through non-approved supply arrangements delivers value for money and is controlled so that there are no additional or consequential financial risks to the Trust

Receipt of goods and services and system of payment and payment verification

10.10. The **Director of Finance** shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or with national guidance (such as the Better Payments Practice Code).

10.11. Such requirements will be specified in any SLA with the Shared Business Service provider.

10.12. The **Director of Finance** shall:

10.12.1. ensure the prompt payment of all properly authorised accounts and claims

10.12.2. maintain an adequate system of verification, recording and payment of all amounts payable, including relevant thresholds. The system will include:

- a record of Trust employees, including specimens of their signatures and/or facilities for secure electronic certification, authorised to raise requisitions and certify invoices
- certification that:
  - goods have been duly received, examined and are in accordance with specification and the prices are correct
  - work done or services rendered have been satisfactorily completed in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct
  - contractual measurement units, such as time, materials or expenses are accurate, meet contractual requirements; are supported by appropriate confirmation; and are charged at the agreed rates
  - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained
  - the account is arithmetically correct
  - the account is in order for payment

10.12.3. identify procedures to follow for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.12.4. maintain instructions to employees regarding the handling and payment of accounts within the Finance Department.

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Prepayments and payments on account

10.13. The **Director of Finance** shall specify the circumstances under which goods and services can be paid in advance of receipt, through the use of prepayments. These circumstances will include instances where one or more of the following apply:

10.13.1. the **Director of Finance** has approved that the pre-payment, in part, or in full, is specified in the agreed contractual arrangement

10.13.2. the proposed arrangement is compliant with EU public procurement rules, where the contract is above a stipulated financial threshold

10.13.3. the financial advantages are shown to outweigh the disadvantages and risks

10.13.4. it is customary for the payment in advance for a service that is provided for a specific period of time (eg rates, rentals, service and maintenance contracts, insurance, utilities standing charges)

10.14. The **budget holder** shall confirm that the goods and services due under a prepayment arrangement are received satisfactorily and in accordance with the contractual arrangements.

Payments to contractors by instalments

10.15. The **Director of Finance** shall identify adequate procedures to address interim payments made on-account in contracts for building and engineering works. These will include arrangements for receipt of independent and appropriate certificates and confirmations of work completed, to the required standards.

10.16. Final payments certificates shall only be issued after the Trust's nominated contract manager has certified the accuracy and completeness of the value of the final account submitted by the contractor; and has confirmed that the procedure set out in the contract terms has been followed properly.

10.17. Overruns to contracts shall be reported in accordance with the Scheme of Delegated Authorities.

10.18. With reference to Appendix 3 (SoDA 8x), all planned (including Capital funded) procurements with a projected value of over £100k* must have a signed off Options Appraisal and/or Business Case report for the Procurement which is produced in conjunction with BWPC. This should be noted only applies to planned procurements with exceptions only via the Single Tender Action process.

10.19. All Options Appraisals, and ultimately procurement Business Case's must include Whole Life Costs estimates as well as identification of projected savings.

10.20. The above process also applies to Extensions and Variations with a projected value which exceeds £100k

*A genuine pre-estimate of contract value must be ascertained and should not automatically be based on previous years expenditure, but also based on an estimate of future demand, and any additional value gained by the supplier.

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Variations and extensions to contracts

10.21. Contracts may be designed to allow for variations to the sum agreed, or the goods and services to be delivered. These variations shall be clearly identified and subject to specific limits; and shall be approved as part of the contract process. Further, or new variations shall be subject to the authorisation process in place for new contracts. Variations shall be authorised in advance of commencement.

10.22. Where variations are needed in emergency, approval should be sought from a relevant authorising officer; and shall be confirmed and authorised, using the relevant contract procedure, on the next working day.

10.23. Extensions to contracts shall be confirmed in writing and authorised in accordance with the Scheme of Delegated Authorities. Contract Extensions should not exceed the maximum term permitted under the terms of the contract defined when the contract was let.

Joint finance arrangements with local authorities and voluntary bodies

10.24. Payments to local authorities and voluntary organisations shall comply with procedures laid down by the Director of Finance which shall be in accordance with current legislation.

11. Terms of service and payment of members of the Trust Board and employees

Board members, directors and specified senior managers

11.1. The **Trust Board** shall be accountable for taking decisions on the remuneration and terms of service of directors and senior managers not on Agenda for Change terms and conditions. The Board shall establish a Remuneration and Nominations Committee responsible for determining the remuneration of; and appointment of directors and senior staff in accordance with Standing Orders.

11.2. The **Remuneration and Nominations Committee** shall:

11.2.1. advise the Board about appropriate remuneration and terms of service for the Chief Executive, other directors and any staff remunerated outside of the Agenda For Change arrangements, (as described in the terms of reference of the Committee), employed by the Trust:

- all aspects of salary (including any performance-related elements and bonuses)
- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms

11.2.2. advise the Board on the remuneration and terms of service of directors and any staff remunerated outside of the Agenda for Change arrangements to ensure they are fairly rewarded for their contribution to the Trust, whilst having proper regard to the Trust's circumstances and performance; and to the provisions of any national arrangements for such members and staff where appropriate

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11.2.3. monitor and evaluate the performance of individual directors and senior employees

11.2.4. advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate

11.3. The Trust shall pay allowances to the Chair and Non-Executive Directors of the Board in accordance with instructions issued by the DH.

Other employees

11.4. The Trust Board shall consider and approve proposals presented by the **Director of People & Transformation** for the setting of remuneration and conditions of service for those employees not covered by the Remuneration and Nominations Committee.

Funded establishment and staff appointments

11.5. The staff establishment plans incorporated within the annual plans approved by the Trust Board shall be regarded as the funded establishment. The funded establishment of any department should reflect the Trust's approved workforce plans, which form part of the Trust's budget plans submitted to the NHS TDA.

11.6. The **Director of People and Transformation** shall ensure adherence to the Agenda for Change rules and approved policies and procedures and terms and conditions for employees paid on alternative contractual arrangements, including the consultant contract. These procedures shall address:

11.6.1. setting starting pay rates and conditions of service, for employees

11.6.2. approving plans to engage, re-engage employees, either on a permanent or temporary nature, or hire agency staff

11.6.3. agreeing to changes in any aspect of remuneration, including re-grading, within the Agenda for Change allowed rules.

11.6.4. ensuring that all employees are issued with a contract of employment in a form which complies with employment legislation

11.7. The **Budget Holder** shall ensure that the cost of the appointment, or change in conditions can be met within the limit of their approved budget and funded establishment.

Processing payroll

11.8. The **Director of Finance** shall maintain procedural instructions for delivery of the Trust's payroll function. These procedures shall be compliant with employment legislation, the Data Protection Act and HM Revenues and Customs regulations.

11.9. The **Director of Finance** shall ensure that the arrangements for providing the payroll service are supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures; and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies

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11.10. Under the delegated authority of the Director of Finance, the **Head of Payroll** shall:

11.10.1. specify timetables for submission of properly authorised time records and other notifications

11.10.2. agree the final determination of pay and allowances

11.10.3. arrange to make payment on agreed dates

11.10.4. agree allowed methods of payment.

11.11. **Nominated managers** shall ensure that the electronic staff record, including the approved staff establishment, is kept up to date. Nominated managers shall ensure that all staff are keeping their records complete, including requirements to:

11.11.1. submit time records, and other notifications in accordance with agreed timetables

11.11.2. complete time records and other notifications in accordance with the Director of Finance's instructions

11.11.3. submit forms notifying change in circumstances and termination of employment in the prescribed form, as soon as these changes are reported to them

Travel and subsistence expenses

11.12. Reimbursement of expenses incurred by Trust staff shall be made by the Payroll Service in accordance with the Trust's relevant current policy and procedures; and subject to verification and authorisation of the claim by an officer with delegated authorisation for this purpose.

Use of self-employed management consultants and contractors

11.13. The **People Division** shall establish procedures to ensure that the Trust's interests are protected in the contractual arrangements entered into with self-employed consultants and contractors. These procedures shall ensure that the contractual arrangements do not contravene HM Revenues and Customs' requirements regarding the avoidance of tax and national insurance contributions through the use of intermediaries, such as service companies or partnerships, known as Intermediaries Legislation, or "IR 35".

11.14. All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.

12. Insurance, including risk pooling schemes administered by the NHS Litigation Authority

12.1. The **Trust Board** shall determine the Trust's arrangements for insurance cover, including the option to insure through the risk pooling schemes administered by the

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NHS Resolution; or to self-insure for some or all of the risks covered by the risk pooling schemes.

12.2. If the Trust Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers and third party liability) covered by the scheme, this decision shall be reviewed annually.

12.3. The **Director of Finance** shall ensure that:

12.3.1. documented procedures cover the Trust's insurance arrangements, including for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed

12.3.2. the arrangements entered into are appropriate and complementary to the risk management programme.

12.3.3. the Trust Board is informed of the nature and extent of the risks that are self-insured in the event that the Board decides not to use the risk pooling schemes administered by the NHSR for one or other of the risks covered by the schemes

12.4. The Director of Finance shall determine the level of insurance cover to be held by the Trust in the three discrete areas where the Trust can use commercial insurers:

12.4.1. insuring motor vehicles owned by the Trust including insuring third party liability arising from their use

12.4.2. where the Trust is involved with a consortium in a PFI contract and the other consortium members require that commercial insurance arrangements are entered into

12.4.3. where income generation activities take place, which are not covered by the NHSR risk pool

13. Capital investment, private financing, fixed asset registers and security of assets

13.1. The **Director of Finance** is responsible for compiling and submitting for Board approval an annual capital programme, which is affordable within available resources over the lifetime of the investment.

13.2. The **Director of Finance** shall report to the Board, the progress of delivery of the capital programme, against plan, during the year.

13.3. The **Chief Executive** shall ensure that:

13.3.1. there is an adequate appraisal and approval process in place for determining capital expenditure priorities and supporting systems to identify and assess the financial effect of each proposal on business plans

13.3.2. all stages of capital schemes are managed and controlled adequately; and that schemes are delivered on time and to cost

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13.3.3. capital investment is risk assessed against the declared commissioning strategic plans of significant commission organisations and is consistent with the Trust's long term strategic plans

13.4. For every capital expenditure proposal, the Chief Executive shall ensure that a business case, or statement of need, is produced in accordance with the Trust's approved procedures and is considered by the **Finance and Performance Committee**, where required. The business case shall set out, as a minimum:

13.4.1. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs

13.4.2. the involvement of appropriate Trust personnel and external agencies

13.4.3. appropriate project management and control arrangements

13.5. The approval of a capital programme shall not constitute approval for expenditure on any scheme.

13.6. The **Director of Finance** shall:

13.6.1. review the costs and revenue analysis, including revenue consequences included in the business case

13.6.2. ensure that, in higher cost, or higher risk investments, advice has been sought from the NTDA; and that appropriate Risk Evaluation for Investment Decisions (REID) analysis has been completed

13.7. For approved capital schemes, the Director of Finance shall:

13.7.1. issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes

13.7.2. agree arrangements for managing stage payments

13.7.3. maintain procedures for monitoring and reporting on the progress of delivery of contracts; and capital expenditure and commitments against plans and against the Trust's capital programme

13.8. The Trust's **Procurement Service** shall advise the Director of Finance, on the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.9. Authorisations issued to the manager(s) responsible for any scheme shall be made in accordance with the value limits set out in the Scheme of Delegated Authorities:

13.9.1. specific authority to commit expenditure;

13.9.2. authority to proceed to tender

13.9.3. approval to accept a successful tender

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North Bristol NHS Trust Standing Financial Instructions

Private Finance Initiatives (PFI)

13.10. The **Director of Finance** should normally test for PFI when considering capital procurement. If this test supports a proposal to use finance which is to be provided through PFI arrangements, the Director of Finance shall:

13.10.1. demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector

13.10.2. refer any investment proposal over £1 million to the NTDA for a risk assessment and decision to approve the borrowing

13.11. Any PFI proposal shall be specifically agreed by the **Trust Board**.

13.12. Where a capital scheme is funded using the PFI, any variations to the contract will be dealt with under procedures for variations in capital contracts and shall be authorised by the Trust Board.

Instructions specific to the Southmead Hospital PFI

13.13. The **Trust Board** shall approve and authorise the schedule of payments payable by the Trust to the PFI Project Co (Hospital Company (Southmead) Limited), as documented in the Project Agreement made between the Trust and the PFI Project Co dated 25 February 2014 ("Project Agreement").

13.14. The Schedule of Service Payments (Project Agreement, Schedule 18, Appendix I) shall be fixed for the duration of the Project Term save in respect of

13.14.1. inflationary adjustments

13.14.2. procurement of additional works (i.e. Small Works etc.)

13.14.3. variations in accordance with Schedule 22 of the Project Agreement.

13.15. Inflationary adjustments shall be calculated annually and presented to the Trust Board for approval. Arrangements for the procurement of additional works and variations shall be dealt with in accordance with the procedures for variations in capital contracts and shall be authorised by the Trust Board.

13.16. During the Operational Term, the **Director of Facilities** shall be responsible for monitoring the proper performance and implementation of the Project Agreement by the Project Co and the Trust. In accordance with the monthly reporting arrangements, the Director of Facilities will be responsible for ensuring the invoices issued by the Project Co are analysed to ensure compliance with the terms of the Project Agreement. This will include verifying records of:

13.16.1. performance failures

13.16.2. unavailability events

13.16.3. service failure points

and associated "deductions" against Trust records.

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13.17. The **Director of Facilities**, or their nominated deputy shall authorise payment of invoices submitted by the Project Co in accordance with Schedule 18 of the Project Agreement, provided that:

13.17.1. they are satisfied that the appropriate level of Deductions have been applied

13.17.2. the invoice complies with the requirements of Schedule 18

13.17.3. the Trust does not dispute all or any part of the invoice

where all or any part of an invoice is to be withheld, approval of the Director of Finance is required

13.18. The **Director of Finance,** or in their absence, the **Chief Executive** shall approve any decision to withhold, or delay payment of invoices, at the risk of incurring penalties and interest charges for the late payment of amounts due.

13.19. The **Assistant Director of Finance (Financial Services)**, or their nominated deputy, shall process payments of invoices submitted by the Project Co in accordance with Schedule 18, subject to the approval of the Director of Facilities and, where appropriate, the Director of Finance.

13.20. The **Director of Facilities** shall oversee procedures for determining variations to the Project Agreement. Any such variations shall be subject to authorisation in accordance with the limits set out in the Scheme of Delegated Authorities.

Asset registers

13.21. The **Director of Finance** shall maintain registers of assets and shall maintain procedures for keeping the registers up to date, including provision for arranging for physical confirmation of the existence of assets against the asset register to be conducted once a year.

13.22. The **Director of Finance** shall maintain procedures for verifying additions and amendments to the assets recorded in the asset register. These procedures and records will include:

13.22.1. additions to the fixed asset register clearly identified to an appropriate budget manager

13.22.2. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties

13.22.3. records of costs incurred within the Trust, on stores, requisitions and labour including appropriate overheads

13.22.4. lease agreements in respect of assets held under a finance leases

13.23. The **Director of Finance** shall maintain procedures for controlling the disposal of assets and updating of asset registers and financial records to reflect the event. These procedures will include the requirement for the authorisation and validation of the de-commissioning and disposal of the asset.

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13.24. The **Director of Finance** shall approve procedures for:

13.24.1. applying depreciation charges and indexation valuation adjustment to assets, using methods and rates as specified in the Manual for Accounts issued by the DH

13.24.2. reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers

Security of assets

13.25. The **Chief Executive** shall maintain procedures for controlling the security of assets, including fixed assets, cash, cheques and negotiable instruments. The procedures will include:

13.25.1. recording managerial responsibility for each asset

13.25.2. identification of additions and disposals

13.25.3. identification of all repairs and maintenance expenses

13.25.4. physical security of assets

13.25.5. periodic verification of the existence of, condition of, and title to, assets recorded

13.25.6. identification and reporting of all costs associated with the retention of an asset

13.25.7. reporting, recording and safekeeping of cash, cheques, and negotiable instruments

13.26. **All employees** are responsible for the security of property of the Trust and for following such routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices, or damage and losses to Trust property shall be reported in accordance with agreed procedures.

13.27. Where practical, assets should be marked as Trust property.

Disposals and condemnations

13.28. The **Director of Finance** shall prepare procedures for the disposal of assets including condemnations and ensure that these are notified to managers. The procedures will include arrangements to be followed for:

13.28.1. condemning and disposing of unserviceable and redundant assets

13.28.2. maintaining records of assets disposed of, including confirmation of destruction of condemned assets

13.28.3. specific processes to be followed in instances where assets are passed on for future use to another organisation

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13.28.4. the sale of assets, including through competitive bids and negotiated bids; and sales linked to larger contracts for work, such as assets arising from works of construction, demolition or site clearance

13.29. The **departmental manager** responsible for the decision to dispose of an asset shall advise the Director of Finance of the estimated market value of the asset, taking account of professional advice where appropriate.

14. Bank accounts and Government Banking Service accounts

14.1. The **Trust Board** shall:

14.1.1. approve the banking arrangements for the Trust.

14.1.2. As the Corporate Trustee, approve separate banking arrangements for the Trust's Charitable Funds

14.2. The **Director of Finance** is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of bank accounts. This advice will take into account guidance and Directions issued by the Department of Health.

14.3. The **Director of Finance** shall:

14.3.1. establish and maintain necessary commercial bank accounts and Government Banking Service (GBS) accounts

14.3.2. establish separate bank accounts for non-exchequer funds, including charitable funds

14.3.3. advise the Trust's bankers, formally in writing, of the conditions under which each account will be operated (the bank mandate)

14.3.4. seek to limit the use of commercial bank accounts and the value of cash balances held within them

14.3.5. conduct the Trust's main banking services and financial transactions using accounts provided by the GBS

14.4. Only the **Director of Finance**, or their nominated representative, is authorised to open, operate and control a bank account, where monies owned by the Trust, including charitable funds, are received or expended. All such accounts must be held in the name of the Trust. It is a disciplinary offence for any other officer of the Trust to establish and operate such an account.

14.5. The **Director of Finance** 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.

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Banking procedures

14.6. The **Director of Finance** shall prepare detailed instructions on the operation of bank and GBS accounts which shall include:

14.6.1. the conditions under which each bank and GBS account is to be operated

14.6.2. details of those authorised to sign cheques or other orders drawn on the Trust's accounts

14.6.3. details of limits to delegated authority, including the number of authorised signatories required, and arrangements for authorising alternative mechanisms for 'signing' cheques and orders

Tendering and review

14.7. The **Director of Finance** shall review the commercial banking arrangements of the Trust at regular intervals to ensure they continue to reflect best practice and represent best value for money.

14.8. Competitive tenders should be sought at least every five years. The **Director of Finance** shall report to the Trust Board the reason(s) for continuing existing banking arrangements for longer than five years, without competitive review.

14.9. The **Director of Finance** shall report the results of any tendering exercise to the Board. This review is not necessary for GBS accounts.

Trust credit cards

14.10. The **Director of Finance** shall approve the allocation and operation of credit cards on behalf of the Trust; implement arrangements to monitor whether the credit cards are being used appropriately; and take action where inappropriate use is identified.

Security of cash, cheques and other negotiable instruments

14.11. The **Director of Finance** shall:

14.11.1. approve the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable

14.11.2. maintain adequate systems for ordering and securely controlling any such stationery

14.11.3. provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, and procedure notes for the safe storage of keys, and for coin operated machines

14.11.4. prescribe systems and procedures for handling cash and negotiable securities on behalf of the Trust

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14.12. Where such issues are undertaken by the Shared Business Service, detailed requirements will be specified in a Service Level Agreement with The Shared Business Service.

14.13. The Trust's money shall not under any circumstances be used for the encashment of private cheques.

14.14. All cheques, postal orders, cash etc, shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

14.15. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisations or individuals absolving the Trust from responsibility for any loss.

15. Investments

15.1. Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board. The current rules require that surplus funds are held in the Trust's GBS accounts.

15.2. The **Director of Finance** shall advise the Charity Committee on investments made with endowment funds held; and prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

16. Management of debtors

16.1. The **Director of Finance** shall:

16.1.1. maintain effective processes for the appropriate recovery action on all outstanding debts

16.1.2. deal with instances of income not received, in accordance with losses procedures

16.1.3. maintain effective processes to prevent, or detect overpayments and initiate recovery when this occurs

17. Stores and receipt of goods

17.1. The **Director of Finance** shall determine procedures for the management stocks of resources, defined in terms of controlled stores and departmental stores. These will address the procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses; and include the principles that stocks are::

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17.1.1. managed so that best value for money can be achieved whilst maintaining minimum safe stock levels

17.1.2. subjected to annual stock take as a minimum, where rolling stock checks are not in place

17.1.3. valued at the lower of cost and net realisable value

17.2. The **Director of Facilities** shall:

17.2.1. delegate responsibility for the management of stores to relevant, suitably qualified departmental managers

17.2.2. (taking expert advice where necessary) define the security arrangements and the custody of keys for any stores and locations in writing. Wherever practicable, stocks should be marked as health service property

17.2.3. approve alternative arrangements for the management of stores where a complete system of stores control is not justified

17.2.4. identify those authorised to requisition and accept goods supplied

17.3. The **designated store manager** shall:

17.3.1. Maintain stocks in line with clearly defined local procedures that are consistent with the overall requirements set out by the Trust

17.3.2. implement periodic review of slow moving and obsolete items; and for condemnation, disposal, and replacement of all unserviceable articles

17.3.3. report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice in the management and use of stocks

18. External borrowing and Public Dividend Capital

18.1. The **Director of Finance** shall advise the Board on the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The Director of Finance shall also provide periodic reports to the Board concerning the PDC debt and all loans.

18.2. The **Trust Board** shall agree the list of employees authorised to make short term borrowings on behalf of the Trust. This shall include the Chief Executive and the Director of Finance.

18.3. The Director of Finance shall prepare detailed procedural instructions concerning applications for loans and shall ensure that:

18.3.1. all short-term borrowings are kept to the minimum period of time possible, consistent with the Trust's overall cashflow position, represent good value for money, and comply with the latest guidance from the DH

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18.3.2. the Trust Board is made aware of all short term borrowings at the next meeting

18.4. The **Finance and Performance Committee** shall ensure that all proposed long-term borrowing is consistent with the Trust's financial plans; and is approved by the Trust Board.

19. Losses and special payments

19.1. The **Director of Finance** shall prepare procedural instructions for maintaining a register of losses and special payments, including write-offs, condemnations and ex-gratia payments; and on the recording of and accounting for losses and special payments, including ex-gratia payments. The records will include:

19.1.1. the nature, gross amount (or estimate if an accurate value is not available), and the cause of each loss

19.1.2. the action taken, total recoveries and date of write-off where appropriate

19.1.3. the category in which each loss is to be noted

19.2. The **Director of Finance** shall determine the nature and/or value of losses which must be reported immediately to the **Director of Finance** or **Chief Executive**:

19.2.1. where fraud or bribery is suspected, this shall be reported to the Local Counter Fraud Specialist, in accordance with the Trust Counter Fraud and Bribery Policy

19.2.2. where a criminal offence is suspected, the **Director of Finance** must immediately inform the Local Security Management Specialist who may inform the police if theft or arson is involved

19.2.3. where losses, other than those that are clearly trivial, are apparently caused by theft, arson, neglect of duty or gross carelessness, the Director of Finance must immediately notify the external auditor and the Trust Board

19.3. **Any employee** discovering or suspecting a loss of any kind shall immediately inform their head of department and ensure that the loss is recorded in accordance with instructions.

19.4. The **Trust Board** shall approve the write off of losses, compensations and ex-gratia payments, within the limits delegated to it by the Department of Health.

19.5. The **Audit Committee** shall receive regular reports of losses, compensations and ex-gratia payments made.

19.6. The **Director of Finance** and the Shared Business Service shall be authorised to:

19.6.1. take any necessary steps to safeguard the Trust's interests in the event of bankruptcies and company liquidations

19.6.2. investigate whether any insurance claim can be made

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20. Patients' property

20.1. The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival (see "Guidance for NHS organisations on the secure management of patients' property", NHS Protect, July 2012; and Health and Social Care Act 2008, (Regulated Activities) regulations 2010).

20.2. The **Chief Executive** shall ensure that patients or their guardians, as appropriate, are clearly and suitably informed before or on admission into hospital that the Trust will not accept responsibility or liability for patients' property brought into NHS premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

20.3. The **Director of Finance** shall provide procedural instructions on the collection, custody, banking, recording, safekeeping, and disposal of patients' property. (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. These instructions will include arrangements for:

20.3.1. managing large amounts of money handed over by longer stay patients

20.3.2. restricting the use of patients' monies for purposes specified by the patient, or their guardian

20.4. In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

20.5. **Departmental and senior managers** shall inform staff of their responsibilities and duties for the administration of the property of patients.

21. Funds held on Trust

21.1. The **Trust Board**, as Corporate Trustee, is responsible for the management of funds it holds on trust and for meeting the requirements of the Charities Commission.

21.2. The **Trust Board's** corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

21.3. Trustee responsibilities for non-exchequer funds for charitable and non-charitable purposes shall be discharged separately and full recognition shall be given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

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21.4. The Charity Committee shall ensure that each trust fund for which the corporate trustee is responsible is managed appropriately in terms of its purpose and requirements.

22. Retention of records

22.1. The **Chief Executive** is responsible for managing all NHS records, regardless of how they are held; and shall require policy and procedures to be followed that ensure compliance with the current DHSC best practice guidelines on records management. These procedures will include arrangements for:

22.1.1. managing archives of all records required to be retained in accordance with DHSC guidelines

22.1.2. records held in archives to be accessible for retrieval by authorised persons

22.1.3. destruction of records in accordance with the DHSC "Records Management: NHS Code of Practice" Part 1 (30 March 2006) and Part 2 (8 January 2009)

22.2. Where documents are held by a Shared Business Service detailed records storage requirements will be set out in a SLA with the Shared Business Service.

23. Information Technology and data security

23.1. The **Director of Finance** shall be responsible for the accuracy and security of the performance and financial data of the Trust and shall devise and implement any necessary procedures to ensure:

23.1.1. computer assets and data programmes are protected from theft or damage

23.1.2. adequate and reasonable protection of the Trust's data from deletion or modification; accidental or intentional disclosure to unauthorised persons, having due regard for the Data Protection Act 1998

23.1.3. adequate controls operate over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data

23.1.4. controls exist such that the computer operation is separated from development, maintenance and amendment

23.1.5. adequate audit trails exist through the computerised system; and that these are subjected to periodic reviews as the Director may consider necessary

23.2. Where computer systems have an impact on corporate financial systems, the Director of Finance shall ensure that new systems and amendments to existing financial systems are developed in a controlled manner and thoroughly tested prior to implementation. The Director of Finance shall gain assurance that:

23.2.1. systems acquisition, development and maintenance are delivered in line with contractual agreements and Trust procedures

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23.2.2. new systems that have an impact on, or are replacing existing financial systems are developed in a controlled way and thoroughly tested before they are put into practice. External organisations providing this service will need to provide assurances that what they do is adequate

23.2.3. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management audit trail exists

23.2.4. finance staff have the necessary levels of access to such data

23.2.5. such computer audit reviews as are considered necessary are being carried out

23.3. The **Chief Executive** shall maintain a Freedom of Information (FOI) Publication Scheme, consistent with models approved by the Information Commissioner.

Contracts for computer services with other health bodies or outside agencies

23.4. The **Director of Finance** shall ensure that any contract for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract shall also ensure rights of access for audit purposes.

23.5. Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

Risk assessment

23.6. The **Chief Information Officer** shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered; and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

24. Risk management

24.1. The **Chief Executive** shall ensure that the Trust has adequate procedures for managing risk and meeting current DHSC requirements for assurance frameworks, which shall be approved and monitored by the Trust Board.

24.2. The programme of risk management shall include:

24.2.1. arrangements for identifying and quantifying risks and potential liabilities

24.2.2. promotion, to all levels of staff, of a positive attitude towards the identification and management of risk

24.2.3. procedures to ensure all significant risks and potential liabilities are assessed and addressed, including through maintenance of effective systems of internal

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control, cost effective insurance cover, and decisions on the acceptable level of retained risk

24.2.4. contingency plans to offset the impact of adverse events

24.2.5. arrangements for reviewing the effectiveness of the risk management processes in place, including: internal audit; clinical audit; and health and safety review

24.2.6. arrangements for reviewing the risk management programme

24.3. The Chief Executive shall ensure that the existence, integration and evaluation of the risk management system is used to inform the Annual Governance Statement within the Annual Report and Accounts as required by current DHSC guidance.

25. Audit

25.1. In accordance with Standing Orders, the Board shall formally establish an **Audit Committee**, with clearly defined terms of reference. The Committee will seek assurance for the Board on the range of issues in accordance with guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

25.1.1. overseeing internal and external audit services

25.1.2. reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments

25.1.3. reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

25.1.4. monitoring compliance with Standing Orders, Standing Financial Instructions, delegations and reservations

25.1.5. reviewing schedules of losses and compensations and advising the Board where necessary

25.1.6. reviewing the arrangements in place to support the application of the Assurance Framework on behalf of the Board and advising the Board accordingly.

25.2. Where the Audit Committee considers there is evidence of *ultra vires* transactions, or improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health (to the Director of Finance in the first instance).

25.3. It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided. The Audit Committee shall be involved in the selection process when the internal audit service provision is subjected to market testing.

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25.4. In the case of the Shared Business Service, the Director of Finance shall ensure that maintenance of an adequate internal audit service is specified in any service level agreement and shall further specify assurance arrangements between the Trust's internal and external auditors and the Shared Business Service's auditors.

25.5. The **Director of Finance** shall ensure that:

25.5.1. there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an independent and effective internal audit function

25.5.2. the Head of Internal Audit is sufficiently qualified and experienced to perform that role; to facilitate the effective discussion of the results of internal audit work with senior management

25.5.3. the internal audit service is adequate and meets the NHS Internal Audit Standards (DH, April 2011)

25.5.4. the internal audit service provides the Audit Committee with an annual report of the coverage and results of the work of the service. The report must address, as a minimum:

- a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health
- major internal financial control weaknesses identified
- progress on the implementation of internal audit recommendations
- progress against plan over the previous year
- strategic audit plan covering the forthcoming three years
- a detailed audit plan for the next financial year

25.5.5. the police are informed at the right time, in cases of misappropriation and other irregularities not involving fraud or bribery

25.5.6. there is effective liaison with the Trust's appointed Local Counter Fraud Specialist (LCFS), or NHS Counter Fraud Authority on all suspected cases of fraud and bribery and all anomalies which may indicate fraud or bribery

25.6. The **Director of Finance** and designated auditors are entitled to require and receive, without necessarily giving prior notice, the following:

25.6.1. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature

25.6.2. access at all reasonable times to any land, premises or members of the Board or employees of the Trust

25.6.3. sight of any cash, stores or other property of the Trust under the control of any member of the Board or Trust employee

25.6.4. explanations concerning any matter under investigation

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Internal Audit

25.7. The internal audit service shall:

25.7.1. provide an independent and objective assessment for the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance arrangements support the achievement of the Trust's objectives.

25.7.2. operate independently of the decisions made by the Trust and its employees; and of the activities which it audits. No member of the team providing the internal audit service will have executive responsibilities.

25.8. The **Head of Internal Audit** shall develop and maintain an Internal Audit Strategy for providing the Chief Executive with an objective evaluation of; and opinions on the effectiveness of the Trust's risk management, control and governance arrangements. The planned programme of work will inform the Head of Internal Audit's opinion. This will contribute to the framework of assurance that supports completion of the Annual Governance Statement, which forms part of the annual financial accounts.

25.9. The **Head of Internal Audit** shall ensure that the audit team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience needed to deliver the internal audit plan in line with the NHS Internal Audit Standards (DH, April 2011).

25.10. The **Head of Internal Audit** will normally attend Audit Committee meetings and has an independent right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

25.11. The **Head of Internal Audit** shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards.

25.12. The internal audit service will review, appraise and report upon:

25.12.1. the extent of compliance with and the financial effect of, relevant policies, plans and procedures

25.12.2. the adequacy and application of financial and other related management controls

25.12.3. the suitability of financial and other related management data

25.12.4. the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from

25.12.5. fraud and other offences

25.12.6. waste, extravagance and inefficient administration

25.12.7. poor value for money or other causes

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25.13. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

25.14. In obtaining third party assurance from other auditors, for example SBS's auditors, the Head of Internal Audit should follow the Internal Auditors Practitioners Group (IAPG) assurance guidance.

External Audit

25.15. The **External Auditor** is appointed by the Trust's Auditor Panel and paid for by the Trust. The Audit Committee shall ensure that a cost-effective service is provided. If the Trust Board has concerns about the service provided by the External Auditor, which cannot be resolved by the Board, this should be raised with the External Auditor.

Counter Fraud and Bribery

25.16. In line with their responsibilities the Trust **Chief Executive** and **Director of Finance** shall ensure compliance with section 24 of the NHS Standard Contract;

25.17. The **Director of Finance** shall ensure that:

25.16.1. the Trust's Counter Fraud and Bribery Policy is maintained and remains up to date;

25.16.2. an NHS accredited Local Counter Fraud Specialist is appointed to the Trust to deliver the requirements of the Policy in accordance with the NHS Counter Fraud Authority Standards;

25.18. The appointed **Local Counter Fraud Specialist** shall report to the Director of Finance and shall work with staff in NHS Counter Fraud Authority, when required;

25.19. The Local Counter Fraud Specialist will provide a written report to the Audit Committee, on an annual basis at least, on the counter fraud work completed within the Trust;

25.20. In accordance with the Trust's Counter Fraud Policy, any suspicions involving financial crime must be reported to the Local Counter Fraud Specialist, and/or the Director of Finance or via the NHS Fraud and Bribery Reporting Line.

All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010.

Where evidence of Fraud and/or is identified all available sanctions will be pursued against offenders. This may include internal and professional body disciplinary sanctions, criminal prosecution and civil action to recover identified losses.

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Security Management

25.21. The **Director of Facilities** shall ensure that a qualified Local Security Management Specialist is appointed to provide security management services to the Trust, in accordance with the requirements of the NHS Standard Contract (currently 2013/14).

25.22. The **Local Security Management Specialist** will provide a written report to the Audit Committee, on an annual basis at least, on the security management work completed within the Trust.

ENDS

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Appendix 3 – Scheme of Delegated Authorities

1. Trust Policies and procedural guidance

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Adoption (and responsibility for currency of): - 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)	Director of Finance	SFI 2.14

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2. Planning and budget management

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Financial Framework Advising the Board on the financial framework within which the Trust operates	Director of Finance	SFI 3.1
	Compliance with and update of Trust financial framework	Director of Finance	SFI 3.1
	Business and budget plans		SFI 4
	Preparation of strategic and annual plans for the Trust	Chief Executive	SFI 4.1
	Preparation of annual (and longer term) financial budget for the Trust	Director of Finance	SFI 4.3
	Contribute to the preparation of annual budgets	All nominated Budget Managers	SFI 4.4
	Budget management (and responsibility levels)		SFI 5
	i. at individual cost centre level	Budget Manager or nominated deputy	SFI 5
	ii. at department level	Departmental Manager or nominated deputy	SFI 5
	iii. division level	Clinical Director / Corporate Manager (some or all of the Division Management Team as authorised by the Clinical Director / Corporate Manager)	SFI 5
	iv. at Executive Director level	Executive Director, or nominated deputy	SFI 5

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SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Recognition and adoption of the annual budget at cost-centre level	Budget Managers	SFI 5.9
	Variations from reserves (additional funds provided to address inflationary pressures and/or investments and/or risks) *Report periodically to the Finance & Performance Committee*	Director of Finance or nominated deputy	SFI 5

Approval of variation of budgets, including authority to vire

SoDA	Delegated Authority	Between budget lines	Capital to revenue & *vice versa*	SFI reference
	Within a cost centre	Budget manager **plus** one of: Head of Nursing, Matron, Divisional Operations Director, Assistant Department Manager	Agreement between Business Partner and Director of Operational Finance , with the express agreement of the Director of Finance	SFI 5.9
	Within a department, or specialty; between cost centres	Department Manager **plus** one of: Director, Deputy Director, Head of Nursing, Matron, Divisional Operations Director		SFI 5.9
	Within a division; between departments and specialties	Director, **or** Deputy Director **or** Divisional Operations Director		SFI 5.9
	Between divisions, up to **£5,000**	Deputy Director of both divisions		SFI 5.9
	Between divisions, over **£5,000**	Executive Director of both divisions		SFI 5.9

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Preparation of financial reports and returns

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Preparation of annual financial accounts and associated financial returns For Board approval	Director of Finance	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	Director of Finance or nominated deputy	SFI 6.1

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3. Contracted Income and Expenditure[1]

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Setting of fees and charges for NHS services		SFI 7
	Agree service level agreements, in accordance with NHS standard contract		SFI 7.6
	i. under £1 million	i. Director of Finance, or nominated deputy	
	ii. over £1million	ii. Chief Executive and Director of Finance	
	Subject to any required approvals being obtained, execute Agreements/Contracts (including Service Level Agreements and Deeds of Variation[2]) with NHS and non-NHS bodies for the purchase or provision of goods and/or services ii. under £1 million iii. over £1million	i. Director of Finance ii. Chief Executive and Director of Finance	SFI 7.6 SFI 7.7 SFI 7.8 SFI 9.5 SFI 9.6
	Contract management, monitoring and reporting	Director of Finance or nominated deputy	SFI 7.9 SFI 7.10
	Private Patients i. set pricing policy and price structure	i. Director of Finance ii. Director of Finance iii. Director of Finance, Medical	SFI 7.3

[1] All legally binding documentation must be entered into in the name of "North Bristol NHS Trust" as the relevant legal entity
[2] If any variation is not included within the original Agreement/Contract, such variation shall require approval as if a new Agreement/Contract (SFI 10.18)

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SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	ii. set payment policy, including use of deposits, income guarantees, arrangements with insurance companies 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	Director of Finance	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. Director of Finance iii. Chief Executive	SFI 7.13
	Authorise and execute concession arrangements	Director of Finance	SFI 7.15
	Authorise research projects and clinical trials, including approvals to apply for research funding and approvals to undertake research, once considered by the Research and Development Committee i. execute required Agreements/Contracts and authorise grant submission ii. execute documentation where the Trust Seal is required	i. Deputy Director of Research or nominated Deputy ii. As per SFI 8e	SFI 7.12

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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 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. Director of Finance ii. As per SFI 8e	SFI 7.4
	Approve rent based on professional assessment	Director of Finance or nominated deputy	SFI 7.4
	Legal Services 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

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4. Approval of Business cases

Before any case can progress through the approval processes detailed below, divisional and corporate support is needed for both capital and revenue cases as follows:

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Divisional support	Prior to any scheme advancing the Divisional Management Board should consider and approve the case

Business Case Review Group	The Business Case Review Group is a sub-committee of the Trust Management Team. The purpose of the Committee is to:
	• Review all capital and revenue business cases of value greater than £100k (defined as annual cost for recurring commitments or over life-time of contractual commitments, combined capital and revenue values):
	  ○ To ensure trust-wide impacts have been understood within the case
	  ○ To maintain consistent quality standard for cases going through for approval
	  ○ Appendix A outlines the process for cases of value below £100k
	• Provide an approval recommendation to TMT on finalised business cases;
	• Monitor development and delivery of business case pipeline

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The business case process outlined below applies to all contract renewals and extensions as well as new revenue spend

Approval Process - Revenue Business Cases

	Full life cost of new expenditure				
	Under £100k **DoF business case template**	**£100k - £500k** **Single-stage business case template**	**£500k – £1m** **OBC and FBC business case templates**	**Over £1m- £14,999k** **OBC and FBC business case template**	**Over £15m** **SOC, OBC and FBC busines s case template**
Director of Finance (or nominated deputy)	Approval	Approval	Approval OBC & FBC	Approval OBC & FBC	Approval SOC, OBC & FBC
Chief Executive	-	Approval (via Trust Management Team)	Approval (via Trust Management Team) OBC & FBC	Approval (via Trust Management Team) OBC & FBC	Approval (via Trust Management Team) SOC, OBC & FBC
Finance & Performance Committee	-	-	Approval OBC & FBC	Approval OBC & FBC	Approval SOC, OBC & FBC
Trust Board	-	-	-	Approval FBC	Approval FBC

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NHSI					Approval SOC, OBC & FPC

Approval Process – Capital Business Cases.

Gross expenditure on project (Full life costs, including all internal staff costs attributable to the project)						
	Up to £5k	**£5k - £100k**	**£100k to £500k**	**£500k to £1m**	**over £1m - £14,999k**	**Over £15m**
	Treat as revenue	**DoF business case template**	**Single-stage business case template**	**OBC and FBC business case templates**	**OBC and FBC business case templates**	**SOC, OBC and FBC business case templates**
Director of Operational Finance and Head of Sustainable Health and Capital Planning	N/A	Approval	Approval	Approve OBC and FBC	Approve OBC and FBC	Approve SOC, OBC and FBC
Director of Finance or nominated deputy	N/A	N/A	Approval	Approval of OBC and FBC	Approval of OBC and FBC at FPC	Approval of SOC, OBC and FBC at FPC
Finance & Performance Committee	N/A	N/A	N/A	Approve OBC and FBC	Approve OBC and FBC	Approve SOC, OBC and FBC
Trust Board	N/A	N/A	N/A	N/A	Approve FBC	Approve FBC
NHSI	N/A	N/A	N/A	N/A	N/A	Approve SOC, OBC and FBC

Key
DoF – Director of Finance
SOC – Strategic Outline Case
OBC – Outline Business Case

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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:

Joint Revenue and Capital Cases

Where a case involves both revenue and capital consequences then both approval routes should be followed. For example a case for capital investment of £250k and revenue consequences of £495k should be approved as follows:

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5. Approvals to Award from Tenders and quotations (revenue and capital)

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.

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Management of non-Contracted Spend			
	Description	**Consortium**	
1. Up to £5,000	*No requirement to evidence value for money*	5,000	Budget manager
2. £5,000 to £25,000	*Trusts responsible for quotation provision, BWPC operate a validation activity*	25,000	Divisional Operations Director or Executive Director or nominated Deputy
Written Quote Requirement	*The number of quotes required prior to a Purchase Order being progressed*	3	

Procedure (between SFI threshold & £25K)	**Procedure Detail**		**Consortium**
Quotation Process	*3 or more valid quotes provided*		PO Progressed
Quotation Process	*2 or less valid quotes*		STA
3. Above £25,000	Outcome Detail		Consortium
Tender Process (Local, OJEU, Quote)	*3 or more competitively priced bids received*		Recommendation Report
Tender Process (Local, OJEU, Quote)	*Less than 3 competitively priced bids received*		Recommendation report, followed by STA if approved

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Tender Process (Local, OJEU, Quote)	*Contract not awarded to process winner*		Exception Report, followed by STA if exception awarded
Framework Agreement (External, Internal)	*Mini-Competition - 3 or more competitively priced bids received*		Recommendation Report
Framework Agreement (External, Internal)	*Mini-Competition – Less than 3 competitively priced bids received*		Recommendation report, followed by STA if approved
Framework Agreement (External, Internal)	*Compliant direct award (without proof/evaluation of competition)*		Recommendation report, followed by STA if approved
Framework Agreement (External, Internal)	*Non-compliant direct award*		Exception Report, followed by STA if exception awarded
VEAT Notice	*VEAT Notice*		Recommendation report, followed by STA if approved
Contract Modification	*Contract Extension (In scope)*		Recommendation Report
Contract Modification	*Contract Extension (Out of scope)*		Exception Report, followed by STA if exception awarded
Contract Modification	*Contract Variation (In scope)*		Recommendation Report
Contract Modification	*Contract Variation (Out of scope)*		Exception Report, followed by STA if exception awarded

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Non-contracted to contracted spend	*Non-PO to PO (first 12 months/specified period)*		Single Tender Action, with commitment to run procurement within 12 months
Non-compliant direct award			Single Tender Action

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STA & Exception report Authorisation Financial Values

Up to £25k
Director of Procurement

£25k to £100K
Director of Finance

£100K to £1m
Chief Executive

£1m+
Trust Board

Recommendation Report - Authorisation Levels

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

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

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

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5 Contract Signature

The following applies for contract signatures (after all relevant approvals have been given):

- **Up To EU threshold – Divisional Operations Director or relevant Corporate Director**
- **EU threshold to £500,000 – Director of Finance**
- **Over £500,000 - Chief Executive**

6. 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. Director of Finance or nominated deputy. ii. Director of Finance or	SFI 12.1 SFI 12.4

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		nominated deputy.	
	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

Non-pay requisitions, orders and payment authorisation

Financial thresholds in this section mirror the procurement limits and as such exclude VAT and/or delivery charges. Where there is an order/contract for more than one financial year, the total cost must be included not just the 12 months element.

	Delegated Matter	Authority Delegated to	Delegation Ref.
	Maintain records of officers who are authorised to place requisitions and orders; and the maximum value of orders that they have the authority to place.	Director of Finance	SFI 10.2
	Identify the Trust's approved supply arrangements (controlled procurement systems, framework agreements)	Director of Finance	SFI 10.4

Trust-wide ***(excepting elements of delegated authority for specific disciplines specified in the subsequent tables)***

7. Ordering limits (EROS)

Up to £2,500	Authorising manager approved by Divisional Operations Director/Corporate manager
Over £2,500	Vetting manager approved by Divisional Operations Director/Corporate manager

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8. Oracle Limits - Invoice processing

a. General Oracle Limits

Up to £25,000	Budget holder/manager designated by Divisional Operations Director or equivalent
£25,000 to £100,000	Divisional operations Director//Corporate Manager
£100,000 to £1m Grouped NHS Supply Chain invoice up to £500K	Executive Director Director of Procurement
Over £1m	Director of Finance/Chief Executive

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b. Subsidiary Systems

Subsidiary Systems where grouped requisitions are used.

	Pharmacy	**Capital Estates**
Grouped requisitions up to £500k per week	Director of Pharmacy or nominated deputy	Capital estates Mailbox
Grouped requisitions over £500k per week	Director of Pharmacy	Director of Facilities or nominated Deputy

c. In addition to the general oracle limits, additional limits are in place within the finance department which are used to process high value pre-approved invoices e.g Unitary Payment, loan repayments etc.

Up to £1m	Head of Financial Control
£1m-£10m	Assistant Director of Finance (Financial Services) or Assistant Director of Finance (Planning & Income) (or nominated deputies in their absence)
Over £10m	Director of Operational Services or Director of Finance

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9. Workforce and payroll

Appointment of Senior Medical Staff and team (investment may include capital elements)

		Replacement posts	New posts / clinical teams[1]	
		Within existing budget	**Up to £500k**	**Over £500k**
	Approval / Sign-Off[2] by:			
	Trust Management Team		Agree project mandate and priority	
	Finance Business Partner	Sign	Sign	Sign
	HR advisor	Sign	Sign	Sign
	Divisional Operations Director or equivalent corporate manager	Sign	Sign	Sign
	Clinical Director	Sign	Sign	Sign
	Chief Operating Officer	-	Sign	Sign
	Director of Finance	-	Sign	Sign
	Consultant Post Panel	**Approve**	**Approve**	Recommend
	Finance & Performance Committee			OBC & FBC
	Trust Board			**Approve** FBC

[1] New clinical teams to deliver new services. Approach follows the same sign-off steps as for new service developments

[2] Signature indicates sufficient understanding and confidence in the details of the business case to confirm responsibility for support for the

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proposal

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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	-	Director of Finance	
	- over **£500k** gross commitment	-	Chief	

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			Executive
	- over 6 months length of contract	-	Chief Executive

[1]Need to ensure fit with workforce plans

Bank, agency and locum staff	Within establishment		Extra to establishment	
	Within budget	Without budget	Within budget	Without budget
SoDA reference	11g		11h	
Nursing	(Deputy) Budget Manager	Director of Nursing **or** Medical Director and Director of Finance **or** Chief Executive	Budget Manager	Director of Nursing **or** Medical Director and Director of Finance **or** Chief Executive
Clerical support services	(Deputy) Budget Manager		Budget Manager	
Medical	(Assistant) General / Corporate Manager		Divisional Operations Director/ / Corporate Manager	
Through non-framework agency	As above, plus Executive Director approval		As above, plus Executive Director approval	

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Approvals relating to staff on the payroll

	General approvals	Approval / sign off
	Grant additional increments to staff (outside of Department of Health national T&C)	Director of People & Transformation **and** Director of Finance
	Authorise (electronic and paper) timesheets and other positive reporting forms which will affect the amount of salary to be paid to confirm: attendance at work; sickness and absence records; overtime and unsocial hours	Line Manager **or** Authorised Signatories
	Authorise travel and subsistence claims (only available through e-expenses)	Line Manager
	Approve departure under compromise agreement (excluding mutually agreed resignation scheme (MARS) arrangements) i. directors and very senior managers ii. other staff	i. Remuneration and Nominations Committee and Director of Finance ii. Director of People & Transformation and Director of Finance
	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 Director of Finance ii. Remuneration and Nominations Committee and Director of Finance

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10 Approval for variations to capital plans

Delegated authority	Variations to approved sum
Up to **£100k**	Capital Planning Group
£100k to **£500k**	Finance & Performance Committee
Over £500k	Trust Board

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Funding capital investments through Private Finance Initiative

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Assess comparative merit of progressing scheme through PFI	Finance and Performance Committee, advised by Director of Finance	SFI 13.10
	Authorise payment of the sums identified in the schedule of the unitary payment (being the annual service payment defined in Schedule 18 of the Project Agreement) to be made to the PFI partner over the lifetime of the scheme (project term). Authorise annual Retail Price Index (all items) adjustment, in accordance with the PFI Project Agreement.	Trust Board	SFI 13.13
	Oversee delivery of the PFI contract terms, ensuring appropriate delivery and monitoring of the PFI contract; and including agreement of fee adjustments resulting from facilities management service and performance issues, to verify the invoice total.	Director of Facilities	SFI 13.14 SFI 13.15
	Approve decision to withhold, or delay payment of all or part of an invoice submitted by the PFI partner, at risk of incurring penalties and late payment charges	Director of Finance	SFI 13.16
	Process payment of monthly account to the PFI partner, in accordance with the Trust Board authorisation.	Assistant Director of Finance (Financial Services), or nominated deputy	SFI 13.17

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Fixed assets records and accounting for fixed assets

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Maintain register of (fixed) assets Including verification of additions and disposals, revaluations, calculation of annual capital charges	Director of Finance	13.19 to 13.22

11. Bank and cash and investments

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Day to day operation of bank accounts 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	Director of Finance	SFI 14.8
	Establish, or close a petty cash facility	Director of Finance (or nominated deputy)	Not within SFIs
	Approve the use of Trust credit cards (in the name of North Bristol NHS Trust only)	Director of Finance (or nominated deputy)	SFI 14.10

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SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Investment of funds i. surplus exchequer funds ii. charitable fund cash balances	i. Director of Finance ii. Investment advisors appointed by the Charity Committee	SFI 15

12. External borrowing and Public Dividend Capital

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Short-term borrowing (temporary borrowing limit)	Trust Board	SFI 18.2 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

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13. Disposals, write-offs losses and special payments

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Terminate lease and rental arrangements early at cost to the Trust	Director of Finance **and** Director of Facilities	SFI 13.21
	Condemn and arrange for disposal of equipment assets 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
	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 iii. Director of Facilities **and** Director of Finance	SFI 13.26
	Approve sale, or transfer (eg donation) of equipment assets to another organisation for continued use i. clinical equipment ii. IT equipment iii. other equipment	i. Medical Director ii. Director of Finance iii. Director of Finance **and** relevant Executive Director	SFI 13.26

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SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Approve losses, write-offs and compensation payments due to / made under: • 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 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.*	i. Assistant Director of Finance (Financial Services) or nominated deputy in their absence ii. Director of Finance or deputy iii. Audit Committee	SFI 19 Schedule of reservations 3

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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. Director of Finance or Local Counter Fraud Specialist	SFI 19 *Counter Fraud and Bribery Policy*

14. 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

15. Access to charitable funds

Delegated authority	Approve expenditure from charitable funds
Up to £1,000	One fund signatory
£1,000 to £10,000	Two fund signatories

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Delegated authority	Approve expenditure from charitable funds
£10,000 to £50,000	Two fund signatories plus the Director of Finance (or nominated deputy)
Over £50,000	Two Fund signatories and the Charity Committee.

Spending plans will be submitted to the Charity Committee for approval in March each year. Approval is delegated to approve additional spending plans that arise during the year as follows:

Delegated authority	Approve expenditure from charitable funds
Up to £10,000	Assistant Director of Finance (Financial Services) or nominated deputy in their absence
£10,000 to £50,000	Director of Finance (or nominated deputy)
Over £50,000	Charity Committee.

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Glossary of terms and acronyms

BC	**Business case**
CEO	**Chief Executive Officer**
Director	Non-Executive or Executive Director, with or without voting rights at Trust Board. The term excludes Clinical Directors, who are identified separately
DoF	**Director of Finance**
FBC	**Full Business Case**
Divisional Operations Director /Corporate Manager	The senior operational manager(s); and their formally nominated deputy, for the division or specialty, as designated by the Executive Director.
OBC	**Outline Business Case**
PMO	**Programme Management Office**
SBS	**Shared Business Services.** The Trust's provider of accounts transactions and ledger process
SFI	**Standing Financial Instruction.** Reference to the detail in the full SFIs
SOC	**Strategic Outline Case**
SoDA	**Scheme of Delegated Authorities**. Reference to the detail in the full SoDA

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North Bristol NHS Trust

Appendix to the Standing Orders and Standing Financial Instructions - COVID-19 related amendments (October 2020 Update)

1. Background

1.1. The anticipated “second wave” of Covid-19 has resulted in EPPR command and control arrangements being increased. In order to prepare and respond to the fast-changing situation, agile and responsive decision making processes are required, including decisions on financial investment.

1.2. The decisions implemented by the command and control structure will, in some cases, entail a deviation from the Trust’s Standing Orders and Standing Financial Instructions.

1.3. This document sets out the areas of agreed deviation relating to COVID-19 related activity. This document has been in force since 1 April 2020, with changes as follows:

- 26 March 2020 – Original financial delegations for Gold, Silver and Bronze command approved;
- 1 April 2020 - Changes to STA processes approved;
- 30 April 2020 - Consolidated Appendix to Standing Orders/Standing Financial Instructions approved;
- 28 May 2020 - Frequency of command and control meetings reduced, and financial delegations reduced;
- 29 October 2020 – Frequency of command and control meetings increased, and financial delegations increased.

1.4. These specific authorities to deviate from Standing Orders and Standing Financial Instructions relate only to activities relating to COVID-19 activity and will be in place only for the duration of the COVID-19 response (as determined by the Trust Board, on advice from the Executive Team).

1.5. All activity not directly in support of the COVID-19 response must follow the standard Standing Orders and Standing Financial Instructions.

1.6. The Trust has been advised that for the first half of the year revenue and capital expenditures relating to COVID-19 will be reimbursed nationally, in line with rules

October 2020

published by NHSE/I. For the second half of the year, the Trust has agreed a level of funding for the expected level of Covid-19 expenditure.

2. Command and Control Structure

2.1. The Trust's command and control structure comprises:

- Strategic gold command chaired by the Deputy Chief Executive;
- Operational silver command chaired by the Deputy Chief Operating Officer;
- A series of bronze command cells focusing on specific areas; and
- Expert reference groups and advisers.

2.2. The command and control structure has the following delegated financial decision-making powers for COVID-19 spend:

Gold Command	£250k (COVID-19 related, non-recurrent revenue only*)
Silver Command	Follows normal SFIs (makes recommendations to Gold Command on any COVID-19 spend)
Bronze cells	Follows normal SFIs (i.e. usual divisional limits apply)
* This reflects the strict national controls on any COVID-19 capital expenditure. If capital spend is required, Gold Command will task Capital Prioritisation Group to prioritise spend from existing plan, and displace something else.	

2.3. Any individual COVID-19-related revenue expenditure over £250k will come with a gold command recommendation, and follow existing approval routes (Trust Management Team, Finance & Performance Committee, Trust Board) or if time critical will be approved in line with the emergency powers under the Standing Orders:

"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 Chair shall be reported to the next formal meeting of the Trust Board."

3. Situation, Background, Assessment, Recommendation (SBAR)

3.1. For COVID-19 related expenditure, the Trust's usual business case templates have been replaced with an EPPR "Situation, Background, Assessment, Recommendation" document (SBAR). An SBAR must be completed for each investment, and

discussed/approved at the relevant command meeting (investment decisions made at bronze level are collated by the Finance, Procurement & Logistics cell). Meetings at silver and gold level are recorded via minutes/logging by an administrator, and key decisions, risks and issues are also captured at bronze cell level and recorded on a specific part of Datix.

4. Amendments to the Single Tender Action process

4.1. All COVID-19 investment is being managed via national frameworks and single tender actions (STAs). On 30 March 2020 a decision was taken by gold command to streamline the STA process to reduce the level of input required by end users, as this was being found to significantly slow down expenditure on much-needed COVID-19 supplies.

4.2. The changes to the STA process are:

4.2.1. Removal of the requirement for an STA for COVID-19 expenditure below £100k. Rigour and control is still exercised via a risk based approach with additional procurement controls at the front end:

- Expenditure approved by relevant bronze, silver, gold meeting;
- Approval and requirement or quotation provided to BWPC;
- BWPC sourcing undertakes review to ensure value for money (VFM) is being obtained, identifying and mitigating any risks where possible;
- Director of Procurement or delegated deputy reviews the proposal to provide assurance of VFM, communicating any risk to the Trust;
- Catalogue item made available on EROS for the requirement;
- Requisition raised and authorised by Division against COVID-19 branch code;
- Purchase order despatch to supplier again reference ‘NBT COVID-19’;
- BWPC provide weekly report to relevant Trust forums of purchase orders despatched against reference ‘NBT COVID-19’.

4.2.2. Streamlined STA process for COVID-19 expenditure requirements above £100k. Rigour and control is still exercised via a risk based approach with additional procurement controls at the front end:

- Expenditure approved by relevant silver or gold meeting;
- Approval and requirement or quotation provided to BWPC;
- BWPC sourcing undertakes review to ensure value for money (VFM) is being obtained, identifying and mitigating any risks where possible;
- BWPC sourcing agent populates Trust STA form, attaching approval email in place of budget holder signature;
- STA submitted to Director of Procurement or delegated deputy for reviews to ensure compliance, provide assurance of VFM and communicate any risk to the Trust;
- STA submitted to Director of Finance or delegated deputy, including assurance and detail of any risks for final approval (this also goes to the

Chief Executive, in line with our existing non-COVID-19 STA approval process under the SO/SFI);

- If STA is approved, STA reference created by BWPC;
- Catalogue item made available on EROS for the requirement;
- Requisition raised and authorised by Division against COVID-19 branch code;
- Purchase order despatched to supplier against STA reference.

4.3. This revised process ensures that any expenditure under £100k is subject to scrutiny by the Director of Procurement or delegated deputy, with the opportunity to communicate risks to more senior officers in the Trust. Any expenditure over £100k is still scrutinised by the Director of Operational Finance/Director of Finance/Chief Executive via the STA approval process.

October 2020