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 25 November 2021
10.00 – 13.05
Virtual via Microsoft Teams

A G E N D A

No.	Item	Purpose	Lead	Paper	Time
OPENING BUSINESS					
1.	Welcome and Apologies for Absence: John Iredale, NED, will join the meeting late	Information	Chair	Verbal	10.00
2.	Declarations of Interest	Information	Chair	Verbal	10.02
3.	Minutes of the Public Trust Board Meeting Held on 30 September 2021	Approval	Chair	Enc.	10.05
4.	Action Chart from Previous Meetings	Discussion	Trust Secretary	Enc.	10.06
5.	Matters Arising from Previous Meeting	Information	Chair	Verbal	10.08
6.	Chair's Business	Information	Chair	Verbal	10.10
7.	Chief Executive's Report	Information	Chief Executive	Enc.	10.20
KEY DISCUSSION TOPIC(S)					
8.	Patient Story Anela's Story: Accessible Information Standards *Gifty Markey, Head of Patient Experience, attending to present*	Discussion	Director of Nursing & Quality	Pres.	10.30
9.	Genomic Medicines Alliance program *Prof. Chrissie Thirlwell, Clinical Director South West GMSA and Rommel Ravanan, CCS Clinical Director and Genomics lead, attending to present*	Information	Medical Director	Pres.	10.55
PEOPLE					
10.	Bi- Annual Freedom to Speak-Up report *Hilary Sawyer, FTSU Lead, attending to present*	Discussion	Director of Corporate Governance	Enc.	11.15
BREAK (10mins)					11.30
11.	Guardian of Safe Working (Junior Doctors) – Board Update *Lucy Kirkham attending - if possible - to present*	Information	Medical Director	Enc.	11.40

No.	Item	Purpose	Lead	Paper	Time
12.	People Committee upward report 12.1. Safe Staffing reports	Information	NED Chair	Enc.	11.55
PERFORMANCE					
13.	Integrated Performance Report	Discussion	Chief Executive	Enc.	12.00
FINANCE & PLANNING					
14.	Finance & Performance Committee Upward Report 14.1. Finance Month 7 Report	Information	NED Chair	Enc.	12.20
QUALITY					
15.	Quality Committee Upward Report *Maternity Assurance Tool and minimum data set (Ockenden action) is included in the IPR*	Information	NED Chair	Enc.	12.30
GOVERNANCE & ASSURANCE					
16.	Audit Committee Upward Report 16.1. Revised Terms of Reference 16.2. Board Assurance Framework 16.3. Revised Standing Orders & Standing Financial Instructions (SFIs)	Approval	NED Chair	Enc.	12.40
17.	Patient & Carer Experience Upward Report	Information	NED Chair	Enc.	12.50
18.	Fit & Proper Person Requirements – Annual Report	Information	Director of Corporate Governance	Enc.	13.00
CLOSING BUSINESS					
	Any Other Business	Information	Chair	Verbal	13.05
	Questions from the Public in Relation to Agenda Items	Information	Chair	Verbal	-
	Date of Next Meeting: Thursday 27 January 2022, 10.00 a.m.				
	Resolution: Exclusion of the Press and Public. It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, Section 1(2), the press and members of the public be excluded from further items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.				

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.
Mr John Everitt	Non-Executive Director	• Councillor, Newton St Loe Parish Council. • Member of Bath Abbey Appeal Committee. • 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
		  ○ Foundation for Liver Research
		• Chair of the governing board, CRUK Beatson Institute.

Mr Tim Gregory	Non-Executive Director	• Employed by Derbyshire County Council – Director of Environment, Economy and Transport, commencing 03/08/2020. Likely to be until May 2021.

Name	Role	Interest Declared
Mr Richard Gaunt	Non-Executive Director	• Non-Executive/Governor of City of Bristol College. • Non-Executive Director of Alliance Homes, social housing and domiciliary care provider
Ms Kelly Macfarlane	Non-Executive Director	• Sister is Centre Leader of Genesiscare Bristol – Private Oncology. • Sister works for Pioneer Medical Group, Bristol. • Managing Director, HWM Limited, a Halma Company.
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 Maria Kane	Chief Executive	• Advisory Group Member of CHKS, a provider of healthcare intelligence and quality improvement services (remuneration donated to charity)
Mr Jon Scott	Chief Operating Officer	• Director of Monkton House Limited • Faculty member Francis Health
Mr Tim Whittlestone	Medical Director	• Director of Bristol Urology Associates Ltd. • Undertakes occasional private practice (Urology Specialty) at company office. This is undertaken outside of NBT contracted hours.

Name	Role	Interest Declared
Mr Glyn Howells	Chief Financial Officer	• Governor and Vice Chair of Newbury College (voluntary). • £25 voucher received as a thank you gift for speaking at a Royal College of Surgeons/Society of British Neurosurgeons Leadership Development Course on 18 November 2021. Donated to Southmead Hospital Charity.
Ms Helen Blanchard	Director of Nursing and Quality	• Nothing to declare.
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.
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.

3

DRAFT Minutes of the Public Trust Board Meeting held virtually on Thursday 30 September 2021 at 10.00am

Present:

Michele Romaine	Trust Chair	**Maria Kane**	Chief Executive
Tim Gregory	Non-Executive Director	**Evelyn Barker**	Deputy Chief Executive
John Iredale	Non-Executive Director	**Jon Scott**	Chief Operating Officer
Kelly MacFarlane	Non-Executive Director	**Helen Blanchard**	Director of Nursing & Quality
Richard Gaunt	Non-Executive Director	**Neil Darvill**	Director of Informatics
LaToyah Jones	Associate Non-Executive Director	**Tim Whittlestone**	Interim Medical Director
Ade Williams	Associate Non-Executive Director	**Simon Wood**	Director of Estates, Facilities & Capital Planning
		James Drury	Assistant Director of Financial Management
		Jacqui Marshall	Director of People & Transformation

In Attendance:

Xavier Bell	Director of Corporate Governance & Trust Secretary	**Isobel Clements**	Senior Corporate Governance Officer & Policy Manager *(Minutes)*

Presenters (present for Patient Story, minute item 07):

Gifty Markey	Patient Experience Lead	**Susan**	Patient story guest

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

Action

TB/21/09/01 Welcome and Apologies for Absence

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

Apologies had been received from John Everitt, Non-Executive Director, and Glyn Howells, Chief Finance Officer (James Drury deputised).

TB/21/09/02 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/21/09/03 Minutes of the previous Public Trust Board Meeting

RESOLVED that the minutes of the public meeting held on 29 July 2021 were approved as a true and correct record.

TB/21/09/04 Action Log and Matters Arising from the Previous Meeting

Xavier Bell, Director of Corporate Governance, presented the action log noting all actions were closed bar action 54 requiring redefinition of the Covid-

19 Board Assurance Framework risk. This would be revised when the next version of the Board Assurance Framework was reviewed by Trust Board in November 2021.

RESOLVED that all actions on the log were closed as above. No matters arising were raised.

TB/21/09/05 Chair's Business

Michele Romaine described her recent series of visits across the hospital to the following areas:

- **Ward 7b:** Which had been converted to a Covid-19 ward from an orthopaedic ward during the pandemic. Staff had also adapted to caring for multiple speciality patients. Currently there were no Covid-19 patients on the ward but the patient base was mainly frail, medical outlier patients which meant drug rounds took much longer due to multiple co-morbidities.
- **Pressure Injury (PI) team:** Michele spoke to staff re their approach to improvement, which had been very successful in reducing PI numbers over the last few years.
- **Porters:** Michele also took on the role of a porter the previous day, largely moving patients from ICU into other wards in the hospital. The busy-ness and consistent high level of compassion was noted; care was taken to call patients by their names and explain exactly what was happening in order to make it a positive experience for the patients.
- In addition, Michele thanked the NEDs for their ward visits which were greatly appreciated by staff.

Michele also informed Trust Board that she had been on the panel for ICS Chair recruitment, results of which would be announced shortly. The panel for ICS Chief Executive appointment was scheduled for 18 October 2021; further announcements to follow.

RESOLVED that the Chair's report was noted.

TB/21/09/06 Chief Executive's Report

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

- **Operational pressures**: Maria had met with SWAST's Chief Executive regarding flow across the hospital and issues around ambulance offloads into the hospital. There had been concerning stories regarding people left in the community with no vehicle to convey them into hospital. To tackle these issues, there was a focus on exploring cohorting options and city-wide bed base. Conversations were also ongoing regarding NBT's high numbers of medically fit for discharge patients and Local Authority and Social Care support required.
- **Blood tube issue:** Learning for NBT and Primary Care had been garnered regarding inappropriateness of some testing as a number of tests had been paused to save blood tubes with no effect on patient safety.
- Dr Sanjoy Shah had been appointed as **Deputy Medical Director**.

Following discussion, the below key points were noted:

- Richard Gaunt, NED, queried if any learnings around Emergency Department (ED) processes had occurred throughout the pandemic. Maria responded that some pre-pandemic processes needed to be approached differently. For example, managing major vs minors' ED attendances. This was a time for the Trust to go back and review these processes, especially in light of the NHS paper released detailing 10 areas to concentrate on for Urgent & Emergency Care (U&EC). This included using data to predict attendances in upcoming hours which NBT's Director of Informatics and Medical Director were investigating in order to be able to flex the workforce to better meet hospital and patient demand.
- Tim Whittlestone, Medical Director, noted that Covid-19 impact elicited various changes in the hospital from changing physical layouts of areas, ward reconfiguration, Infection Prevention Control (IPC) measures and different patient mixes on ward. Covid-19 had had a cultural effect on team dynamics around which processes would be revisited through development of Internal Professional Standards.
- Kelvin Blake, NED, emphasised the need to map system-wide capacity and noted there was capacity to be put back into the system from places such as the Minor Injuries Unit walk-in centre in central Bristol which was still closed. Jon Scott, Chief Operating Officer, responded that walk-in centres were described in the U&EC paper mentioned above, and the intention was to reopen them in the system to take on minors' demand.
- Kelvin also asked how involved the CCG had been in creating solutions for capacity. Maria responded that system calls were held regularly, and workforce was the biggest issue discussed re system capacity; especially the impact of low numbers of domiciliary care staff which impacted on NBT through higher numbers of attendances and lower numbers of discharges. In addition, discussion often focused on competition for staff resource within the system. Work was ongoing to reduce this and standardise rates of pay. The CCG were acutely aware of the issues, but solutions were not obvious. Evelyn Barker, Deputy Chief Executive, also described system work focussed on reducing minors' attendance to ED by directing people to 111 first which would be useful going into winter. This was led by Jenny Theed who had been seconded from Sirona.
- John Iredale, NED, highlighted the benefits of working in the NHS including pensions, job stability and satisfaction, etc. and suggested these be emphasised when advertising for roles. Jacqui Marshall, Director of People & Transformation, stated the system was launching a 'Proud to Care' campaign across the whole community, going into schools and highlighting that values of the younger generation and NHS were aligned, to encourage staff into the NHS.
- Michele Romaine highlighted that NBT also needed to focus on internal staff being able to progress and have long-term NHS career aspirations.
- LaToyah McAllister-Jones, Associate NED, highlighted the positive W&CH CQC inspection.

RESOLVED that the Chief Executive's briefing was noted, and Evelyn Barker was thanked immensely for her 40 years of NHS service.

TB/21/09/07 Patient Story: A mother's story; care and support provided to her son who has a learning disability and autism

The Trust Chair welcomed Gifty Markey, Patient Experience Lead, and Susan, who was thanked on behalf of the Board for sharing her and her son Brandon's story. Helen Blanchard, Director of Nursing and Quality, introduced the patient story as showing how far NBT had come in terms of supporting patients with learning disabilities and autism and their families through undertaking reasonable adjustments. It was noted that this way of working should be the norm for all patients to achieve person-centred care.

Gifty Markey presented the slideshow outlining the need to provide a holistic, joined up service when patients present with complex needs.

The Board watched a video which highlighted the positive experience Susan and Brandon had at NBT, and also suggested potential improvements and learning. During the ensuing discussion the following points were noted:

- Kelvin Blake thanked Susan for sharing her story and asked how her experience at NBT compared to previous hospital experiences. Susan detailed that previous hospital visits with Brandon had been highly stressful experiences for all involved.
- Michele agreed this example was how all NBT services should be provided and queried if a care plan for Brandon had been created, and if there were any improvements required for future visits. Susan responded that a care plan was in place and in future, small improvements could be made such as ensuring all staff were ready, which would avoid Brandon requiring holding for prolonged periods of time. Susan commended and thanked NBT's security team for keeping Brandon calm.
- LaToyah McAllister-Jones stated this was a powerful illustration of person-centred care and queried what made the biggest difference in creating a positive experience. Susan responded that staff truly listening to her was the key element for the positive visit.
- Tim Whittlestone asked how Brandon was. Susan replied he was well and had annual scans and other routine blood tests booked in for future.
- John Iredale asked if the same process used in Brandon's case could be used for other patients – specifically regarding NBT having a dentist available to carry out appointments when patients had been anaesthetised. Helen Blanchard agreed this was a good idea and would be explored through the LD team, who were well established in the Trust and were a credit to NBT.
- Ade Williams queried how this excellent approach towards patients with complex needs could be communicated to others who may have had similar previously negative experiences in hospitals. Gifty Markey responded that the LD service in NBT were the link for anyone admitted with LD and/or autism, were available 7 days a week and were well known to specialities.

RESOLVED that the Board:

- **Noted the Patient Story and thanked Susan for sharing her story.**
- **Thanked Gifty and the LD team- particularly Jamie - for their excellent work.**

- **Requested that availability of an NBT-specific dentist to utilise in similar future situations be explored with the LD team.** **HB**

Gifty Markey and Susan left the meeting

TB/21/09/08 Integrated Performance Report (IPR)

Maria Kane presented the IPR for discussion and highlighted that data was from the previous month. Jon Scott noted that planning guidance for the second half of the year and winter were due imminently, with focus likely to be on clearing backlogs. The Trust was also hoping for a slight relaxation in IPC guidelines to increase productivity.

Jon Scott highlighted the key operational performance elements of the IPR:

- NBT was performing well in comparison to other major trauma centres though improvement was required compared to all Trusts nationally.
- 197 patients in NBT beds were awaiting community/ social care support to allow discharge.
- Patient discharge pathway categories were clarified as follows: P0 for complex, P1 for community support, P2 for bedded short-term rehab, P3 for long-term nursing home support.
- As discussed above, there was serious workforce issues within community support and domiciliary carers which meant NBT was discharging only 40% of pre-pandemic levels. Discussions were ongoing with the CCG and partners. Ideas included paying families to take loved one's home. However, NBT would focus on enacting earlier discharges, enabled by release of Junior Doctor time from prioritising the sickest patients followed by patients due for discharge when on ward rounds.
- Performance was higher than August however performance deteriorated out of hours/ at weekends.
- SWAST was being impacted by inability to offload patients into ED due to social distancing requirements. The Trust would be putting in a bid for NHSE/I support for additional capacity in the ED zone to ensure patients were looked after appropriately.
- Elective care and diagnostics was in a similar position: Focussed on 104 week waits and experiencing the national shortage of non-obstetric ultrasound radiographers.
- Cancer: Improvements had been seen in breast and skin performance.

Queries and comments from the Board were as follows:

- Maria Kane furthered that some care packages were not being provided as Local Authority and private providers were unable to find staff.
- Tim Gregory raised concern that NBT's winter plan was dependent on Sirona and Local Authority's to free up beds, and the workforce situation was likely to worsen. Jon Scott responded that work was ongoing to close the bed gap in the winter plan and more could be done internally through increased use of SDEC which decreased admissions (by up to 42%) and decreased community support required following discharge. All improvements possible would be done to create more capacity internally.

- Tim Gregory queried how sustainable increased weekend working to improve discharges was in the current staffing context. Jon responded that weekend working for therapists was already under consultation and in previous roles, he had found that staff were keen for additional shifts in the run up to Christmas. There was also an option to have a mobile unit for ambulances to offload into, which Facilities was exploring.

Helen Blanchard reported on key Quality and IPC elements:

- PMRT issues: Staffing challenges (midwifery and obstetrician time compounded by sickness though 12 midwives had been recruited using Ockenden funding which meant NBT was nearer to the BirthRate+ compliance); Antenatal sonography was still a challenge but sonographers were returning from sickness and maternity leave and NBT was insourcing, with all women with missed scans being tracked; and complaints had increased, mainly related to rearrangements of antenatal screening appointments and limited administration capacity to answer calls. This had now been remedied.
- Continuity of Carer was far from the national target and the Trust was focussing limited resource on the most vulnerable women.
- The W&CH leadership team had received positive CQC feedback, though the Divisional Director of Nursing was not substantive, and the Divisional Operational Director would start a phased introduction in October. Head of Midwifery substantive role was also out for advert.
- John Iredale reported that QRMC had a lengthy assurance discussion regarding maternity issues.
- Pressure Injury numbers had increased which triangulated with other quality and workforce indicators and reflected a pressured month due to significant staff sickness absence and increased demand.
- BNSSG still had a high number of C.Difficile infections in both the community and hospitals. The region were assisting in exploration of this and the Trust had now reverted back to the pre-pandemic antibiotic prescription policy which hoped to reduce C.Difficile infections.

Tim Whittlestone highlighted key medical data in the IPR:

- Following the national trend, NBT mortality had increased December 2020 - December 2021 (majority excess deaths were Covid-19-related) but had now fallen back to expected levels.
- Medical Examiner Service was reviewing 97% of all hospital deaths. Very few of NBT's cases had required further investigation or comment.
- Covid-19 numbers had stabilised.
- Medical error rate (which had previously increased) had fallen back to expected numbers. The vast majority of errors had been deemed insignificant to patient care.

Jacqui Marshall reported on the IPR's key People elements including vacancies and the sharp rise in short term sick numbers from anxiety and stress which underpinned the general fatigue felt in the workforce and meant the Trust was reliant on bank and agency staff. Recruitment was strong but

concerns were raised re maintenance of this and keeping up with rates of staff departure. Following a query, Jacqui confirmed that staff were leaving NBT as part of a national trend of people leaving the NHS, reasons at departure included the need to improve work/life balance.

James Drury, Assistant Director of Financial Management, stated that the Trust was at break-even position for the year to date in line with achieving the NHSE/I control total for H1.

RESOLVED that the Board:

- **Noted the contents and key points of September's IPR as described.**
- **Approved the Provider Licence Compliance Statements.**

TB/21/09/09 Finance Month 5 Report

James Drury presented the Finance Report for Month 5 and highlighted that the diagnostic hub bid was still awaiting feedback. H2 planning guidance had not yet been received from the national team.

RESOLVED that the finance month five report was noted for information.

TB/21/09/10 Green plan 2021/22 update: Biodiversity Management Plan 2020/21

Simon Wood, Director of Estates, Facilities & Capital Planning, presented the Green Plan 2021/22 bi-annual update. The key focus was on working towards being carbon-neutral by 2030, for which a carbon route map would shortly be created and for which investments would be required to achieve.

It was noted that the ICS would also require a Green Plan by March 2022 which NBT was feeding in to. Michele Romaine queried who was leading its creation as a plan by March was a big ask. Simon responded that a Public Health doctor would likely lead, supported by the Green regional group.

Following queries, Simon stated that longer-term plans and resources required would be established following creation of the carbon route map. The Trust had also received a £2.4m public sector decarbonisation fund for LED schemes and NBT would ensure future funding opportunities were landed when available. Tim Gregory, NED, further queried if the Green agenda would be sufficiently prioritised in the context of many operational priorities.

Michele Romaine queried the impact of vastly increased use of PPE during the pandemic. Simon responded that the pandemic had led to immense increases in plastic and clinical waste but had elicited other green savings such as large reductions in travel pollution (to work and appointments).

Maria Kane reported that NBT worked well with partners across Bristol including local councils and the city had fantastic green aspirations that NBT wanted to help to deliver. Additionally, Maria suggested the Green Agenda was a recruitment tool to encourage workforce into NBT and was a part of the Trust's overarching ambition.

RESOLVED that the Board noted and approved the draft annual Green Plan 2021/22 and recommended it for publication. It was also requested that the Green impact of the pandemic be presented to Board in future. **SW**

TB/21/09/11 WRES/WDES submission and action plan

Jacqui Marshall presented the Equality, Diversity & Inclusion (EDI) update. The slideshow presented a detailed overview of 2021 ethnicity, disability and gender data, key Trust initiatives and prioritised next steps. It was noted that the Trust compared well nationally but gaps still existed and Trust staff was not representative of the BNSSG population.

Regarding ethnicity data, there was no BAME representation at Band 9 and above (national rate of 6.7%) and BAME colleagues felt less opportunity for career progression and were more likely to be involved in performance management/ bullying at work.

Regarding disability data, only a small number of staff were registered as disabled in the Trust, which suggested many people may not be disclosing their disability which meant reasonable adjustments could not be made.

Regarding gender data, NBT's pay gap was comparatively good but the gap widened at senior clinician level and the Clinical Excellence Awards showed the largest gap. The process and selection around the awards would be explored to attempt to remedy this.

Lastly, Jacqui stated a want to set-up an EDI Committee to increase power and airplay to report into the People Committee.

Comments/ queries from the Board were as follows:

- John Iredale suggested that senior female clinicians could be written to directly to encourage self-nomination for Clinical Excellence Awards as evidence had found women were more reticent to put themselves forward for awards.
- Ade Williams queried where the Trust was with the People Plan and requested reflection on the last 12months in the context of Black Lives Matter and if impact could be seen in the workforce from this movement. Jacqui responded that all progress towards targets were shown in the paper; the target NBT was furthest away from was increasing diversity at Board level. It was emphasised that the Talent management programme aimed at BAME colleagues was critical to ensure strong succession planning. Regarding BNSSG, the last 12 months had been powerful in Bristol and awareness had been raised. Now action was required to turn the dials on the culture, which people were keen for.
- Maria Kane furthered that the South West Regional Chief Executive Group were embarking on a programme for increasing inclusion, particularly re recruitment differences and expectations, and going into schools to raise aspirations. There was also 'what's in a name' work ongoing across the network.
- Lastly, re gender, menopause was a big issue for NHS organisations including how menopause could be considered and reasonable adjustments made. Jacqui agreed and added that work was ongoing across the various protected characteristics.

- Kelvin Blake highlighted that disabled people make up 19% of the working population and raised concern that only 1.79% of NBT staff had declared a disability. Kelvin suggested more work was required to encourage staff to declare and know there was support available. Kelvin offered his help with this where required as he had lived experience.
- LaToyah McAllister-Jones highlighted the importance of ensuring staff know they would be supported when challenging abuse and requested recognition that it was often hurtful for BAME members of staff which may prevent them from challenging patients directly.
- LaToyah also acknowledged culture change was a slow process and queried how NBT would keep staff resilient and motivated. Jacqui responded that progress was slow due to staff fatigue, absence rate and staff capacity to absorb the many ongoing initiatives.
- Kelly Macfarlane suggested career paths should be established to show potential for progression when recruiting and retaining staff. Michele also noted the lack of clear progression within lower banded staff at NBT and suggested these career paths needed active development. Jacqui replied that this would be included in the 1-, 3- and 5-year People Plan and work with schools. NHS was the biggest employer in the Bristol area and could have a huge impact.
- Regarding work with schools, LaToyah asked if NBT wanted to be part of St. Pauls Carnival's pilot programme in Autumn 2021 focussed on exposing primary school children to different careers, working with 16 – 20 schools. Jacqui accepted the offer for NBT to be involved.
- Michele Romaine suggested that the EDI Committee extend to patients as well as staff and that it needed to have a clear purpose in order to take impactful actions.
- In addition, Michele emphasised the need for NBT to have difficult conversations with the 80% of non-BAME staff in order to empower them to call out abuse when seen and support BAME colleagues.

RESOLVED that the Board noted the key findings from relevant data returns, approved priorities, and key actions for 2021 – 2023 and agreed publication of key data and action plans on the Trust website.

TB/21/09/12 Integrated Care System (ICS) Memorandum of Understanding

Xavier Bell presented the ICS Memorandum of Understanding (MoU) for approval ahead of Heathier Together Board in October. The document had been drafted with input from all system partners and was progressing through all organisation's Boards. The MoU would be in place until April 2022 when the Statutory Body would come into being. It would need to be revised at that point.

RESOLVED that the Board approved the ICS MoU and delegated to the Chief Executive to approve any final amendments on behalf of the Board.

TB/21/09/13 Patient & Carer Experience Committee (P&CEC) Upward Report

Kelvin Blake presented the P&CEC Upward Report and noted that in addition to content of the report, the pipeline for patient stories at Trust Board had been developed for the upcoming six months.

Helen Blanchard also highlighted the excellent result NBT received from the nation-wide ED survey: NBT had placed second out of 56 Trusts across the country, which was an excellent result during a very challenged time.

RESOLVED that the Board noted the P&CE Upward Report.

TB/21/09/14 Quality & Risk Management Committee Upward Report

John Iredale presented the Quality & Risk Management Committee (QRMC) Upward Report and stated the full meeting had been rearranged and condensed to an hour focussed on active issues from operational pressures. QRMC had received assurance regarding maternity issues (discussed in IPR section above) and requested a further detailed Ockenden report and deep dive into the Paterson Inquiry at October's meeting.

The annual safeguarding reports (children and adults) were also received at the committee, though QRMC requested that the Trust leads attend a future committee to present highlights as per previous years.

RESOLVED that the QRMC Upward Report and annual safeguarding reports were noted.

TB/21/09/15 Healthier Together update

RESOLVED that the Healthier Together update was noted for information.

TB/21/09/16 Any Other Business

Michele Romaine encouraged Board members currently on-site to watch the bystander/upstander event and receive a flu jab during lunch time.

Michele also extended a personal thanks to Evelyn Barker at her last Board meeting, and specifically commended the excellent, calm and supportive way she led the Trust through the pandemic and the transition of Chief Executives. Evelyn responded by thanking the Board and stated it had been an absolute pleasure to work at NBT.

TB/21/09/17 Questions from the public – None received

TB/21/09/18 Date of Next Meeting

The next Board meeting in public was scheduled to take place on Thursday 25 November 2021, 10.00 a.m. Trust Board papers will be published on the website and interested members of the public are invited to submit questions in line with the Trust's normal processes.

The meeting concluded at 12.35pm

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
29/07/2021	Board Assurance Framework	TB/21/07 /15	54	COV2 risk be expanded to an Infectious Diseases risk.	Xavier Bell, Director of Corporate Governance	Sep-21	Regular report	Closed	Revised wording is under development, for agreement with Chief Operating Officer & Director of Nursing & Quality. Wording will appear in the next version reviewed by Trust Board in November 2021. Propose action is closed.	27/09/2021
30/09/2021	Patient Story: A mother's story; care and support provided to her son who has a learning disability and autism	TB/21/09 /07	55	Availability of an NBT-specific dentist to utilise in similar future situations be explored with the LD team.	Helen Blanchard Director of Nursing & Quality	Jan-22	No	Closed	Helen has spoken to the LD team and the dentistry service will be offered as a Reasonable Adjustment via the LD team when appropriate for future patients.	18/11/2021
30/09/2021	Green plan 2021/22 update: Biodiversity Management Plan 2020/21	TB/21/09 /10	56	Requested that the Green impact of the pandemic be presented to Board in future.	Simon Wood, Director of Estates, Facilities & Capital Planning	Mar-22	Yes, in bi-annual update	Closed	Scheduled for May 2022, within bi-annual Green Plan presentation/ update	18/11/2021

Report To:	Trust Board Meeting		
Date of Meeting:	25 November 2021		
Report Title:	Chief Executive's Briefing		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance		
Executive/Non-executive Sponsor (presenting)	Maria Kane, Chief Executive		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is asked to: • Receive and note the content of the briefing.		
Report History:	The Chief Executive's briefing is a standing agenda item on all Board agendas.		
Next Steps:	Next steps in relation to any of the issues highlighted in the Report are shown in the body of the report.		

Executive Summary	
The report sets out information on key items of interest to Trust Board, including engagement with system partners and regulators, events, and key staff appointments.	
Strategic Theme/Corporate Objective Links	**1. Provider of high-quality patient care** **2. Developing Healthcare for the future** **3. Employer of choice** **4. An anchor in our community**
Board Assurance Framework/Trust Risk Register Links	Does not link to any specific risk.
Other Standards Reference	N/A
Financial implications	None identified.

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

1. Purpose

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

2. Background

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

3. Influenza & Covid-19 Vaccination Campaign Update

For 2021/22 the Trust is required to deliver a combined vaccination programme offering eligible staff a Covid-19 booster vaccination and an influenza vaccination. The Trust's vaccination programme forms a part of the wider Bristol, North Somerset and South Gloucestershire (BNSSG) vaccination programme and reports into the system governance structure.

National targets required that:

- 100% of staff are offered an influenza vaccine by the end of Winter 2021/22, and
- All eligible staff (those with a minimum of 180 days since their second dose) are expected to have received their Covid-19 booster vaccination by 17 December 2021

To date, the on-site vaccination hub has delivered 2805 influenza vaccines and 1939 COVID-19 boosters to NBT staff. NBT staff are also able to access the UWE vaccination site, which has delivered 889 influenza vaccinations and 1275 COVID-19 boosters.

Based on a staff denominator of ~12,000 this equates to a staff uptake of 27% for the COVID-19 booster and 31% for the influenza vaccination.

Work is ongoing to ensure that data from other vaccination venues can be included in our vaccination statistics. NHSEI recognise that it is impossible to provide accurate data for Trust specific staff at this time.

4. Urgent & Emergency Care System Pressures

Performance in our Emergency Department continues to be challenged, and this same pressure is being felt across the BNSSG system as a whole. Colleagues across the system are focusing on maintaining a safe service for our patients as we work to improve this situation.

Within NBT we have launched our refreshed Internal Professional Standards, which outline how the hospital as a whole supports the Emergency Zone in times of pressure. We have also continued our regular "think tanks" bringing leaders together to focus on improving performance for our patients.

In early November, in light of increasing Covid-19 hospitalisations and ongoing workforce challenges, the BNSSG Integrated Care System moved into its highest state of operational alert (OPEL 4). The ICS leadership issued a call to the public urging people to stay away from busy emergency departments and minor injury units unless absolutely necessary.

There has also been an increased focus on asking patients being admitted to hospital to start thinking about their discharge arrangements straight way. The step is being taken to ensure hospital beds are available for those who are most acutely unwell.

NBT continues to work closely with South West Ambulance Service Foundation Trust and other system partners and the regional team to reduce ambulance handover delays. In early November, Professor Julian Redhead, newly appointed Urgent and Emergency care lead for NHS England visited the Trust to talk about internal pressures. Professor Redhead met key members of the ED leadership team and we discussed ambulance waits, mental health patients presenting in ED, and how we ensure we prioritise our sick waiting patients by making sure those patients who do not need to be in hospital anymore are moved safely to the next part of their journey.

5. System Oversight Framework segmentation

As previously reported to Trust Board in private in October, NHS England and Improvement have issued the final NHS System Oversight Framework (SOF) for 2021/22. The SOF requires each Integrated Care System (ICS) and each provider to be placed in a support segment:

Segment 1	No specific support needs identified.
Segment 2	Flexible support delivered through peer support, clinical networks and the NHSEI "universal support offer"
Segment 3	Bespoke mandated support via the regional improvement hub
Segment 4	Mandated intensive support (system, regional and national teams)

On 15 October 2021 we were advised that NBT has been placed in segment three. This is due to the Trust having undertakings in place (relating to Urgent & Emergency Care, RTT 52 week waits, and financial position), alongside issues relating to cancer wait time performance and reporting.

We have now been notified that BNSSG ICS has also been placed in Segment three, and the Healthier Together Partnership Board has been briefed on the implications. This will include working with the regional NHSEI team to undertake a diagnostic stocktake to identify key drivers of areas of concern, including the system financial deficit.

6. Trust Leadership Strategy & Development Away-day

On 16 November 2021 the Trust Management Team had its second leadership strategy and development away-day, focusing on compassionate leadership, continuous improvement and the leadership challenges we will face over the coming winter period.

Together with a wider group of NBT clinical leaders we had the opportunity to hear from Michael West CBE, Professor of Work and Organisational Psychology at Lancaster University, Visiting Professor at University College, Dublin, and Emeritus Professor at Aston University. He spoke to the group on compassionate leadership and sustaining wisdom, humanity and presence in Health and Social Care.

7. Mortuary Security Assurance

Following the serious security breach impacting on dignity of care of the deceased in a mortuary in an NHS organisation (widely reported in the media), all NHS organisations have been required to review mortuary security arrangements.

NBT has undertaken the required Security, Risk & Vulnerability Assessment (SRVA) and has confirmed that appropriate security is in place. A number of additional recommendations will be implemented in order to provide enhanced protection. Due to the sensitive nature of the security arrangements, further detail will be overseen by Trust Board in its meeting in private.

8. Integrated Care System – Chief Executive

Shane Devlin has been announced as the Chief Executive-designate for the BNSSG Integrated Care Board (ICB).

The appointment follows a nationally run competitive process to secure Chief Executives for ICBs across England, ahead of the bodies coming into being in April 2022. The new statutory body will form part of the wider Integrated Care System (ICS) for the area, known as the Healthier Together Partnership. Shane will be responsible for overseeing complex services and population health improvement programmes for a population of just over 1 million people.

Shane has been Chief Executive of the Southern Health and Social Care Trust, Northern Ireland, since March 2018, and was previously Chief Executive of the Northern Ireland Ambulance Service. Shane will be relocating to the area and takes up his new role early next year.

9. Consultant Appointments

Since this report was last issued in September 2021 the Trust has substantively appointed the following new consultants across several key specialities:

Name:	**Appointment date:**	**Specialty:**
Dr Andrew Ray	04/10/2021	ICU Consultant
Dr Julia Colston	01/11/2021	NBT Microbiology Consultant
Dr Shirjel Alam	01/11/2021	Cardiology Consultant
Dr Reiko Ashida	08/11/2021	Neurosurgery Consultant
Dr Jean-Brice Rodriguez	25/10/2021	Obs & Gynae Consultant

10. Engagement, Service Visits & Consultant Conversations

I am continuing to spend time with as many services and teams across the hospital as I can. Since I last reported in September 2021, I have visited with:

- The Upper GI and Bariatric Team

- Medicine Divisional Team at their divisional briefing
- Research Department
- Physiotherapy Team
- Site Management Team
- Chairs of the BAME Network for Black History Month
- Patient Experience Team
- Immunology and Allergy Team
- Plastics and Dermatology
- Safeguarding Team
- Palliative Care Team
- Pharmacy Team
- Care of the Elderly and Frailty Specialty Team

I have also met with several Consultants from across the clinical divisions, including colleagues from General Surgery, Immunology, Respiratory Medicine, the Emergency Department, ICU, Orthopaedics and Obs. & Gynae. This continues to give me a very helpful insight into the priorities and concerns of the organisation's senior medical leadership.

11. Summary and Recommendations

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

NHS
North Bristol
NHS Trust

Anela's Story

NHS
North Bristol
NHS Trust

Achieving Accessible Information Standards(AIS)

NBT is committed to listening to the experience of people with additional needs in order to provide exceptional healthcare, personally delivered .

Experience of Care of a Patient

https://youtu.be/k9pJAG4Ghso

Learning and Actions

- Ongoing work in place to move from Lorenzo to the new EPR system next year.

- Working with IM&T leads to a system easier to flag and identify individual's additional needs.

- The Bristol Sight Loss Council (BSLC) are currently working on training with the Move Makers to make them more aware of how to assist people with sight loss as a results of this feedback

- As part of Accessible information standards implementation plan, there is an opportunity to create awareness of these needs for staff within NBT- e.g. Matrons

NHS North Bristol NHS Trust

Thank you,

Any Questions?

NHS
South West
Genomic Medicine Service Alliance

South West Genomic Medicine Service Alliance

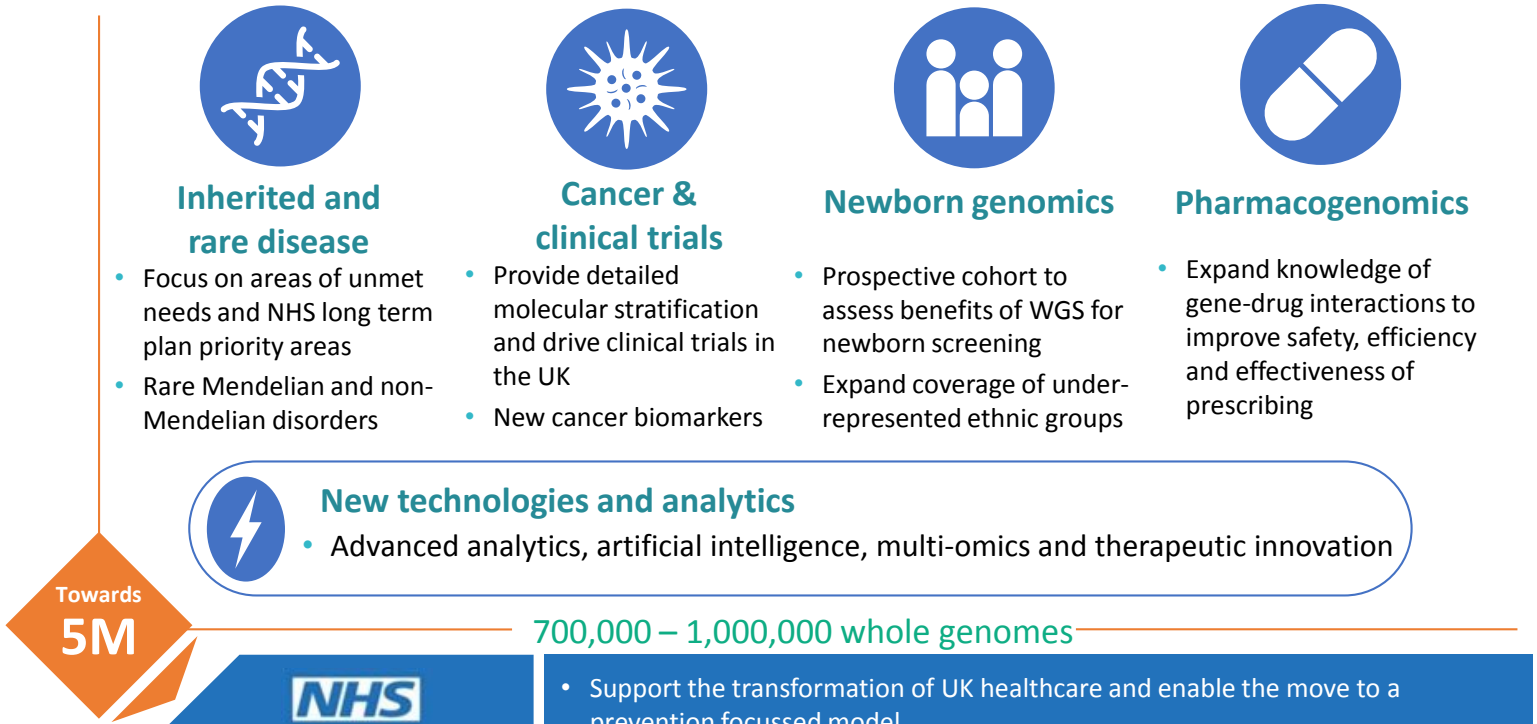
Prof. Chrissie Thirlwell Clinical Director SW GMSA

North Bristol NHS Trust Board
25th November 21

@SWGenomics

NHS
South West
Genomic Medicine Service Alliance

Genomic sequencing linked to NHS long term plan priorities



The National Genomic Test Directory

NHS South West Genomic Medicine Service Alliance

- The 2020/2021 National Genomic Test Directory specifies which genomic tests commissioned
- For rare & inherited disorders and cancer
- Explains which patients will be eligible to access to a test
- https://www.england.nhs.uk/publication/national-genomic-test-directories/
- Updated in October 2021 with more indications for whole genome sequences

Genomic Medicine Service Alliances

NHS South West Genomic Medicine Service Alliance

- Seven GMSAs established from February
- Aligned with 7 Genomic Laboratory Hubs
- Bring together providers to work in partnership support the systematic implementation of genomic medicine into the NHS by creating a learning environment to support the rapid adoption and spread of scientific advances.
- Accountable for:
  - i) equitable access to standardised genomic testing and clinical genetics and genomic counselling services;
  - ii) access to treatments and medicine optimisation driven by comprehensive genomic and diagnostic characterisation;
  - iii) increasing access to clinical trials
  - iv) active participation in genomic research across England

South West Genomic Service Alliance

NHS South West Genomic Medicine Service Alliance

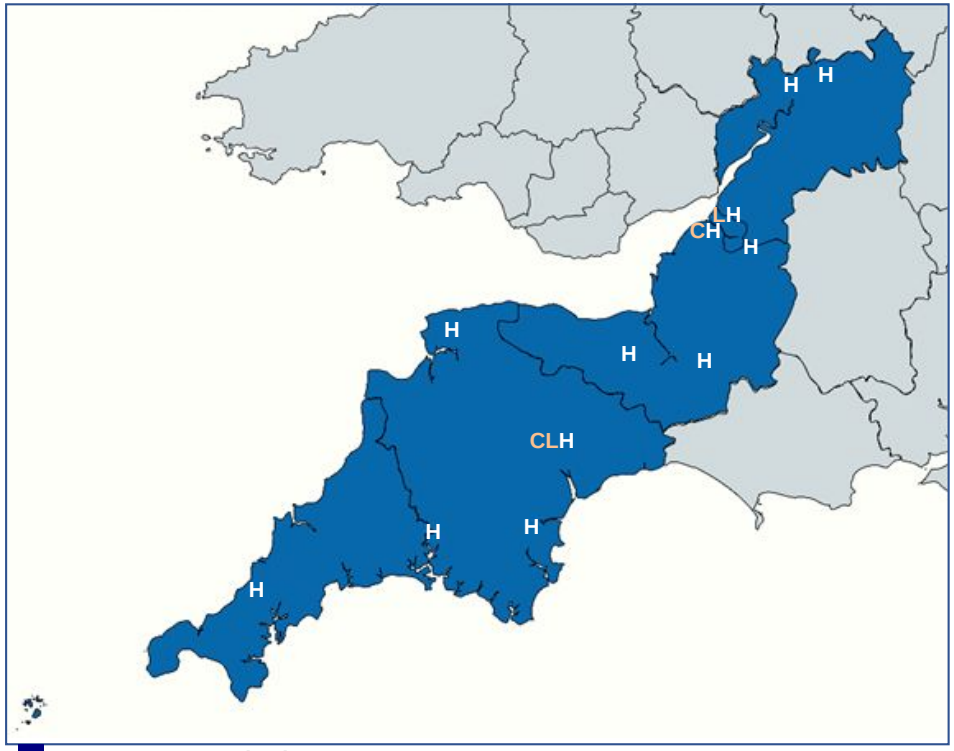
- 6 ICS - Gloucestershire, BNSSG, BSW, Somerset, Devon, Cornwall

Partners

University Hospitals Bristol & Weston NHSFT

North Bristol NHST

Royal Devon & Exeter NHSFT



H=Acute Hospital Trust
L =Genomic Laboratory Hub
C =Clinical Genomic Service

SW GMSA in numbers

NHS
South West
Genomic Medicine Service Alliance

Geography

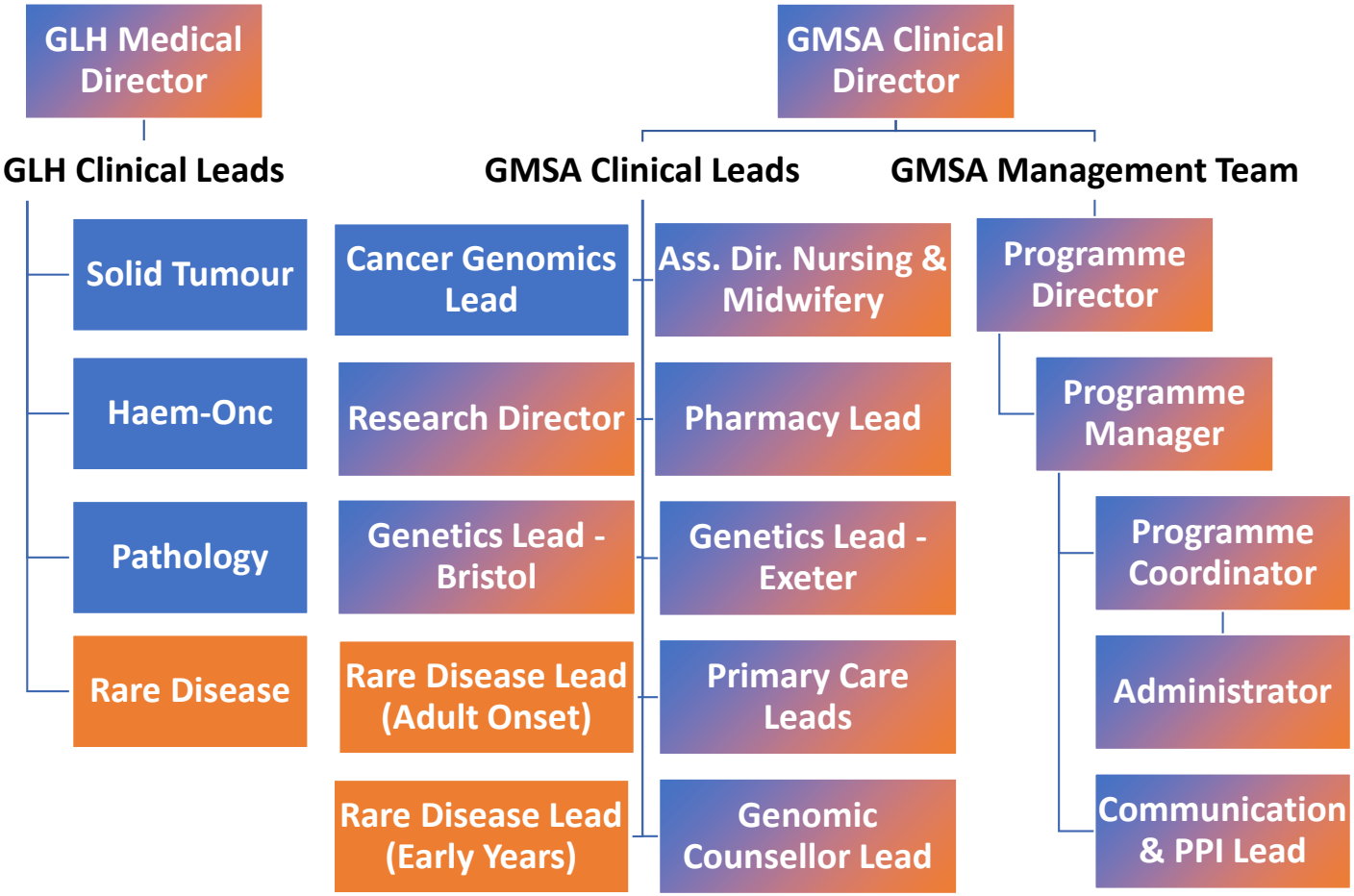
- 4.7 million people
- 6 STPs (inc. part of BSW)
- 11 Acute providers

Funding

- £958k for Infrastructure (core team)
- £133k for 100,000 Genomes Additional Findings
- £538k for Transformation Projects

SW GMS Core Team

NHS
South West
Genomic Medicine Service Alliance



All Genomics

Cancer

Rare & Inherited Disease

SW GMSA Governance

NHS South West Genomic Medicine Service Alliance

SW GMSA Board

- Chair, Robert Wooley, CEO UHBW
- Medical Directors of 3 Partners
  to represent the GLH and both Clinical Genetic Services
- NHS E&I SW Medical Director
- Nurse Director, Chief Pharmacist, Chief Midwife, Chief Operating Office, Finance Director drawn from partners and members

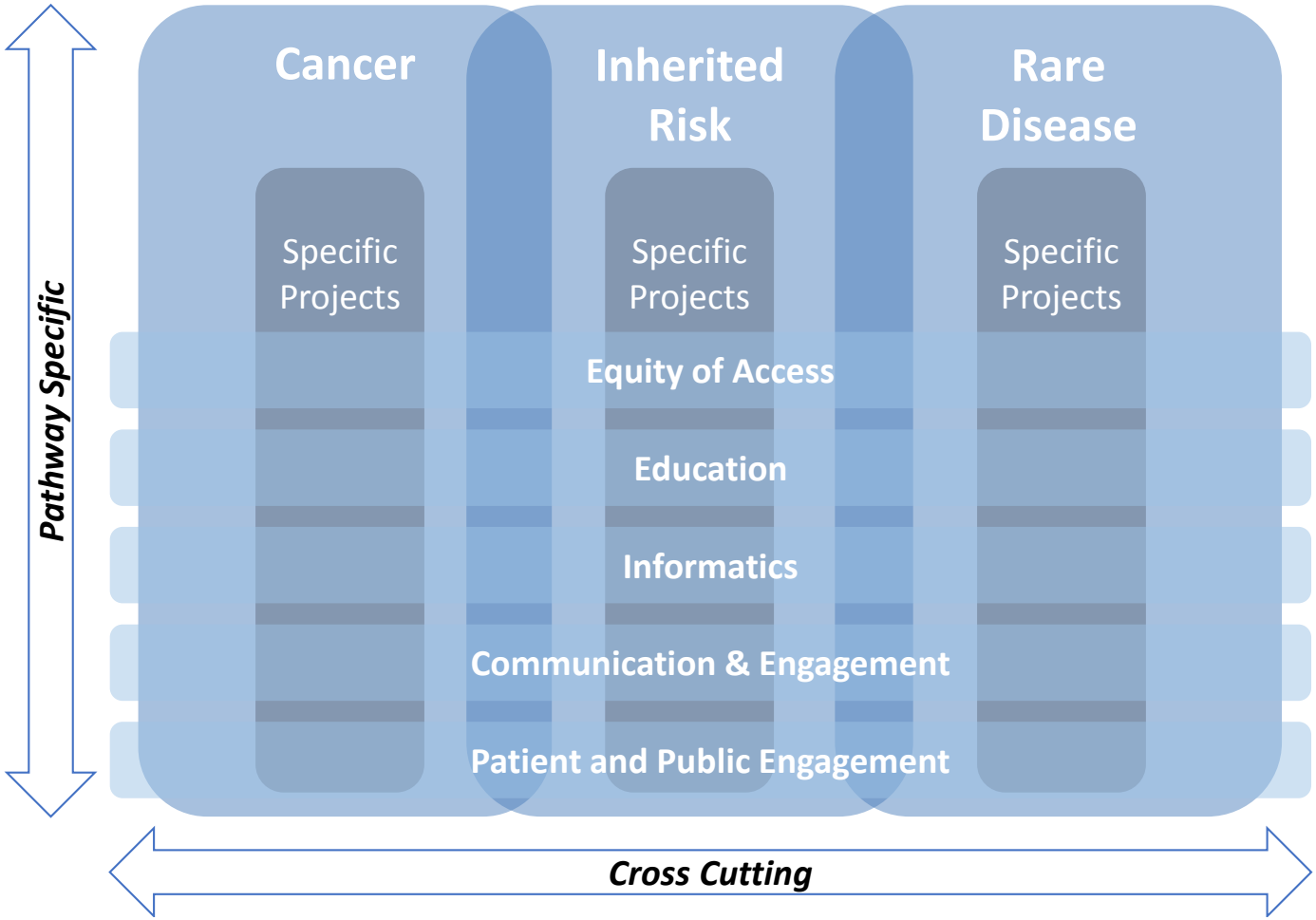
GMSA and its Partners

NHS South West Genomic Medicine Service Alliance

- SW GMSA is a partnership of the 3 providers of genomic services and the wider NHS.
- Although the GMSA has dedicated staff, it is should not be seen as a separate entity, but a collaboration of the partners and the wider NHS
- NHS England has asked for an “integrated governance” between GMSAs and GLHs. We believe the current Board delivers this.
- A number of requirements of the GLH arose in the absence of the GMSA, whose establishment was delayed by Covid. We are committed to a coordinated approach to delivering the collective objectives.
- Important relationships exist between
  - NBT and the RD&E in running the GLH
  - NBT and UHBW – as the provider of not only Bristol Clinical Genetics but a number of specialist services that are heavy users now of genomics

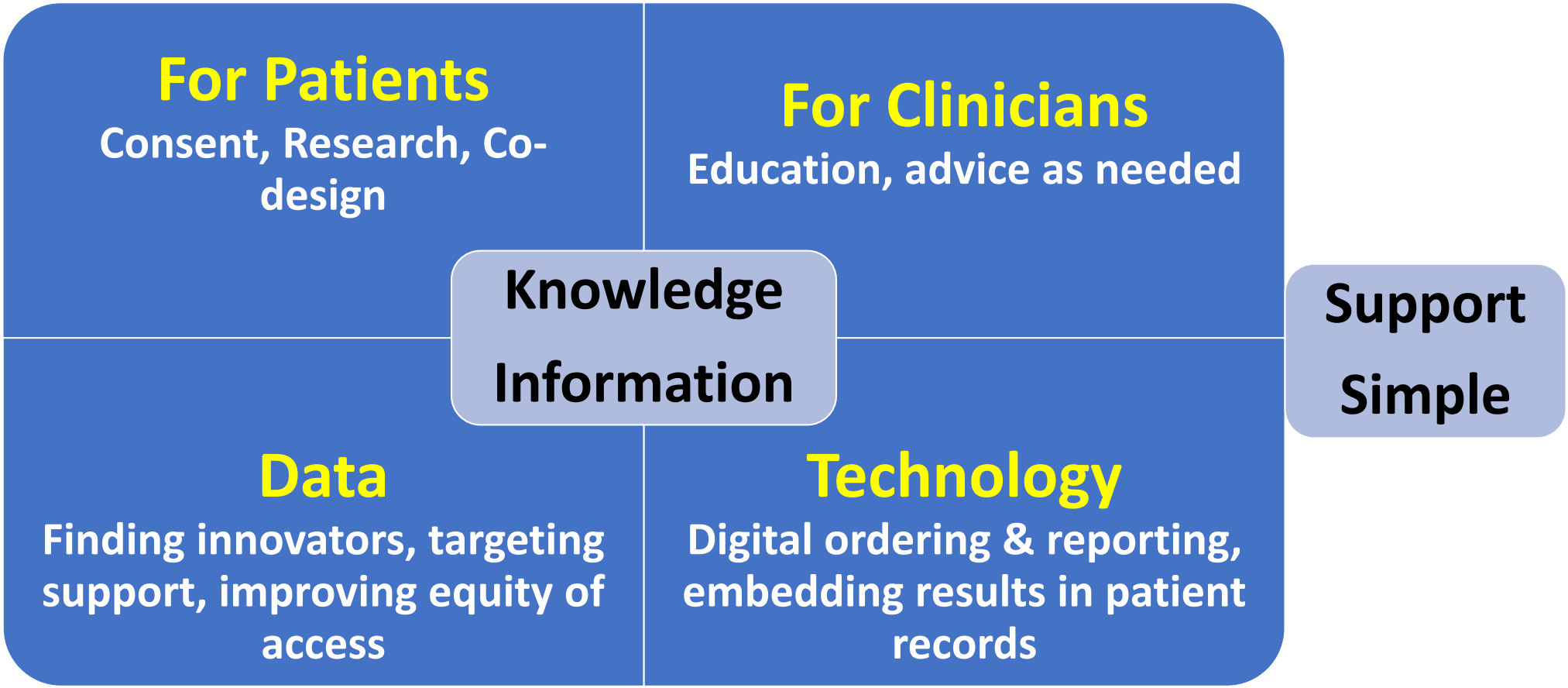
SW GMSA Approach

NHS South West Genomic Medicine Service Alliance



Mainstreaming

NHS South West Genomic Medicine Service Alliance



Risk Register – SW GMSA Board

NHS
South West
Genomic Medicine Service Alliance

- Pathology – Cancer pathways
- Clinical Genetics – Increased workload
- Whole Genome Sequencing – increasing clinical indications

NHS
South West
Genomic Medicine Service Alliance

Any questions?

christina.thirlwell@nhs.net

Report To:	Trust Board		
Date of Meeting:	25 November 2021		
Report Title:	Freedom to Speak Up Bi-Annual Report November 2021		
Report Author & Job Title	Hilary Sawyer, Lead Freedom to Speak Up Guardian		
Executive/Non-executive Sponsor (presenting)	Xavier Bell, Director of Corporate Governance & Trust Secretary		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose	**Approval**	**Discussion**	**To Receive for Information**
		x	
Recommendation:	Board is asked to: • Review the FTSU data and themes triangulated against key themes from the People, Staff Wellbeing Psychology and Communication teams • Discuss the report, findings and recommendations		
Report History:	This is a bi-annual report to Trust Board. The last report was in May 2021.		
Next Steps:	• Proactive role modelling and clear communication of visible support from the Board to Freedom to Speak Up at NBT including the importance and value to NBT as an open, learning organisation. • Board self-review tool gap analysis due March 2022 • Consider a future Board development session in 2022		

10

Executive Summary
NHS Trusts are required to appoint a FTSU Guardian or Guardians and follow the National Guardian Office's guidance on Freedom to Speak Up (FTSU). The current Lead FTSU Guardian has been in post since 18 January 2021, working with a network of volunteer Guardians from various substantive roles across the Trust. A refreshed Vision, Strategy (and Action Plan) aligned to Restorative Just Culture, based on Psychological Safety, were presented to Board in May 2021.

Since the May 2021 Board report, the first FTSU Champions have been appointed to increase reach and diversity of representation (of role, seniority, workplace and pattern, protected characteristic) and increase engagement and visibility across the organisation. This network will evolve further during 2021/22.

Summary position on 2021/2022 Q1 and Q2 data

In the 6-monthly report to Board of May 2021, data indicated a lower rate of concerns reported at NBT compared to the national average for Q1-3 2020/21, with an increased number reported in Q4.

This trend of increasing numbers has continued in Q1 and Q2 2021/22. This appears to confirm a correlation with introduction of the Lead Guardian role including more time available for proactive awareness raising, and staff feeling more trusting of the independent nature of the role.

This report:

- explores the most recent data around concerns being raised and compares this with the available national average for all Medium Acute Trusts
- Triangulates with feedback from the People, Staff Wellbeing Psychology and Communications teams, and
- Highlights progress and challenges

Recommended actions for NBT Leadership:

Overtly and proactively promote and embed Board, Executive, Trust Management Team and Divisional/Directorate Management Team support for FTSU and the value of staff speaking up at NBT as a gift to the organisation to be used wisely, including at a time of pressures on workforce. As highlighted in the National Guardian Office's Annual Report 2020, information from FTSU concerns can be used for safety of an organisation and deep culture change.

Support communication of the importance of managers proactively listening up with subsequent timely response, follow-up and feedback, backed up by consideration of how managers can have headspace for this in current times.

Support buy-in and joined-up planning and resourcing for organisational training for listening-up and following-up effectively.

Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Work in partnership to deliver great local health services **2. Developing Healthcare for the future** a. Training, educating and developing our workforce **3. Employer of choice** a. A great place to work that is diverse & inclusive b. Empowered clinically led teams

[1] Report template - NHSI website (nationalguardian.org.uk)
[2] Report template - NHSI website (nationalguardian.org.uk)
[3] Recording Cases and Reporting Data (nationalguardian.org.uk)

	c. Support our staff to continuously develop d. Support staff health & wellbeing
Board Assurance Framework/Trust Risk Register Links	Freedom to Speak Up supports the Trust's ambition to be an Employer of Choice and is an important mitigation for the Recruitment and Retention risk recorded on the Board Assurance Framework
Other Standards Reference	NHSI Guidance for Boards on Freedom to Speak Up[1] NHSI Supplementary information on Freedom to Speak Up in NHS Trusts[2] National Guardian's Office (NGO) Guidance Freedom to Speak Up arrangements form part of the CQC Well-Led Key Lines of Enquiry
Financial implications	N/A
Other Resource Implications	The FTSU Champion model requires support from line managers to participate and engage in FTSU activities. The role is focused on awareness raising and visibility, and the need to backfill posts is not anticipated. The time requirements will be kept under review.
Legal Implications	No specific legal implications associated with this report. Compliance with the CQC and NGO Guidance on Freedom to Speak Up is a requirement under the NHS Standard Commissioning Terms & Conditions.
Equality, Diversity and Inclusion Assessment (EIA)	Freedom to speak up relies upon a fair, inclusive and open culture that supports all staff, including those with protected characteristics to speak up and bring diversity of voice and experience. Demographic data of staff speaking up has not been collected robustly to date although are being improved with the aim to provide more detail in future. The Trust is gradually improving the diversity and representation of all staff groups within the FTSU network; see Strategy and Action Plan.
Appendices:	Appendix 1: Speak Up Month activity summary

[1] Report template - NHSI website (nationalguardian.org.uk)
[2] Report template - NHSI website (nationalguardian.org.uk)
[3] Recording Cases and Reporting Data (nationalguardian.org.uk)

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; and comparing this activity where possible to the national picture, relevant internal data.

2. Background

2.1 Freedom to Speak Up Guardians have been in role since November 2017. The number of voluntary Guardians has varied and has recently reduced to 5, due to retirement and clinical pressures. A (0.6WTE) substantive Lead role was introduced in mid-January 2021.

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

- a positive speaking up culture of continuous learning
- all workers at NBT
- the organisation in becoming a more open and transparent place to work, where staff are valued for speaking up
- training for managers in 'listening up'
- managers and leaders to 'follow up'
- identification and addressing any barriers to speaking up
- assessment of trends and responses to issues being raised

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

2.3 A refreshed Vision, Strategy (and Action Plan) aligned to Restorative Just Culture, based on Psychological Safety, were presented to Board in May 2021.

2.4 The first FTSU Champions have been appointed to increase awareness, reach and diversity of representation (of role, seniority, workplace, work pattern, protected characteristic) and increase engagement, accessibility and visibility across the organisation.

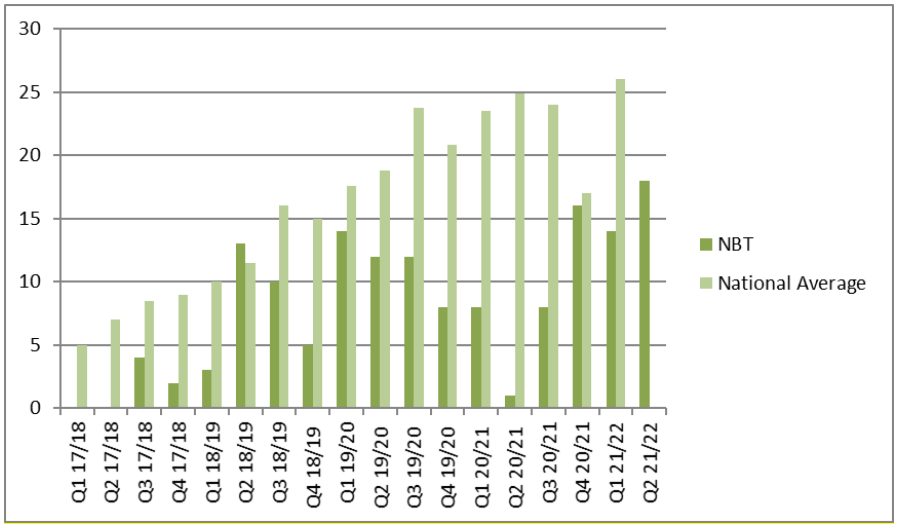
10

3 An update of NBT FTSU data and themes vs. national benchmarking:

3.1 Chart 1 shows the comparison with the national average for Medium Acute Trusts. National data is only available currently to Q1 2021/22. The data show that the number of concerns raised at NBT has been consistently lower than that of the national average, however the increased number of concerns noted in the May 2021 Board report has continued in the subsequent two quarters, with concerns levels at the highest to date in Q2.

[1] Report template - NHSI website (nationalguardian.org.uk)
[2] Report template - NHSI website (nationalguardian.org.uk)
[3] Recording Cases and Reporting Data (nationalguardian.org.uk)

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



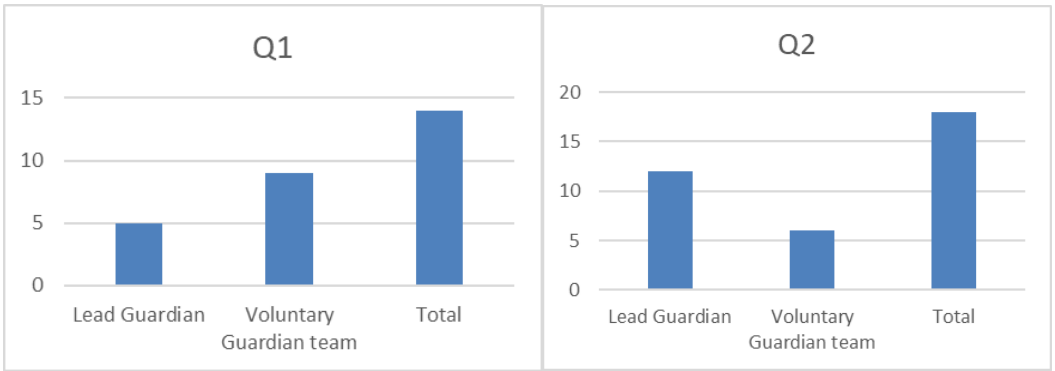
This increase appears to be due to raised awareness through more proactive work (communications, Divisional huddles, walk-arounds, links with stakeholders) possible through creation of the Lead role.

Almost all workers speaking up to a Guardian have already spoken to a line-manager beforehand but not felt listened to and responded to adequately, or due to the nature of the concern have not felt able to raise the matter openly with a manager.

The number of cases is only one measure; cases can be complex and involve several colleagues and multiple interactions over an extended period of time.

3.2 Concerns raised have been increasingly raised with the Lead Guardian rather than the volunteer guardians:

Chart 2: Relative proportion of concerns raised with the Lead Guardian compared to voluntary Guardian team:



[1] Report template - NHSI website (nationalguardian.org.uk)
[2] Report template - NHSI website (nationalguardian.org.uk)
[3] Recording Cases and Reporting Data (nationalguardian.org.uk)

3.3 **Routes concerns have been raised:**

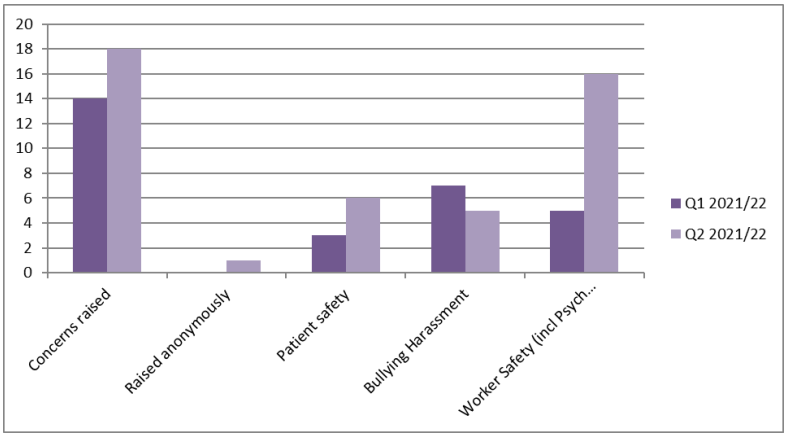
Concerns have been raised through a mix of the central 'Speak Up' email box, Guardians' individual NBT email boxes, phone and in person following a walk-around. Since the first FTSU Champions had their initial training in September, concerns and themes have started to be reported via this route also.

Anecdotally it has been reported that finding timey and confidential space to raise concerns at work can be a challenge during work time; ability to raise concerns through a confidential electronic system remotely would be welcomed. Some staff indicate the desire to have an anonymous reporting system due to concerns about detriment for speaking up.

A new Clinical Governance electronic system is being explored, which may also have functionality to record FTSU concerns, although our ambition is to keep the numbers of concerns reported anonymously at a minimum to enable effective follow-up and feedback.

4 A closer look at NBT's data:

Chart 3: 2021/22 Q1 and Q2 data by type of concern[3]:



4.1 From April 2021 the NGO included 'Worker Safety' as a category in addition to the existing 'patient safety/quality' and 'bullying and harassment' categories. This category includes elements that may indicate a risk of adverse impact on the worker and should be interpreted broadly (including psychological safety), focussing on the perception of the person speaking up.

4.2 A case may include elements of patient safety/quality, bullying or harassment, and/or worker safety, as well as other matters. All categories that apply for each case must be recorded[3].

4.3 As is similarly noted in a recent informal South West Guardian survey, concern levels are highest in the 'Bullying and Harassment' category and the new 'Worker Safety' category; the latter is now increasingly being used as it reflects an increased consideration under Psychological Safety in addition to other more obvious physical safety aspects (e.g. provision of PPE, safety on site). Some concerns have recorded the knock-on effect to patient safety of issues of worker safety/bullying and harassment.

[1] Report template - NHSI website (nationalguardian.org.uk)
[2] Report template - NHSI website (nationalguardian.org.uk)
[3] Recording Cases and Reporting Data (nationalguardian.org.uk)

4.4 One concern did not fit any of the three categories.

4.5 The NGO is currently consulting on proposals to change the reporting data from April 1, 2022, including:

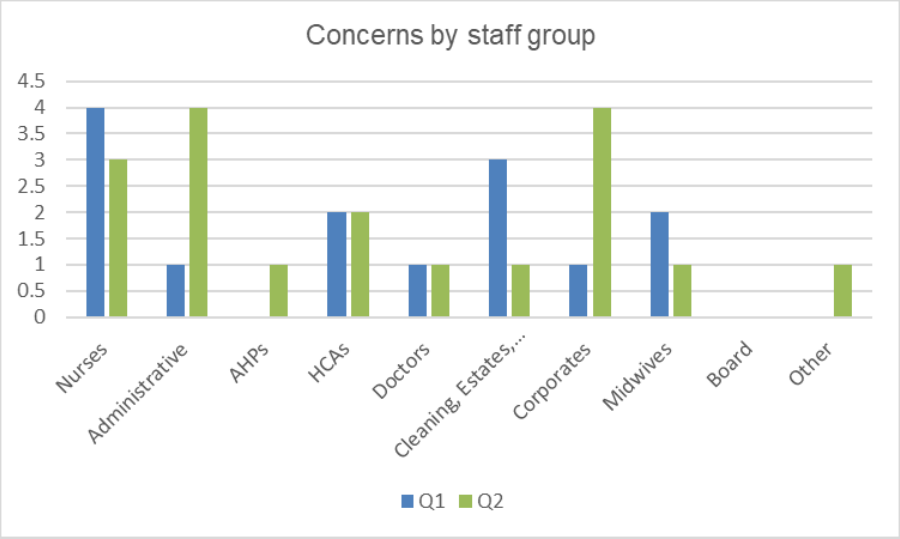
- A new category for inappropriate/unprofessional behaviours and attitudes
- Updating example definition of harassment
- More clearly defining and updating examples in the more inclusive worker safety category (including wellbeing)
- Reporting demographics quarterly

Clarity on definitions will be welcomed as currently categorisation can be challenging.

4.6 Only one case was raised anonymously to the Trust (via the CQC) and related to workforce pressures.

4.7 A majority of concerns were raised confidentially, although a number were openly reported. Staff feeling safe to raise matters openly allows for issues to be resolved efficiently and effectively. It is recommended that this should be an area of organisational focus within NBT to ensure staff feel able to raise matters with no fear of any disadvantageous treatment. This should be strongly communicated by NBT's leadership as an expectation of all managers.

4.8 **Chart 4: 2021/22 Q1 and Q2 data by staff group[3] raising concerns** (where recorded):



The majority of concerns have been raised by 'workers' (as opposed to managers or senior leaders)[3] and have been raised across most broad staff group categories, with nurses continuing to have raised the highest number, with relatively high numbers from Administration, Ancillary and Corporates.

[1] Report template - NHSI website (nationalguardian.org.uk)
[2] Report template - NHSI website (nationalguardian.org.uk)
[3] Recording Cases and Reporting Data (nationalguardian.org.uk)

There remains more work however to ensure staff in all professions are aware of the FTSU route of raising concerns and that this is for anyone working at NBT. The Lead Guardian is working with the Learning team to develop appropriate material for inclusion in the refreshed Corporate Induction (at offer stage and at actual start of employment). Material is also being incorporated into role-specific induction processes for some staff groups (e.g. volunteers, junior doctors, medical trainees).

The HEE/NGO e-learning modules on Speaking Up and Listening Up are now available on NBT's MLE/LEARN system, promoted during October Speak-Up Month. These are currently non-mandatory; the Trust leaders may wish to consider aligning with some other Trusts (including UHBW) to make these mandatory modules.

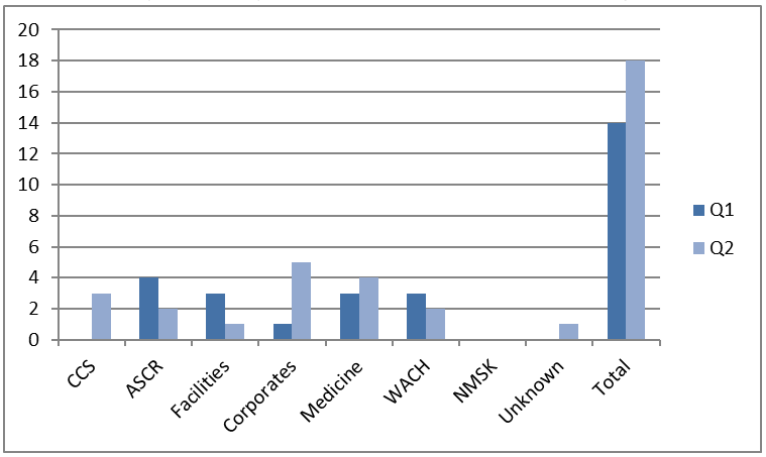
It has become clear from walk arounds that student nurses and other trainees are not aware of FTSU. The Lead Guardian is continuing to explore the most effective route to amend this situation through links in the Learning and Development team, and UHBW and UWE colleagues. Support for medical trainees has also been discussed recently with the Undergraduate Medical Education Manager, North Bristol Academy.

The NBT Inclusion network newsletter also includes information about FTSU.

Awareness of FTSU for staff that do not easily access LINK or emails (e.g. clinical and facilities staff) will be a focus in person through the Guardian and Champion network and through printed promotional materials.

4.9 Chart 5 illustrates that concerns have been raised from across NBT's Divisions other than NMSK (NMSK had the lowest numbers of concerns in May's Board report also).

Chart 5: 2021/22 Q1 and Q2 NBT Concerns raised by Division/Directorate:



4.10 **Satisfaction levels with the FTSU Service 2021/22 Q1 and Q2:** it has not been possible to obtain a response for all concerns however of those that responded to the question: 'Given your experience, would you speak up again?' all responded 'Yes' other than one 'Maybe'.

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Feedback has included: really appreciating the Guardian taking time to listen, support and escalate matters safely, knowing that someone is supporting working through concerns, finding it a relief that the matter was heard and raised with a senior leader.

Concerns have been dealt with in a variety of ways depending on the situation: some staff have felt it has been sufficient to decompress through talking and being listened to - this enabled them to order their thoughts and consider the action (if needed) they would take themselves; staff have then felt empowered to action the issues in some cases, others have required escalation via a Guardian either openly or in confidence.

Not only are more staff coming forward with concerns, but issues raised are at times rather complex (and multifactorial) and a series of ongoing interactions with staff and managers are required over time. The time needed for this can be considerable, especially where staff do not feel able to raise matters openly. A great deal of flexibility from the Guardian needs to be employed to discuss with staff and with managers at a time that is possible under these circumstances. This requirement will need to remain under review in terms of resourcing of Guardian time and for the Lead Guardian, demands for the proactive, responsive and follow-up aspects of the role.

Resolution of concerns: due to the complexity of the concerns some are still ongoing but are actively being followed up. Some challenges are experienced in receiving a timely response by the Lead Guardian either on initially raising a concern or during follow-up. Although the Guardian will work flexibly, compassionately and restoratively, and current pressures are being felt at all levels, managers need to take response to concerns seriously even amongst other challenges. The length of time taken to respond and resolve concerns raised by staff has an impact on those staff and on the Guardian supporting them over an extended period of time. Slow response also affects whether staff feel it is worth the perceived risk of speaking up and the importance and value the organisation places on this.

4.11 Data-related actions to be taken:

The following will be areas for improvement in the coming months:

i. Sharing findings and issues regularly with Divisional/Directorate Management Teams to triangulate and ensure robust and effective follow-up
ii. Consider how successes and learning from staff speaking up at NBT can be communicated while maintaining staff confidentiality
iii. Consideration of use of the new Clinical Governance system for FTSU data

4.12 Themes of FTSU Concerns 2021/22 Q1 and Q2 (and from anecdotal conversations):

- Staffing levels/low morale/staff wellbeing/feeling undervalued/struggling to take leave; across several professions including nursing, HCAs, midwives
- Patient safety (some related to staffing levels)
- Staff not feeling listened and/or responded to
- Relationship issues with manager
- Allegations of bullying or harassment (managers and/or other colleagues)
- Anxiety around moving to fill gaps in staffing

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- Staff psychological safety
- Security of belongings (locker space for F1 doctors)
- Parking concern (related to staff safety and wellbeing including accelerator work)
- Fairness and not feeling listened to in planning of shifts
- Issues compounded by gaps in or interim leadership

Identified areas for improvement continue to include:

- Improved presence, listening and response 'on the ground' of managers and leaders
- Clearer communication on decision-making
- Clarity on timeframes for actions
- More openness and transparency in communications
- Civility in interactions

4.13 Detriment:

Please note that from 1 April 2021 the NGO replaced the term 'detriment' with 'disadvantageous and/or demeaning treatment' (although the term detriment is still used in brackets to avoid any confusion).
To date there have been no incidences of disadvantageous treatment reported for concerns in Q1 and 2.

5 Triangulation of Speaking Up Data Against Other Data

5.1 **In May 2021 the FTSU Board report triangulated data against 2020 NHS Staff Survey results.** As the 2021 Staff Survey is still live at the time of writing this report, results are not available but will be reviewed for the May 2022 report.

5.2 For this Board report the following general triangulation around themes has been possible:

It is noted that in the Oct 2021 Integrated Performance Report (IPR) that there has been a higher level of patient complaints and concerns since June and a rise in overdue complaints. The highest number appear to be in ASCR, Medicine, and WACH with the highest theme being clinical care and treatment.

There appears to be possible corelation with the increase in concerns raised to FTSU around filling nursing shifts including agency and temporary staffing, high bed demand and rising acuity. It also aligns with some staff concerns describing moral distress at the perceived reduced quality and safety of care that staff feel they able to provide, along with increasing fatigue and low morale.

Anecdotally, staff are aware of the various actions in place around safe staffing on wards and recently around bank and shift payments and 'assign on arrival' which may help improve the situation. Improvement actions around workforce resourcing, supply and demand, system wide and winter planning are noted.

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The IPR noted that days lost to stress/anxiety/depression continue to be higher than any other reason and days lost in the last quarter were at their highest point in the last four years.

Concerns being raised to the FTSU network increasingly provide a thermometer to the mood of the organisation: Reports of exhaustion, staffing level challenges, increase in numbers and acuity of patients that staff are looking after, low morale, plus added anxiety over winter pressures. Staff also report being moved to cover areas they are unskilled for and feeling ending up like they are more of a burden than a support. This appears to be felt throughout and across the organisation in different staff professions nurses, HCAs, midwives, AHPs etc along with effects of localised issues of organisational change or interim leadership challenges.

Those raising concerns are increasingly reflecting that they are raising concerns as they want to feel they have done everything they can in speaking up about issues.

NBT is full of passionate but very fatigued staff working long hours and displaying high anxiety with knock on to interpersonal behaviours. There are also some reflections of concern around the current situation becoming normalised. Similar themes of concerns are being raised at other Trusts locally around staffing pressures, resulting potential effects on quality of patient care and low morale.

Staff who have engaged with the Lead Guardian report wanting:

- to feel safe to flag issues
- for managers to actively make themselves available (going to staff) to listen with compassionate calm and genuine curiosity
- for direct personal interaction to discuss what is happening with transparency
- to be understood and valued
- more space locally for decompression, having private discussions, wobble/break-out rooms, rather than wellbeing programmes that they do not have time to access.
- to not get to the point of individual burnout
- to feel part of proactive solutions, feel empowered to raise and make any co-creative changes (however small) that may make their day better or more efficient, boosting morale and ownership.
- role-modelling ‘walking the talk’ by senior leaders of calm self-care and compassionately challenging behaviours of colleagues

These themes are reinforced and emphasised by similar feedback collected via the Staff Wellbeing Psychologist team, and Communications team engagement sessions over the summer, which also included issues around the sickness policy, strain for international staff, issues around outliers and patients with mental health challenges, and teams in conflict.

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People team thematic feedback:

- **Grievance numbers and themes**: increase in grievances and complaints around discrimination and relationship with colleagues/managers, possibly from increased awareness of routes to speaking up. From conversations with other Trusts this seems to be consistent.
- **Employment tribunal claims:** seeing an increase but possibly due to some trade unions changing stance on initiating claims early

A key message is that staff need to be able to speak up to managers and leaders, be listened to and have a follow-up response as emphasised in the NGO's Speak Up theme this year.

The Patient First methodology being considered (Western Sussex Hospital approach) for continuous improvement and empowering staff to make improvements, may set clear direction on ways forward including behaviours and culture.

6. National updates:

The Board's attention is drawn to the following:

- **Henrietta Hughes stood down as National Guardian in September** after 5 years: here.
- **The new National Guardian, Dr Jayne Chidgey-Clark, has recently been appointed: here**
- **NGO Strategic Framework 2021:** NGO-Strategic-Framework-2021.pdf (nationalguardian.org.uk); promoting quality, consistency, greater assurance and working in a more integrated, aligned and accountable healthcare system.
- **Delivery of the HEE/NGO third e-learning module for leaders 'Follow-Up' is delayed** from October until the New Year
- **NGO FTSU Newsletter (Issue 14) articles:** July-Newsletter.pdf (nationalguardian.org.uk)
  - '**The Critical Success Factors to embedding a Freedom to Speak Up culture in the NHS**, and why your Non-Executive Directors are essential' Anita Day, Vice Chair, Worcestershire Acute Hospitals NHS Trust, and Freedom to Speak Up Board Lead
  - **'The role of senior leaders and Chief Executives in creating the organisations of the future'** Thea Stein, Chief Executive at Leeds Community Healthcare NHS Trust
    - Focusses on working with people and their hopes, stories and struggles
    - Leaders and mangers to seek to listen and hold what others say - acting in dialogue rather than defensiveness.
- **UNODC (UN Office on Drugs and Crime) has published guidelines on protection for whistle-blowers in the health sector.** Fast-tracking the Implementation of the UN Convention against Corruption (UNCAC) - Resources (unodc.org)

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7. Summary and Recommendations

For NBT's FTSU culture to be successful, the organisation needs sufficient buy-in, headspace and training for managers and leadership to listen up and follow up.

The Trust Board is asked to:

- Discuss the report and findings
- Review the FTSU data triangulated against themes
- Proactive role modelling and repeated clear communication of visible support and commitment to Freedom to Speak Up at NBT including the importance and value to NBT as an open, learning organisation. Leadership is asked to consider how this may be done effectively, for example through pledges to FTSU, walk arounds and organisational planning of resourcing for joined-up training (L&D, OD, People and Wellbeing teams etc).

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NHS North Bristol NHS Trust

Appendix 1: Summary of Speak Up Month activity

October is Speak Up Month: 'Speak Up, Listen Up and Follow Up'.

Throughout October, Freedom to Speak Up (FTSU) Guardians and their organisations raise awareness of FTSU and the work which is being done to make speaking up business as usual.

This year the National Guardian's Office (NGO) is encouraging everyone to play their part to 'Speak Up, Listen Up and Follow Up'
and to complete **the Freedom to Speak Up E-learning**.

Speaking up creates opportunities for the Trust to make changes to deliver the best patient care and a safe environment for staff.

The free e-learning from HEE/NGO is now live on NBT's MLE (Self Service Courses & eLearning - Management & Leadership - Freedom to Speak up):

- **Speak Up module** (for all NHS workers including volunteers, band staff, students)
- **Listen up module** (for managers): information on how to foster an environment that encourages and supports speaking up.

Speak up Month is for everyone: it doesn't matter whether you are a new starter, a volunteer or student, have worked at NBT for some time, or are a line manager, or leader.

- Do you feel unsure who to speak up to and what would happen when someone speaks up?
- Are you a manager who wants to know more about listening up and the psychological safety and trust that is needed?
- Are you a leader at NBT?

During this month we will also be:

- Launching our first group of FTSU Champions, who will be supporting our Guardian team
- Developing our new Freedom to Speak Up team LINK pages:
  - Speak Up Pledges, Champions, Resources
- Raising awareness of Freedom to Speak Up through:
  - visits to services (Cossham Imaging (Hilary, Deb), BCE: (Hilary, Dave), WACH (Hilary and Fiona), Frenchay (Will), Facilities (Karoline and Mobin), Evening shift at Southmead (Hilary and Annie), Walk around at Southmead with Jacqui Marshall (Hilary)
  - a FTSU Awareness Board competition

National Guardian Office (NGO) Webinars during October Speak Up Month: four now available via their Youtube channel: **highly recommended**; including Listen Up, Follow Up (now available via NBT's FTSU LINK team page here)

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Report To:	Trust Management Team Meeting		
Date of Meeting:	November 2021 (Report covering 01/07/21 – 31/10/21)		
Report Title:	Trust Board report		
Report Author & Job Title	Dr Lucy Kirkham Trust Guardian for Safe Junior Doctor Working		
Executive/Non-executive Sponsor (presenting)	Dr Lucy Kirkham		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	X
Recommendation:	The Board of Directors will discuss current pandemic Junior Doctor contract issues and as a public authority must, in the exercise of its functions, have due regard to the need to: • All contractual obligations in place • Be satisfied that the role of Trust Guardian is being fulfilled • Exception Reports being acted upon • Gaps on Junior Rotas being filled as a priority • Risks to Trust considered – Guardian fines; accountability; staffing		
Report History:	This paper sets outs the background and context around the introduction of the Guardian of Safer Working as part of the 2016 Terms and Conditions for Junior Doctors and implementation of that role in the Trust. It shows: • Exception Report data • Locum data • Guardian's actions • Gaps on rotas and plans to fill		
Next Steps:	• Promote and support exception reporting system to consultants and trainees • Consideration of converting some Clinical Fellow positions to Physicians Associate posts to stabilise and support NBT's workforce		

Executive Summary

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

Junior Doctor Contract Refresh - 2019

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

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

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

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

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

The NBT Trust Guardian for Safe Junior Doctor Working will:

1. Interact with the Trust Board in a structured report covering rota gaps, gap management, locum usage exception reporting and the JDF

2. Ensure Exception Reporting by junior doctors for breaches of contract are acted upon. These comprise exceptions for:
   - Safety reasons
   - Excess hours – Leading to TOIL (the preference) or Payment where TOIL is not possible
   - Excess hours leading to work pattern reviews
   - Missed education sessions

3. Set up and attend a Junior Doctor Forum – these forums harness the junior doctor's ideas and energy on better ways of working as well as offering a channel to discuss contract, education and rota issues. The DME, HR and exec attendance is desirable.

4. The Guardian may levy a fine if a breach of the following occurs:

   - The 48-hour average weekly working limit
   - Contractual limit on maximum of 72 hours worked within any consecutive 7-day period
   - Minimum 11-hour rest has been reduced to less than 8 hours
   - Where meal breaks are missed on more than 25 per cent of occasions over a 4-week period.
   - The minimum 8 hours total rest per 24-hour non-resident on-call (NROC) shift
   - The minimum NROC overnight continuous rest of five hours between 22:00 & 07:00
   - The maximum 13-hour shift length
   - The minimum 11 hours rest between resident shifts

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

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

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

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

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

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

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

Medicine Bank	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct
Hrs requested	**2408**	**2524**	**3028**	**2850**	**4308**	**2769**	**1933**	**1536**
Hours filled	**2257**	**2307**	**2775**	**2300**	**2490**	**2340**	**1579**	**1268**
Deficit	**151**	**217**	**253**	**550**	**1818**	**429**	**354**	**268**

Unfilled rota slots currently know about:

DIVISION	Nov
ASCR	5CF & 2 Trainees
NMSK	1 CF
Core Clinical	1 trainee
W&C	1 CF
Medicine	6.5 ST3+ Trainees

Known future Clinical Fellow gaps: xs

- Feb – 2 medicine CF gaps
- April – 9 medicine CF gaps

2. **GAP MANAGEMENT**

A. **CF Adverts** – Go out in Dec for 2022
B. **Medical Support workers** – 24 Doctors from Myanmar to start at NBT in Nov 2021 – should be able to apply for CF roles from April 2022
C. **Optimising NBT locum reach**
   - JDF suggestion of using 'LocumNest' app – successfully used at Gloucester/Cheltenham
     - HR looking at collaborative bank models to increase locum reach
     - Demonstration of apps organised for Nov – JDs invited to attend
D. **Decrease dependence on CFs by converting more CF posts into Physicians Associate posts**
   - Potential conversion of 2-3 CF into substantive PA posts in April on COTE
   - OMB report written by Sue Nutland and the PA lead (Dr Phil Braude) ready for discussion. This outlines the role of PAs, benefits to the organisation, and business case model to convert existing clinical fellow posts. Therefore the case is based upon staffing skill mix rather than additional investment.
   - If supported by the Execs the conversion of further CF posts would **need support at a specialty level to ensure appropriate uptake and integration of the PAs into the team**

- Advantages of PAs:
    - Already have 8 working at NBT with calls currently for up to 8 more across the Divisions
    - We train 24 a year so have an in-house pool familiar with NBT ways of working
    - Permanent experienced member of the team – helps with JD changeover time
    - Can train juniors
    - Work at Junior Doctor level – admitting, discharging, examining, taking blood, forming a differential, can transcribe drug charts
    - Not subjecting NBT to seasonal departure gaps
    - Work clinically 100% (majority of current CFs are 80% clinical)
    - Can work out of hours
- Disadvantages of PAs:
    - Currently cannot order X-ray or CT or prescribe – this will change once under GMC regulation >2023
    - Not on 2016 JD T&Cs so integration into JD minimal ward staffing levels and leave allocation needs consideration

3. LOCUM USAGE - BANK AND AGENCY – 01/07/21 – 31/10/21

BY DEPARTMENT: Biggest user of Bank - Medicine

Locum Bookings (Bank) by Department	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
ASCR Division	498.00	4665.34	3703.84	£260,744.60
Clinical Governance Division	34.00	194.00	194.00	£10,285.00
Core Clinical	19.00	201.00	177.00	£13,057.50
Medicine Division	1168.00	10548.59	7679.34	£547,852.75
NBT Extra Bank Division	14.00	117.50	117.50	£6,427.50
Neuro & MSK Division	508.00	4849.96	3582.46	£260,392.40
People & Transformation Division	3.00	20.00	20.00	£855.00
W&C Division	46.00	467.00	359.50	£28,060.00
Winter Pressures	642.00	5267.25	4003.25	£233,816.25
Grand Total	**2932.00**	**26330.64**	**19836.89**	**£1,361,491.00**

Locum Bookings (Agency) by Department	Requested Shift	Agency Filled Sl	Requested H	Agency Filled H	Estimated Cost
Medicine Division	17	17	158	158	£7,965.00
Neuro & MSK Division	32	32	260	260	£18,532.26
Grand Total	**49**	**49**	**418**	**418**	**£26,497.26**

BY GRADE: Commonest grade is F2/ST2-3 Core

Locum Bookings (Bank) by Grade	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
Locum CF	248	2122.76	1211.76	£105,875.50
Locum F1	65	532.75	286.75	£21,583.75
Locum F2				
F2	12	115	39	£5,050.00
Locum F2/ST1-2 Core	1634	14434.58	11175.83	£661,084.40
zzLocum F2/ST1-2 OoH	26	233	29	£11,987.50
ST/CT1	1	8	0	£337.50
Locum Senior CF	2	17.5	17.5	£1,077.50
Locum ST3+	944	8867.05	7077.05	£554,494.85
Grand Total	**2932**	**26330.64**	**19836.89**	**£1,361,491.00**

Locum Bookings (Agency) by Grade	Requested Shift	Agency Filled Sl	Requested H	Agency Filled H	Estimated Cost
Locum F2	17	17	158	158	£7,965.00
Locum ST3+	32	32	260	260	£18,532.26
Grand Total	**49**	**49**	**418**	**418**	**£26,497.26**

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

Locum Bookings (Bank) by Request Reason	Requested Shifts	Requested Hours	Filled Hours	Estimated Cost
Additional Capacity	1261	11108.13	8219.38	£580,895.55
Annual Leave	50	402.75	330.25	£22,201.25
Covid 19	80	787.17	429.67	£42,248.70
Emergency Domestic Carer Leave	1	13	0	£640.00
Sickness	195	1969.42	1350.42	£109,345.60
Study Leave	6	70.5	70.5	£3,387.50
Vacancy	1278	11473.67	9065.17	£569,602.40
Waiting List Initiative	42	296.5	196.5	£20,467.50
Supernumerary	1	16	0	£1,085.00
Parental Leave	18	193.5	175	£11,617.50
Grand Total	**2932**	**26330.64**	**19836.89**	**£1,361,491.00**

Locum Bookings (Agency) by Request Reason	Requested Shift	Agency Filled Sl	Requested H	Agency Filled H	Estimated Cost
Additional Capacity	15	15	127	127	£6,399.00
Vacancy	34	34	291	291	£20,098.26
Grand Total	**49**	**49**	**418**	**418**	**£26,497.26**

4. EXCEPTION REPORTS - 01/07/21 – 31/10/21

Exception Reports (ER) over past 4 months – 01/07/21 – 31/10/21		Number flagged as immediate safety concern (ISC)
Number relating to hours of working	149	0
Number relating to pattern of work	0	0
Number relating to educational opportunities	14	0
Number relating to service support available to the doctor	12	3
TOTAL NUMBER OF EXCEPTION REPORTS	**175**	**3**

BREAKDOWN OF REPORTS

IMMEDIATE SAFETY CONCERNS

Rota name	Date	Issue	Steps taken on the day	Other exceptions in this rota
Medicine ST3+	24/9/21	Should be 2 Medical Registrars out of hours. Down to one necessitating the 1 remaining Reg to hold the 'take' bleep and cover the ward	Concern escalated prior to shift. To look for locums/increase pay	3
Medicine ST3+	25/9/21			
Medicine ST3+	26/9/21			

Steps taken after the ISCs as there is a 6.5-person gap in the Med Reg rota (dropping to 5.5 in Dec):

- 6 weekly meetings with Jarrod Richards (Med Consultant), Med management and Med Registrars
- SOP in place (attached) to arrange step down cover of nights if no locum found – pay at locum rate
- Close working with NBTExtra to ensure locum reach is optimal
- If unable to attract Med Reg locum accept SHO locum/PA locum to at least have an extra person
- Encouraged team to continue to Exception report
- HR and NBTExtra plan involving JDF to look at locum apps to optimise locum advertisements reach

EDUCATIONAL EXCEPTION REPORTS

Number of exceptions	Rota	Issues
9	F1 Medicine*	5 x Understaffing on ward – unable to attend mandatory F1 teaching 4 x Taken of clerking week to cover wards
2	CF CT1-2 Medicine	Short staffed – missed IMT teaching
2	F2/CT acute block	1 x Minimum staffing – missed clinic 1 x Missed PD day due to minimum staffing
1	F1 general surgery	Missed surgical teaching

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

'HOURS' EXCEPTION REPORTS BY ROTA AND OUTCOME

Most reports from medicine rotas (surge in surgical reporting in 1st week Sept due to large number in-patients)

Rota	Outcome TOIL	Outcome Payment	Pending	No further action	TOTAL Reports
F1 Medicine	21	22	6	1	**50**
Clinical Fellow CT1-2 Medicine	2	21	12		**35**
General Surgery F1	6	15	9		**30**
F2/CT Acute Block	1	5		1	**7**
General Surgery F2-CT	4				**5**
Neuroscience F2 – C/ST2	1		2	1	**4**
Medicine ST3+		2	2		**4**
Renal Medicine F2-CT	3				**3**
T&O F2	2				**2**
T&O F1			1		**1**
	40	65	32	3	**141**

5. **<u>JUNIOR DOCTOR FORUM</u>** – Held in person and via Teams in Aug 2021 and Oct 2021
   - Format change after D/W junior BMA reps – Solo forum with Committee (meeting with executives) to occur 1-2 weeks after every other JDF
     - Great attendance at August JDF, poor attendance with Execs 2 weeks later
     - → further change in format → combined forum (30min) and committee (20 min) with 10 min break to allow departure to ward if needed
     - Delivered in Oct – great attendance – 22 junior doctors – productive meeting with exec - TW
   - Increased engagement at forums achieved – 22 juniors attended last meeting
   - Terms of reference refreshed in Aug
   - Re-instated Reps as of August – currently 22 reps across specialties
   - Ideas generated in JDF – app for locum contacts

<u>Other issues arising:</u>

1. **Possible lack of awareness of process/value of exception reporting**
   - → New hyperlink to Allocate on Trust all apps intranet space – May 2021
     - Signposted via posters in Mess and PGME newsletter
     - Reason why to exception report and potential benefits outlined in posters
   - →Refreshed video for junior induction for August
   - →Lecture delivered to Foundation doctors – plan to deliver each August
   - → Reps appointed - part of role to champion exception reporting
   - →Monthly GOSW update newsletter with tips on exception reporting

2. **Anecdotal evidence that exception reporting is seen as 'complaining' by some consultants and trainees**
   - →New video for educational supervisor update days recorded asking them to signpost and encourage exception reporting at their first trainee meetings
   - →Monthly 'You said, we did' exception reporting element in a new GOSW newsletter to all trainee doctors

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

Networking

- The Guardian is in contact by WhatsApp and Zoom with national and regional groups
- NHS-Employers remote meetings to network with them and other Guardians
- Allocate training sessions x 2
- Webinar GOSW conference – Dec 9th

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

SUMMARY

NBT is compliant with:

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

Concerns:

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

Recommendations:

1. NHS Employers recommends the GOSW report to Trust Board quarterly. However, in light of the bi-monthly nature of Public Trust Board the GOSW agrees with The Board that reporting at every other Board i.e. 3 x a year is acceptable with the caveat that any urgent arising matters would be presented at the next occurring Board.
2. The Board are asked to read and note this report from the Guardian of Safe Working
3. The Board are asked to note ongoing Junior Doctor Contract changes.
4. The Board are asked to consider the appointment of PA to previously held CF posts

Dr Lucy Kirkham, Trust Guardian for Safe Junior Doctor Working

Standard Operating Protocol for Managing On-call Take SpR Staffing Gap

Problem: There are expected gaps in the registrar rota due to vacancies/LTFT posts/parental leave, and unexpected gaps due to sickness. Every effort must be made where possible to fill these high priority shifts with locums. As the ward cover registrar does not start clinical duties until 4pm, if there is a take Registrar Gap then there is a period between 8am and 4pm where there is no registrar on call.

SPR1 = take SPR2 = ward cover SPR3 = AEC

Lead 1 Consultant to implement SOP

SpR2/3 covers SpR1

- Lead 1 AMU Consultant initiates SOP:
- Medical Staffing Contact SpR2 (followed by SpR3) to cover SpR1 from 08:00.
- Consultants in their speciality should help relieve them of ward duties (ie cover speciality referral bleeps) to enable them to switch to SpR1.
- If there is debate between SPR2 and 3 as to whom should cover, this must be undertaken in a constructive manner. Final resolution will be determined by Lead 1 AMU Consultant if agreement canot be reached.
- If SPR 2 *and* 3 are unable to cover due to commitments that cannot be covered within their speciality then they will start 1st on call cover as soon as they are able, and at the latest 16:00.
- *If it is a planned absence/gap and no locum is available the medical staffing team must give SPR2 /3 as much notice as possible of potential switch to SPR1 to enable them to find cover for clinic/ward work.*

Acute block CMT with PACES covers SpR1

- SpR 2 unavailable –Acute block CMT with PACES covers SpR1 with support from Lead 1 consultant and AIM SpRs.
- This is only suitable **IF** the trainee is willing and feels able to cover the bleep, and is appropriately supported. The AMU SpR should carry the "twilight clerking bleep" as this is a spare crash bleep during the day and attend all crash calls to support. If concerns re GP phone calls to take a contact number and either get advice and ring back or hand over query to lead 1 consultant. All concerns re clerking and the take can be discussed with the lead 1 consultant as per usual, as can any ward referrals.
- At the end of the shift there should be a discussion with the lead 1 consultant regarding any issues and reflection on the shift.

AMU Lead 1 Consultant covers SpR1

- AMU Lead 1 Consultant covers SpR1 or delegates to AIM SpR.
- SpR2 must have the ward cover bleep and attend any crash calls.

NHS North Bristol NHS Trust

Report To:	Trust Board - Public		
Date of Meeting:	25 November 2021		
Report Title:	People Committee Upward Report		
Report Author & Job Title	Isobel Clements, Senior Corporate Governance Officer & Policy Manager		
Executive/Non-executive Sponsor (presenting)	Tim Gregory, Non-Executive Director and Chair of People & Digital Committee		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	That Trust Board receive the bi-annual Safe Staffing (nursing and midwifery) reports which had been received at October's People Committee.		
Report History:	Upward reports are standing items to Trust Board following a People Committee meeting		
Next Steps:	The next report to Trust Board will be to the February 2022 meeting following February People Committee meeting.		

Executive Summary
The report is provided to ensure Trust Board has sight of the Bi-Annual Safe Staffing Reports at Public Trust Board as per regulations. These were received at the October People Committee, but not included in the October Upward Report as they needed to be received in Public and published on the website.

Strategic Theme/Corporate Objective Links	**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 **Employer of choice** e. A great place to work that is diverse & inclusive

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	f. Empowered clinically led teams g. Support our staff to continuously develop h. Support staff health & wellbeing
Board Assurance Framework/Trust Risk Register Links	Reports received support the mitigation of various BAF risks.
Other Standards 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	No legal implications.
Equality, Diversity and Inclusion Assessment (EIA)	Full EIA page with EIA form to guide your assessment here: https://link.nbt.nhs.uk/Interact/Pages/Content/Document.aspx?id=9760 N/A
Appendices:	Appendix 1: Midwifery Safe staffing bi-annual review Appendix 2: Nursing Safe staffing bi-annual review

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1. Purpose

1.1. The report is provided to ensure Trust Board has sight of the Bi-Annual Safe Staffing Reports at Public Trust Board as per regulations. These were received at the October People Committee, but not included in the October Upward Report as they needed to be received in Public and published on the website.

2. Safe Staffing Reports (bi-annual)

2.1. The Committee received the Maternity and Nursing Safe Staffing Reports, presented by the Deputy Director of Nursing. These reports are a regulatory requirement, to provide assurance that the Trust has appropriate oversight and processes in place to ensure safe staffing levels.

2.2. Midwifery Safe Staffing Report

This report outlined the progress to date and ongoing actions planned to ensure midwifery staffing levels were safe to support the service. It was noted that additional investment may be required once the “Birthrate Plus” review was complete, and that this business case was under development.

The Report is attached at Appendix 1.

2.3. Nursing Safe Staffing Report

This six-monthly triangulation report determines whether the Trust has the correct nurse staffing establishments to meet patient needs. Generally, funded establishments were felt to be appropriate to meet the requirements across the Trust. Some areas were identified for further review.

The report also identified areas of risk in the nursing workforce, including days lost to sick leave, staff turnover and the pipeline for future nursing workforce. It also outlined some of the opportunities to explore and build on alternative multidisciplinary workforce models.

The Report is attached at Appendix 2.

3. Summary and Recommendations

3.1. That Trust Board receive the bi-annual Safe Staffing (nursing and midwifery) reports which had been received at October’s People Committee.

North Bristol NHS Trust

Report To:	People Committee		
Date:	12 October 2021		
Report Title:	Provision of safe midwifery staffing – recommendations of Birth Rate Plus – a 6-month update (April to September 2021)		
Report Author & Job Title	Sally Bryant Interim Head of Midwifery		
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Director of Nursing and Quality		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	The Committee is asked to; 1. Note the contents of this report which outlines the progress to date and further actions planned to ensure midwifery staffing levels are safe to support the increased complexity in the service, are effectively managed and are being published in accordance with the requirements of national standards of - NHS Improvement (2018) Developing Workforce Safeguards recommendations, - NHS England National Quality Board Safe, Sustainable and Productive staffing (2018), - NICE organisational requirements for safe midwifery staffing (2019) - Ockenden EIA's (2020) - CNST Maternity Incentive Scheme for Trusts year 4 (2021). - Maternity objectives in the NHS Operational Planning guidance 2021/22 2. Receive assurance that the Head of Midwifery in association with the Director of Nursing and Quality has undertaken an updated formal review based on revised activity and acuity analysis of safe staffing for maternity services across hospital and community services. This assurance is as a result of a revision of the detailed Birthrate Plus® report and required changes as included in the workforce Business plans of the W&CH Division. 3. To note the progression of the national direction of maternity services requirements to implement 'Better		

	Births' continuity of carer as the default model of care for all women revised date of March 2023
Report History:	The first Birthrate Plus® report was completed at North Bristol Trust in 2017 which supported a need for increased midwifery staffing. The recommendations were partially taken forwards in 2017 with 10.8wte increase in midwives taking place in 2018. The second Birthrate Plus® report was completed in December 2019 which again supported a further need for increased midwifery staffing based on a significant change in complex pregnancies and associated acuity. This report was used to evidence a shortfall in midwifery staffing for submission of a bid for national monies provided in response to the Ockenden report which aimed to reduce shortfalls in midwifery staffing in England. NBT received funding for 12.5 wte midwives because of this bid.
Next Steps:	NHS England South West, supported by Health Education England are progressing a midwifery workforce review to support full implementation of the mandated continuity of carer programme as the default model of care for all women by March 2023. A further BR+ review is due to commence Oct 2021 with both a service provider and system calculation provided to inform BNSSG maternity system workforce design.

Executive Summary

The purpose of this paper is to provide the People and Digital Committee with an updated report on the progress against the recommendations of the Birthrate Plus® midwifery staffing assessment to provide assurance that the Trust has a clear validated process in place for monitoring and ensuring safe midwifery staffing in line with current national recommendations.

Birthrate Plus® (BR+) is a framework for workforce planning in maternity services and has been in variable use in UK maternity units since 1988. The Royal College of Midwives [RCM] and Royal College of Obstetricians and Gynaecologists [RCOG] recommend the use of Birthrate Plus® and it is cited in the recommendations of the Ockenden report and CNST Maternity Incentive Scheme year 4 as the recommended model of midwifery workforce planning. There is currently no other research-based methodology for workforce planning in maternity services.

The report provides assurance of the following:

A	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
B	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service and a plan for mitigation/escalation to cover any shortfalls.
C	All women in active labour receive one-to one midwifery care and a plan for mitigation/escalation to cover any shortfalls.

D	Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board.

The Head of Midwifery and Divisional leads have reviewed the results of Birthrate Plus®, and triangulated the findings with professional judgement, available budget and current changes in reaching conclusions and making recommendations. The Head of Midwifery has also completed a forward-facing review in the context of the implication of the mandate for maternity services to implement Better Births continuity of carer teams across the service.

NHS England South West, supported by Health Education England are progressing a review of the midwifery workforce to support full implementation as services move towards 51% compliance.

The CNST Maternity Incentive Scheme Year 4 standards for maternity services – safety action 5 requires the service to be able to demonstrate an effective system of midwifery workforce planning and actions to the required standard.

More recently, further scrutiny has been placed on maternity services with the publication of the Ockenden Report on 10 December 2020, 7 Local Immediate and Essential Actions (IEAs) were identified for implementation across all maternity services, pending the completion of the full and final report. IEA's map across to maternity MIS safety action 6. Additionally, the Ockenden maternity services assessment and assurance tool requires providers to undertake a maternity workforce gap analysis and to have a plan in place to meet the BR+ standard

Strategic theme/corporate objective links	Be one of the safest trusts in the UK – *meeting key standards of safe staffing and staff support*	√	Devolve decision making and empower clinical staff to lead- *through multi-professional leadership and challenge*	√
	Change how we deliver services to generate affordable capacity to meet the demands of the future- *through reorganisation of specialist maternity provision*	√	Maximise the use of technology so that the right information is available for the key decisions - *through accessible maternity care out of acute settings*	√
	Treat patients as partners in their care – *through delivery of the maternity personalisation and continuity of care plan*	√	Enhance patient care through research - *specialist midwifery services and senior leadership*	√
	Create an exceptional workforce for the future – *with the right skills in the right place at the right time*	√	Play our part in delivering a successful health and care system – delivering maternity care	√

			in line with the NHS 10 year plan	

Board Assurance Framework/Trust Risk Register Links	Risk to CQC registration if standards are not met to meet recommended safe staffing levels Non-compliance with National Quality Board and NICE requirements on staffing Risk to Maternity Incentive Scheme Year 4 CNST Standards 2021 Trust Risk Register links to this report: WORKFORCE- Not following staffing recommendations identified following a systematic, evidence-based calculation using BirthRate+. Potential risk on impact on clinical outcomes if full establishment is not in place. Risk Score 12
Other Standard Reference	NHS Workforce Safeguards (2018) National Quality Board Requirements (2018) NICE Guidelines for safe maternity staffing (2015,2019) CQC Regulation 9: Person Centred Care CQC Regulation 12: Safe care and treatment CQC Regulation 18: Staffing CQC Regulation 19: Fit and proper persons employed CNST Maternity Incentive Scheme 4 (2021) Compliance with Better Births NHSE (2018) Compliance with Ockenden 7 Essential and Immediate Actions (2020)
Financial implications	Resources and financial implications to be addressed as part of the annual Trust's Business Planning cycle. Transformation funding to support changes via the BNSSG Local Maternity System There is a known gap in income for maternity services currently provided mainly due to recording errors within the maternity pathways, high risk conditions, SGA pathway, and Level 2 Care and an overall reduction in birth numbers.
Other Resource Implications	Effective recruitment of sufficient Band 5/6 Registered Midwives and Specialist midwives to fill the vacancy deficit and the specialist services required
Legal Implications including Equality, Diversity and Inclusion Assessment	Due to high cost of litigation claims in maternity services, there are potential legal considerations to be considered if the recommendations to meet the clinical recommendations for safe staffing are not met.

	Equality, diversity and inclusion have been considered in the recommendations for the clinical specialist posts discussed as part of the Birthrate Plus® recommendations. This is specifically in relation to the services for vulnerable women including mental health, teenage pregnancy, and learning disability. By providing midwives with specialist skills links between teams and improved care pathways will be provided to prevent poor outcomes

Appendices:	
Appendix 1	Explanation of birthrate plus

Contents **Page**

1. Background and strategic context

1.1 Following the Francis report, the National Quality Board (NQB) published guidance that set out the expectations for safe nursing and midwifery staffing, in order to deliver high quality care and achieve the best possible outcomes for patients. The Lord Carter Review (2016) further highlighted the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and get the best use of resources. The NQB publication Supporting NHS Providers to Deliver the Right staff; '*with the Right skills, in the Right place at the Right time'* for Safe, Sustainable and Productive Staffing outlines the framework within which decisions on safe staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis. As part of this 'Safe Care' agenda, The NQB support an overall approach to determining safe staffing levels based on the patients' needs, acuity and risks that should be monitored from 'ward to board'. This triangulation approach to staffing decisions, rather than making judgments based solely on numbers or ratios of staff to patients, is supported by the Care Quality Commission (CQC).
The Maternity Incentive Scheme and the Ockenden EIA's require that NBT demonstrates an effective system of midwifery workforce planning to the required standard.

Table 1 CNST Safety Action 5

A	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
B	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
C	All women in active labour receive one-to one midwifery care
D	Submit a bi-annual midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period .

1.2 Maternity services report their workforce, investments and outcomes through a number of external requests, directly reporting nationally as part of the Safe Care agenda, and more locally through the Regional Perinatal Quality Team (South west) and the BNSSG Local Maternity System (LMS). Midwifery staffing numbers are considered through midwife to birth ratios and also through provision of 1:1 care for all women in active labour. Further requests of midwifery staffing numbers and ratios are now being requested by NHSE as part of the continuity of carer national programme.

1.3 Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making for maternity units and currently the only research-based methodology for workforce planning in maternity services. It is therefore the most widely used system for classifying women and babies according to their needs, using clinical outcome data to calculate the numbers of midwives required to provide antenatal, intrapartum and

postpartum care. The framework is suitable for assessing maternity staffing needs in maternity units ranging from stand-alone community/midwife units through to regional tertiary referral centres. It is sensitive to local factors such as demographics of the population, socio-economic needs, rurality issues and complexity of associated services such as fetal medicine and neonatal services. Birthrate data assessment is based on NICE guidance[1] and available evidence to give an understanding of the time required to meet the needs of women including:

- All antenatal and postnatal care, including parent education
- Antenatal outpatient activity, including clinics and day units
- Antenatal inpatient activity and ward attenders
- Birth in all settings, depending on type of birth (including inductions of labour, escorted transfers and non-registered births)
- All postnatal care in hospital and birth centres, including readmissions and ward attenders, transitional care and neonatal examination of the newborn.
- All specialist activity based on local demographic and subsequent requirements (e.g. FGM, mental health, complex needs and safeguarding)

It is important to note that due to the nationally recognised increase in acuity of mothers and babies and the impact that this has on antenatal, intrapartum and postnatal services, the previous and often cited and published ratio of 28 or 29.5 for hospital births is less reliable and is no longer used. From individual studies in the last 3 years, an average ratio for UK services is now 26/27 births to 1wte although this will vary depending on several factors with tertiary maternity units ratio's requirements often higher.

North Bristol Trust assessment suggests that the ratio of midwives required to meet the patient acuity across all services is a ratio of 27 births to 1wte midwife. This is a clinical and not specialist midwife ratio

Table 2: The midwife : birth ratio 2021

	March	April	May	June	July	August
Midwife to Birth Ratio	1:27.0	1:27.5	1:27.5	1:27.5	1:27.5	1:27.5

Table 3: Birthrate Plus® categories

Category	Process/Outcome indicators
Category I	This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if: The woman's pregnancy is of 37 weeks gestation or more, labour is 8 hours or less; normal delivery and intact perineum. The baby has an Apgar score of 8+; and weighs more than 2.5kg; and mother or baby do not require or receive any further treatment and/or monitoring.
Category II	This is also a normal outcome, very similar to Category I, but requiring other interventions. Perineal tear or a length of labour of more than 8 hours.

[1] Safe midwifery staffing for maternity settings NICE guideline [NG4] Published date: February 2015

Category III	Moderate risk/need such as Induction of Labour with augmentation, instrumental delivery, continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or Syntocinon will become a Category IV.
Category IV	More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.
Category V	This score applies when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical complexities such as diabetes, stillbirth or multiple pregnancy, as well as unexpected high dependency care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may also be in this category.

Together with the case mix the number of midwife hours per patient are assessed, based upon the well-established standard of one midwife to one woman throughout labour, plus the extra midwife time that is needed for complicated categories of patients. Care indicators are given a weighted score designed to reflect the different processes of labour and delivery and the degree to which these deviate from obstetric normality.

1.4 North Bristol Maternity Case mix was assessed in 2019 using the above categories and clinical indicators. In addition, the staffing required for antenatal inpatient and outpatient services is determined along with postnatal care of women and babies in hospital and community care in either the local hospital or neighbouring ones. The clinical establishment decided is based on agreed standards of care and specialist needs and the non-clinical and specialist midwifery roles required to provide nationally agreed services and manage the maternity service. Skill mix percentage adjustment is also agreed with the individual maternity units based on complexity to allow for clinical staffing adjustments between midwives and Band 3/4 qualified support staff.

2. NQB: Expectations and Trust compliance

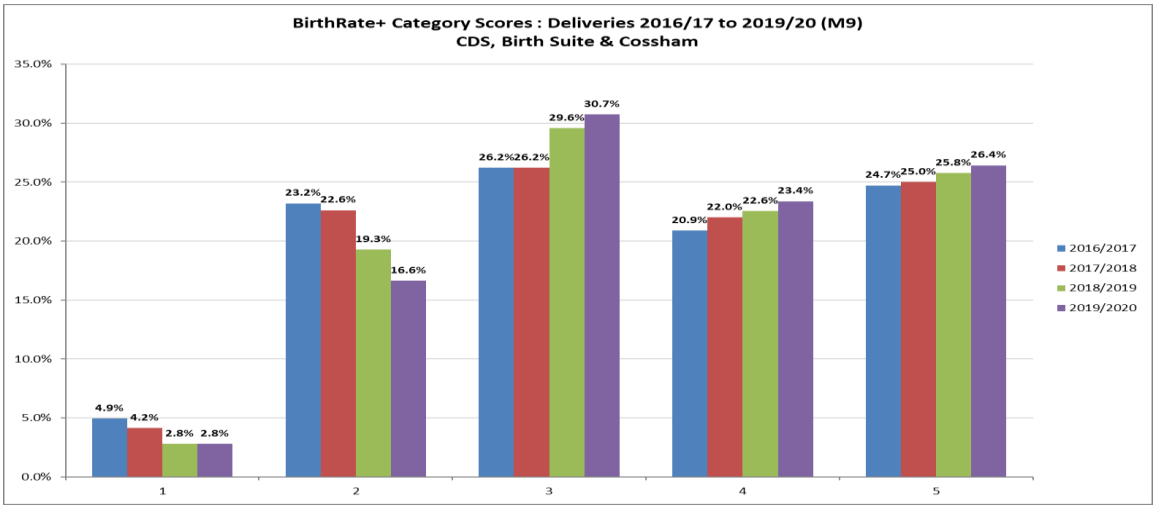
2.1 In meeting the expectations for safe care and North Bristol Trust compliance it is important to understand the factors that influence the numbers of staff needed within maternity as services and the needs of women and babies changes. NBT is a tertiary referral centre for antenatal and intrapartum care. The specialist services provided and more recent changes in national guidance[2] mean that there remains a growing concern amongst Obstetricians and Midwives that the complexity of the service in increasing, creating a need for more midwifery time to manage complicated pregnancies, complex births and high dependency postnatal care.

[2] RCOG Green top guidance no 57 (2011 and updated 2017)- Reduced fetal movements

Table 4 Maternity Case mix at North Bristol Trust

	Cat I	Cat II	Cat III	Cat IV	Cat V
Delivery Suite % Case mix (in labour)	1.4	9.2	23.3	27.6	38.5
Generic % Case mix (before labour)	*5.9*	*14.8*	*20.6*	*24.5*	*34.2*

Table 6 BirthRate+ category scores:



As the graph above shows, by the time women transfer from antenatal to labour 89.4% of all births are in the higher Categories III, IV & V.

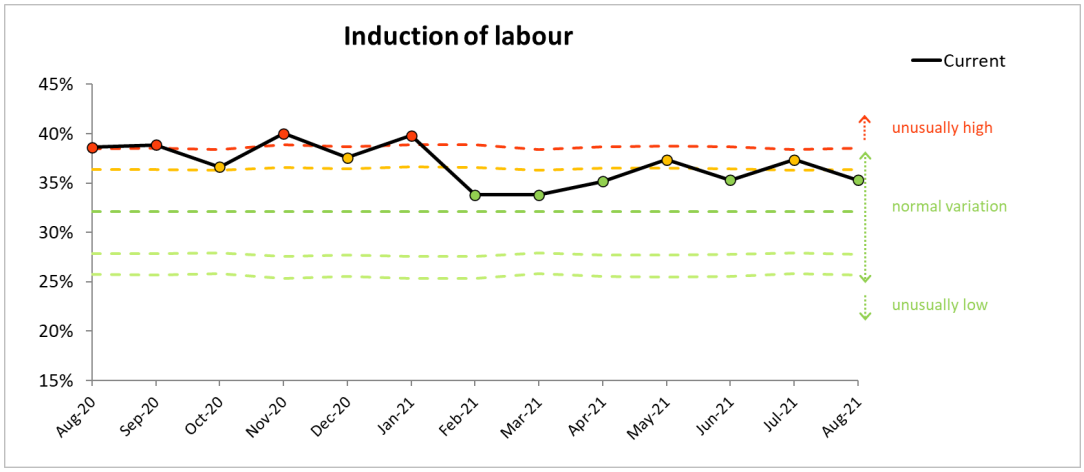
North Bristol Trust has been noted to be in the higher end of UK units and is typical of similar units supporting tertiary care with women with complex obstetric and medical conditions. This evidence certainly agrees with observational analysis of senior midwifery and obstetric staff, working within the service. The greatest impact of this is on the workload on Delivery Suite and the follow-up postnatal care particularly on Percy Phillips and transitional care and ongoing care at home

Analysing the caseload variances has shown that the highest Category V at 38.5% includes emergency CS, and often women with obstetric/medical problems, such as diabetes, obesity related problems, mental health and high incidence of more complex safeguarding issues. The numbers of women in Category III is also high at 23.3%. These women have moderate risk factors and include the increasing number of women having Induction of Labour, instrumental births and births requiring births continuous fetal monitoring.

The women in Category IV at 27.6% is related to elective CS or epidural for pain relief, low birth weight/preterm babies, higher-risk inductions of labour and women having a post-partum haemorrhage. The generic case mix indicates that only 20.7% of total births are in the lower categories I & II with 79.3% in the moderate to high categories, of which 58.7% are in IV & V.

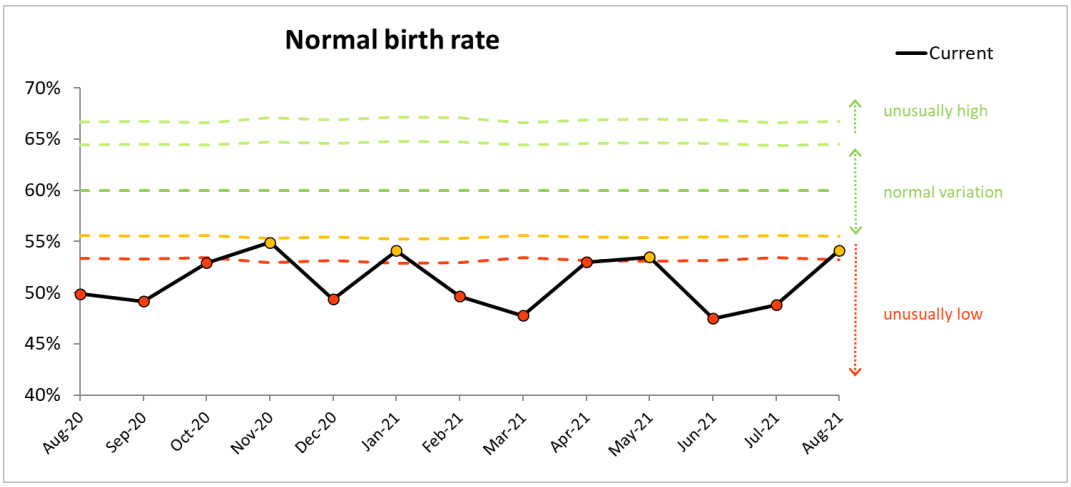
The maternity clinical dashboard from North Bristol Trust shows increasing complexity and induction of labour rates are now sitting at around 36% of all births.

Table 7 Induction of labour rates



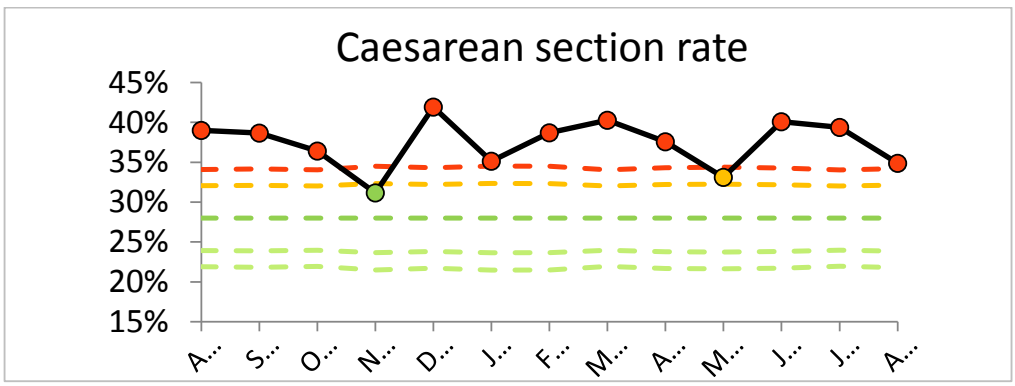
Whilst normal births are comparatively low:

Table 8 Normal Birth Rates:



And cesarean births remain high.

Table 9 Cesarean birth rates:



12.1

3.0 Factors continuing to affect the increasing complexity within Maternity Services

3.1 A number of changes in Antenatal care supported by NICE have had significant influence on the requirement for increased midwifery time. These include that all women must be 'booked' by 10 weeks gestation meaning contacts with maternity services are now earlier. 10-12% of this activity will end as a fetal loss and at North Bristol Trust, similar to most maternity units. Updated figures demonstrate that 7026 women were booked during Aug 20 to Aug 21 and of those 6054 went on to give birth in the system meaning 972 either accessed care outside of BNSSG or miscarried.

The RCOG Green Top Guidelines (2018) and implementation of the Saving Babies Lives Care Bundle Version 2 (2019) has meant noteworthy changes in both antenatal care and the numbers of women being induced in labour. This creates additional demand for antenatal surveillance including ultrasonography services, day care assessment and longer intrapartum stays and more complex delivery outcomes.

Expectations that midwives will take on increasing responsibilities as part of the maternity pathway; these include that NIPE examinations are now completed by midwives instead of junior neonatal doctors in order to meet medical training needs. There have been increasing needs of the Antenatal and Newborn Screening and Immunisation programmes including Sickle cell/Thalassaemia counselling, NIPT, Flu and Pertussis which has again significantly increased the midwifery time needed in this area.

The Better Births[3] governance agenda requires increased evidence-based guidelines, on-going monitoring and audit of clinical practices and delivery of ongoing clinical training programmes. Along with this external scrutiny of maternity services means high numbers of midwifery activities to achieve the results. Birthrate Plus® allows for inclusion of the requisite resources to undertake such activities based on an agreed national requirement of 8-10% in addition to the required case mix of clinical midwives.

The encouragement of early transfer home does mean that the level of midwifery input during hospital stay is considerable. If adequate skilled resources are provided during this postnatal period, problems such as postnatal depression or inability to breast-feed can be reduced or avoided. Community based care is expanding with the emphasis being placed on 'normal/low risk/need' care being provided in community by midwives and MSWs. In order for the service to reduce antenatal admissions and have shorter postnatal stays results in an increase in community care being required to meet the midwifery responsibility of care provision up to 28 days if required.

During 2020 a review of care pathways to create better efficiencies in postnatal care and discharge home for mums and babies in a timely way has taken place. The readmission of babies unnecessarily has been addressed with new postnatal support lines in the community

[3] Better Births – Improving outcomes in maternity services – A five year forward view for maternity services. NHS England 2016

and enhanced feeding support. This has been of particular benefit during the pandemic and supporting keeping mothers and their babies at home during this period.

3.2 Better Births[4], the report of the National Maternity Review, set out a vision for maternity services in England for services to become safer and more personalised. At the heart of this is that women should have continuity of care from the midwives looking after them during their maternity journey, before, during and after the birth. Each maternity unit is required to have the building blocks in place to ensure that continuity of care is the default model for all women by March 2023 this includes:

• Undertake a Birth-rate Plus assessment to understand the current midwifery workforce required and follow this through with recruitment.

• Codesign a plan by July 21 with local midwives, obstetricians and service users for implementation of continuity of carer teams with national principles and standards and phased alongside the fulfilment of required staffing levels. This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic.

• Prioritise those most likely to experience poorer outcomes first, including ensuring most women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived areas are placed by on a continuity of carer pathway by March 2022.

It is now known that compliance with the numbers of midwives required for the provision of safe care as assessed by agreed framework for workforce planning across the maternity pathway is to be monitored and form a part of external regulatory assessments. The Maternity incentive scheme (CNST) year 4 requirements will have consequences for maternity units not demonstrating commitment to full implementation by March 2023.

4.0 Midwifery staffing analysis

4.1 The midwifery staffing analysis undertaken by the BR+ assessment in 2019 concludes the numbers of midwives that are required to provide midwifery care at North Bristol Trust. The total required number is demonstrated below in order for the maternity service to provide total care to women and their babies throughout 24 hours, 7 days a week inclusive of 21% for annual, sick & leave allowance and 15% for travel in community

[4] Implementing Better Births – Continuity of Carer (December 2017)

The overall clinical establishment for total of 5996 births at North Bristol NHS Trust is summarised as follows:

(a) Hospital Services (incl. Mendip Birth Centre)	193.93 wte
(b) Community Services (incl. Cossham)	60.86 wte
TOTAL CLINICAL WTE	**254.79 wte**
(c) Additional non-clinical midwifery WTE at 9%	22.93 wte

The overall clinical establishment required for the assessed number of current births was a total of **254.79wte**.

An additional non-clinical midwifery time establishment at the recommended level of 9% (agreed by Director of Midwifery in 2020 to reduce from 10%) is a total of **22.93wte** as suggested by Birthrate Plus® and cited in the RCM Staffing Guidance.

It is of paramount importance to note that the BR+ non-clinical establishment does not include the following roles (and other specialist roles required subject to local variation).

- Head of Midwifery, Deputy Head of Midwifery & Matrons.
- Practice Development role
- Clinical Governance role
- Time for Baby Friendly Initiative, which is not to assist women with breastfeeding but to produce & monitor guidelines & undertake audits
- Additional hours for antenatal screening over & above the time provided in actual clinics
- Time for clinical specialist midwives who are additional support (Diabetes, Mental Health Drugs and Alcohol abuse etc.)
- Professional Midwifery Advocate
- Coordination for such work as Safeguarding Children
- Better Births Lead

Several of these key roles have been previously included in the establishment calculations or have been in place as a cost pressure when comparing existing establishment to the BR+ recommendations including:

Practice Development PEF roles, Clinical gov support roles, Infant Feeding support, Antenatal screening outside of clinic times, Clinical specialist midwife roles, Professional Midwifery Advocates, Safeguarding coordination role, Bereavement lead and diabetes specialist role.

Funding for these vital roles has been taken from clinical midwifery establishments thus creating a shortfall in clinical midwifery staffing across all areas of the service.

The total percentage of specialist midwives in funded posts at NBT is currently 2.3%. The actual number of midwives in these posts is currently 8.6%. (BR+ accounts for 8-10% of the total establishment).

Work is currently underway to develop a robust business case which aims to secure funding for all additional specialist roles thus creating vacancy within the funded midwifery clinical establishment in which to recruit.

5.0 Calculating the requirements

5.1 Birthrate Plus® analysis demonstrated a shortfall in staffing for both clinical and non-clinical activities.

It was evident that due to the shortfall the Division had a number of cost pressures in the service including the implementation of 'flow midwives' in 2018, support for 7 days a week NIPE service and a shortfall of midwives to support the increase in women requiring care during induction of labour. An increase in these posts initially on a temporary basis was evident from January 2019 as the national drivers were introduced, with a plan to reduce the numbers again at some point. However, not surprisingly, the increased activity related to acuity and complexity, as demonstrated in this report continued and the midwives to deliver the care remained in place.

At this time it was evident that there was a shortfall in WTE clinical midwives to provide the baseline of services across the maternity pathway of 23WTE.

6.0 Updated review

Due to Covid-19 many changes occurred in the Maternity service – ward areas were changed and an extra ward required supporting in-patient care. Many staff were required to shield and resources needed to be moved around to provide safe care. Maternity services, unlike many others continued with usual numbers of births during the pandemic:

Table 10 Number of Births:

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Total
Number of babies born	492	482	508	430	465	437	441	502	462	450	467	507	482	6125

Action plan to address the shortfall in midwifery establishment identified by BR+

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
Shortfall in midwifery establishment identified by BR+2019 report with associated cost pressures to establishments	Full workforce review to identify areas and levels of vacancy across midwifery staffing Full review of specialist midwifery staffing to identify funded and non-funded posts Full review of specialist midwifery posts and requirements of the service in place to identify need for development of posts	HOM HOM HOM	Aug 21 Aug 21 Aug 21	Clinical and non-clinical establishments identified and business case to address shortfalls in development which meet recommendations of BR+, consider external funding (12.5wte)/ internal additional funding agreed (10wte) / substantiating cost pressure posts and developing further posts in line with service requirements	

12.1

Ockenden response:

In response to the Ockenden report (2020) national funding was made available to address the recognised shortfall in midwifery staffing across England. Each Trust in England with an established shortfall in staffing as evidenced by a Birth rate Plus assessment was invited to bid for a share in the fund. NBT submitted a system bid along with UHBW with an agreed level of funding requested to support both each individual trust's shortfall plus a system wide consideration to safe staffing of maternity services. NBT were successful in receiving non-recurrent funding for an additional 12.5 wte midwives. These posts have been recruited to and this took the shortfall in midwifery staffing down to 9.5wte.

W&CH have also been supported at executive level to over-recruit by an additional 10wte to address the remaining shortfall in clinical midwifery post funding. These posts have also been recruited to but remain a cost pressure pending the supporting business case which is being prepared.

In recognition of several unfunded posts currently within maternity services and a lack of specialist posts, the senior divisional team are preparing a series of business cases to substantiate and support these essential roles. These include:

Bereavement Lead Midwife

Diabetic Specialist Nurse/Midwife

Complex Care Midwives

FLOW midwives – including uplift to cover 24/7 service

Uplift to the Infant Feeding team

Uplift to Screening Team

Uplift to Fetal Medicine Team

Service User Experience Midwife

10 x WTE additional midwives (as agreed by exec team)

7.0 Managing safe staffing every day

7.1 A triangulated approach to safe staffing is required by NQB to ensure robust decision making is made around the safe care of patients. Within nursing areas across the Trust the safe care acuity tool is used for real time data of actual staffing levels and patient acuity can be viewed and staff redeployed between clinical areas to balance the risk across the organisation. A RAG rating identifying the agreed funded staffing levels (green) and the

number of staff when there is a cause for concern (red) is used. If there is a cause for concern action may be taken to enhance the numbers of nurses available. Professional judgement is used and there may be times when both metrics are red but care can be delivered safely to the patients and the other end of the spectrum where both metrics could be amber but not adequate to meet the safe care needs of the patients.

The same tool is not recognised as being suitable for maternity services due to the significant fluctuation in activities and the flexibility required to manage activity across acute and community care services. Many influences on safe staffing in maternity affect the number of staff required to keep staffing safe and sustainable: Multifariousness of everyday practices, safeguarding children, a fluctuating birth rate and increasing complexities lead to an increase in interventions that are driven by concerns for patient safety.

In order to recognise this effectively, and in a similar way to nursing acuity tools, Birthrate plus have developed 'Real-time' assessments of maternity staffing levels in relation to patient needs.

Intrapartum Acuity Tool – this has the ability to monitor workload v staffing in real time and take appropriate action to maintain safety levels and reduce risk, giving the ability to monitor the majority of the red flags in real time to take action and longer time to see trends. Red flags include: Delay in IOL, Delay in LSCS, Delay in Triage assessments, Delivery suite co-ordinator is supernumerary and Provision of 1:1 Care in labour.

- This is now in full operation at North Bristol Trust and enable mitigations to be assessed and areas of need identified

Table 11 Provision of 1:1 care in labour

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Total
One to One Care In Labour	Number of women giving birth (excluding not applicable)	432	435	460	391	425	397	401	451	415	421	460	453	433	5574
	Women receiving one to one care in labour	430	433	458	389	421	386	393	447	411	415	458	445	427	5513
	One to one care in labour rate %	**99.5%**	**99.5%**	**99.6%**	**99.5%**	**99.1%**	**97.2%**	**98.0%**	**99.1%**	**99.0%**	**98.6%**	**99.6%**	**98.2%**	**98.6%**	**98.9%**

Table 12 Delivery suite coordinator is supernumerary at all times

2020	April	May	June	July	August	September
Coordinator is supernumerary	100%	97%	83% (5)	87% (4)	100%	97% (1)

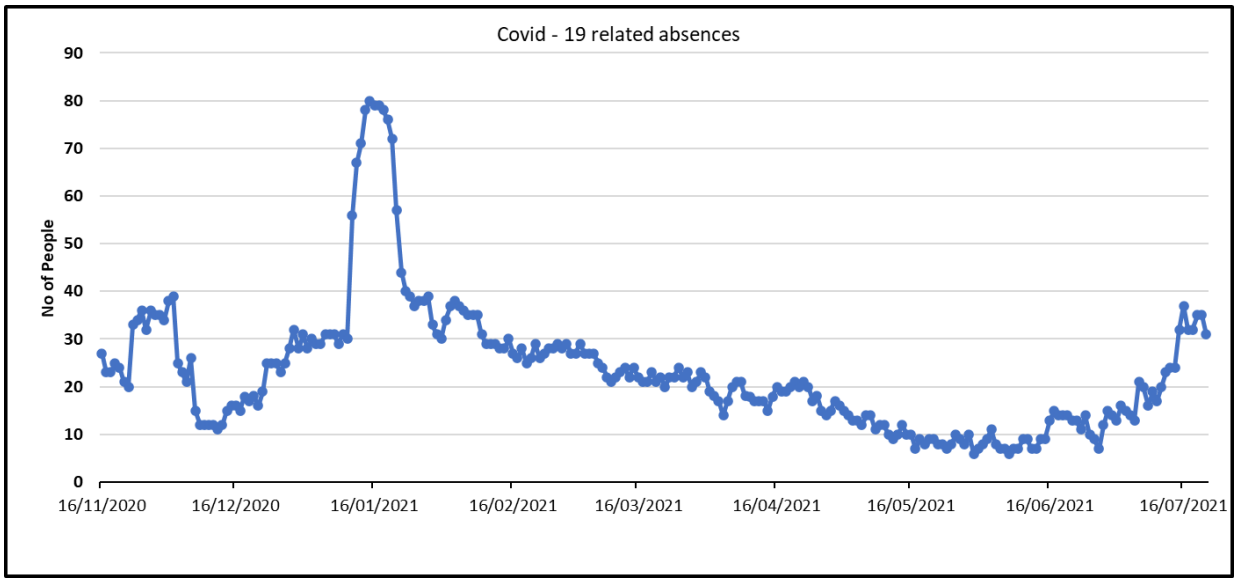
In June and July maternity service at NBT experienced particularly high levels of COVID related sickness which impacted on staffing across the service including the supernumerary status of the delivery suite coordinator. Enhanced bank pay rates were implemented by the trust resulting in an increase in uptake within maternity and associated improvement in delivery suite coordinator supernumerary status.

Report to the Digital and People Committee Sept 2021

Table 13 COVID 19 related sickness

Teams	w/c:	Jul-21																										
						05							12							19							26		
	day:	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
Ante Natal Clinic 01258		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Birthing Centre 01181		-	3%	-	-	-	-	-	-	-	-	-	-	-	-	3%	3%	8%	8%	5%	5%	8%	5%	5%	3%	-	-	-	-
Cedar Team 01247		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Central Delivery 01259		1%	2%	3%	2%	2%	4%	3%	1%	2%	3%	3%	2%	2%	3%	3%	3%	2%	2%	1%	2%	2%	2%	2%	2%	2%	2%	2%	1%
Comm Midwifery - Blue 02611		11%	11%	11%	11%	11%	11%	11%	11%	11%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Comm Midwifery - Centralized Booking Clerks 02611		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Comm Midwifery - Green 02611		8%	8%	8%	8%	8%	17%	8%	8%	8%	8%	8%	8%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Comm Midwifery - Indigo 02611		8%	8%	-	-	-	-	-	8%	8%	-	-	-	-	-	8%	8%	-	-	-	-	-	8%	-	-	-	-	-	-
Comm Midwifery - Lilac 01181		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Comm Midwifery - Orange 02611		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Comm Midwifery - Pearl 02611		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Comm Midwifery - Pink 02611		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	17%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	-	-
Comm Midwifery - Red 02611		-	-	-	-	-	-	-	-	-	-	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%
Comm Midwifery - Yellow 02611		6%	13%	6%	6%	6%	6%	6%	6%	6%	6%	6%	-	-	-	13%	13%	13%	13%	13%	13%	13%	13%	13%	6%	-	-	-	-
Cossham Birth Centre - Jade Team 26079		-	-	-	-	-	-	-	-	-	-	-	-	-	-	6%	6%	6%	6%	6%	-	-	-	-	-	-	-	-	-
Cotswold Gynae O/P 01219		-	-	-	-	4%	7%	11%	4%	4%	-	4%	4%	4%	4%	7%	4%	4%	7%	7%	4%	-	-	-	-	-	-	-	-
Cotswold Ward 01269		5%	5%	5%	5%	3%	3%	5%	3%	5%	5%	5%	5%	11%	8%	5%	5%	3%	3%	3%	3%	-	-	-	-	-	-	-	-
Fetal Medicine Clinic 01198		-	-	-	-	-	-	-	-	-	-	-	-	-	-	10%	10%	-	-	-	-	-	-	-	-	-	-	-	-
Gynae Med Secretaries 01377		5%	5%	5%	5%	5%	5%	5%	5%	5%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Midwife Scanning 01260		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NICU 01255		2%	2%	2%	2%	2%	2%	3%	2%	2%	2%	3%	5%	4%	5%	6%	6%	6%	6%	7%	7%	7%	6%	5%	4%	3%	1%	1%	1%
NICU Admin 01180		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NICU ANNP 01255		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NICU Paediatric Outpatients 01255		25%	25%	25%	25%	25%	25%	-	-	-	-	-	25%	25%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
NICU Services 01255		-	-	-	-	-	-	-	-	-	-	-	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	-	-	-	-	-	-	-
NICU Support 01255		-	-	-	-	-	8%	-	-	-	-	-	-	-	-	8%	8%	8%	-	-	-	-	-	-	-	-	-	-	-
Percy Phillips 01254		2%	2%	2%	2%	2%	6%	4%	4%	4%	6%	6%	6%	7%	7%	9%	17%	15%	15%	17%	17%	15%	15%	13%	11%	9%	6%	6%	6%
Quantock 01253		2%	2%	2%	2%	2%	2%	4%	6%	6%	6%	6%	8%	8%	8%	6%	8%	6%	4%	8%	10%	6%	6%	4%	2%	2%	2%	2%	-
Quantock 01254		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Women & Childrens Mgt 20031		-	-	-	-	-	-	-	-	5%	5%	5%	5%	5%	5%	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Womens Specialist Nurses 01247		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	6%	6%	6%	6%	6%	6%	6%	6%	6%	-

Table 14 Covid-19 related sickness graph



12.1

The service has an action pan in place to address shortfalls in delivery suite coordinator supernumerary status:

Action plan

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
Coordinator not always able to be supernumerary	Delivery Suite matron to do a forward view on staffing twice a week to ensure 9+1 on each shift & escalate when not achieved. For short notice sickness – coordinator to escalate to Matron in hours and Senior Midwifery manager (SMM) out of hours as required. Coordinator to mitigate through redeploying staff from other areas as needed. If suspension of any aspect of service to escalate to SMM & CSM. Hospital on call to be call in to support before suspension of service.	Delivery Suite Clinical Matron Delivery Suite Clinical Matron	Ongoing Ongoing	Bi-weekly staffing review Safety Huddles Acuity tools 3x weekly divisional quality huddles Safety Huddles Acuity tools 3 x weekly divisional quality huddles	

12.1

Red Flags:
Red Flags in maternity services are monitored including those monitored via the acuity tools include:

- Redeployment of staff to other services/sites/wards
- Staff absences due to illness/isolation/shielding/symptoms for Covid-19
- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.

- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of two hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Ward acuity - The Ward tool is now in full operation since April 2020. Red flags for the antenatal and postnatal acuity tool care include MEWS not acted on, critical medication delayed, pain relief not given within 30 mins of request and expected care delayed.

The tools provide for the following reporting;

- Graphs to review acuity in real time as these are generated in the background as the data is entered
- Ability to monitor red flags, the time period when they occurred, were they linked to staffing less than expected / less than workload
- Where workload exceeded demand –actions taken in response to this
- Calculation of workload indices –a measure of average staff time per woman

The acuity tools are completed over three time periods, 2 x 6 hrs in day and 1 x 12 hours at night. The tools give an idea of extra time needed rather than a shortfall of staffing alone. The skill mix of staff required from this analysis can be decided – for example high dependency care increases may need extra nursing rather than midwifery support.

Table 15 Example of outputs of the intrapartum acuity tool

category	% of av casemix	Av hours in delivery	Midwifery input during labour	Total midwifery time required
I	10.9%	6.6 HRS	1 wte mw: 1 woman	6.6hrs
II	22.4%	7.4 HRS	1 wte mw: 1 woman	7.4hrs
III	17.3%	9.4 HRS	1.2 wte mw: 1 woman	11.3hrs
IV	25.9%	10. 7HRS	1.3 wte mws: 1 woman	13.9hrs
V	23.5%	16.4 HRS	1.4 wte mws: 1 woman	22.9hrs
Cat X	122.4%	1 hr.		1 hr.
Cat 1A	11%	4 hr.		4 hr.
Cat A2	3%	15 hr.		15 hr.
Cat R	1.5%	6 hr.		6 hr.
Prostin	33%	2.5hr		2.5 hr.
Transfers	0.5%	8 hr.		8 hr.

8.0 Temporary Staffing

The maternity services have a midwifery bank that consists mostly of staff already in post that will cover extra shifts – there are smaller numbers on the bank of midwives who have a bank contract only. The staff are generally experienced midwives who have recently left the unit following retirement, but offer a range of skills and are able to work across all areas. There is also no routine agency usage in midwifery. Agency shifts would only be utilised if specialist nursing support is required for women with mental health needs such as puerperal psychosis.

An on call system is also in operation to support times of high activity. This is utilised for short periods as and when necessary.

The impact of unfilled shifts is currently being monitored across Maternity to analyse further shortfalls. Shortfalls in staffing without backfill affects women's experience and is a clinical risk and areas of concern will be addressed.

The recruitment of both registered and non-registered midwives and nurses to the temporary staffing bank continues and new staffs are supported by the Practice development team to ensure new starters and existing staff are supported with a preceptorship programme and maintain high professional standards. The Safe Staffing guidelines also support the consistent decision making required for managing fill rates. In light of any low fill rates in maternity further work will take place to review the use of nursing support for high dependency postnatal care and theatre cover at times of high activity.

9.0 Governance

Maternity services governance team report risks in relation to midwifery staffing concerns and complete risk assessment as required.

The Safer Births initiative requires oversight of all risks in relation to delivery of safe care within the service and is reported where needed via the Head of Midwifery and Clinical Director for the Division to the Maternity Safety Champions and to the Trust Board.

Table 16 Maternity Risk Analysis, Impact and Mitigations

ID	Owner	DIV	ERS	What is the risk?	Likely	Impact	Score	Mitigations / Controls in place	Gaps in Controls / Actions
1049	Sally Bryant, Head of Midwifery	Women and Children's Health	Director of Nursing and Quality	***Workforce***: Not following staffing recommendations identified following a systematic, evidence-based calculation using BirthRate+. Potential risk on impact on clinical outcomes if full establishment is not in place.			12	**Control**: We have recruited at risk to begin to address the shortfall and have a remaining shortfall of: 20.5 WTE clinical midwives between BR+ and actual midwives in post. Recent recruitment has seen an increase in B5 midwives therefore we are asking for B6 clinical midwives to provide safe skill mixes across all settings. NBT have good retention and are confident in our ability to recruit midwives being the largest maternity provider in the SW. We are a strong recruiter of midwives from our provider University UWE and are actively supporting retire and return and have good retention. **Mitigations**: 1) Agreement for non recurring funding for 10 WTE from Executives 2) 12.5 non recurrent funding as a direct response from Ockenden from the LMS 3) a large umber of unfunded posts in place which can temporarily cover shortfall. 4) Historical recruitment of 10 WTE in early 2021.	**Gaps**: • Mitigated shortfall with non-recurrent funding in response to the Ockenden report and Exec approval. • Business cases required to substantiate all posts • A new Birthrate Plus exercise due Oct 2021, which calculates staffing requirements for delivery of CoC, as per the national mandate from Better Births. • Majority of new starters now in post. Expected completion of recruitment Jan 2022. • High levels of sickness, mostly related to Covid is also impacting upon staffing levels. **Actions**: • Meeting (29/09/21) to commence BirthRate Plus 2021 assessment planning, • Recruited into all 22.5 posts. Business cases being drafted to support ongoing funding, HOM and DDON. Plan for business case to be submitted to DMB October 2021.

12.1

10.0 Demand & Supply

Maternity services have monthly demand and supply meetings within the division, these are attended by the Head of Midwifery, Human Resources Manager, Finance manager, and transformation and recruitment colleagues to set an agreed pipeline for recruitment based on changes to services required both nationally and locally.

The staffing requirement for midwifery has been reviewed in order to meet the baseline requirement of safe midwifery staffing as demonstrated within the BR+ report and clinical assessments. Recruitment is subject to approval at the monthly demand and supply meetings and ensures that turnover rates are monitored and recruited to accordingly.

11.0 Patient quality measures

11.1 Analysis of women's feedback is via complaints, concerns, letters of appreciation and the friends and family process that take place at four points on the maternity pathway. A Maternity Picker survey also takes place annually with all women who give birth in February of each year sent the national survey.

The 2021 Friends and Family, and the recent Picker report results have recently been reviewed by the Division and reported to the Trust. Women's experience of the service is generally good; however a number of themes where improvement is required are reported to include: Communication, Waiting times, the environment and staffing. Our Picker report identified 4 key areas needing improvement:

- Partners being able to stay overnight
- Not enough information prior to Induction of labour
- Information regarding feeding their baby
- Asking questions after their birth.

There has been a great deal of work to address these themes including:

- Creation of an information about induction of labour video based on service users feedback about their experiences and a training package for staff to support improvements in infant feeding support.
- Creation of an information about induction of labour video based on service users feedback about their experiences and a training package for staff to support improvements in infant feeding support.
- Development of an after birth reflections service
- Improvements in our communications with women using social media and our My Pregnancy App plus linking with the MVP

11.0 Conclusion

This paper provides the People and Digital Committee with an updated report on safe midwifery staffing and changes that have taken place over the last 6 months and plans for future development. It is aimed to provide assurance that the Trust has a clear validated process in place for monitoring and ensuring safe midwifery staffing is in line with current national recommendations.This includes the triangulated approach of the NQB expectations for safe staffing, actions to support recruitment and retention and how staffing is managed daily to support safe and quality patient care.

Midwifery staffing will continue to be reviewed in line with the required business planning processes and live data reporting and a revised plan submitted in line with annual birth rates in January each year.

12.0 Recommendations

This report has demonstrated that the recommended assessment of maternity staffing has taken place and that a follow up assessment of the annual midwifery staffing analysis has taken place in line with business planning and against the triangulated approach. It also demonstrates the need for the division to develop a business case which supports both the additional clinical midwifery staffing required to meet the recommendation of the Birth rate + report and to secure appropriate funding for essential specialist posts.

The Committee is asked to;

1. Note the contents of this report which outlines the progress to date and further actions planned to ensure midwifery staffing levels are safe to support the increased complexity in the service, are effectively managed and are being published in accordance with the requirements of national standards of NHS Improvement (2018) Developing Workforce Safeguards recommendations, NHS England National Quality Board Safe, Sustainable and Productive staffing (2018), NICE organisational requirements for safe midwifery staffing (2019), CNST Maternity Incentive Scheme Year 4 (2021), Ockenden report 7 Essential and Immediate Actions (2020).
2. Receive assurance that the Head of Midwifery in association with the Divisional Director of Nursing has undertaken an updated formal review based on a continuing activity and acuity analysis of safe staffing for maternity services
3. Note the additional requirements of funding to substantiate specialist posts within the service that currently present a cost pressure.
4. Note the intention of the division to repeat the BR+ assessment commencing Oct 21 and likely subsequent increase in clinical midwifery staffing requirements in order to fully implement continuity of carer as the default model of care for all women by March 2023.

Appendix 1 – **Explanation of birthrate plus**

Birth Rate+ additional information for categories and ratiosMethod for Classifying Birthrate Plus® Categories by Scoring Clinical Factors in the Process and Outcome of Labour and Delivery

There are five [5] categories for mothers who have given birth during their time in the delivery suite [Categories I – V)

CATEGORY I **Score = 6**

This is the most normal and healthy outcome possible. A woman is defined as Category I [*lowest level of dependency*] if:
The woman's pregnancy is of 37 weeks gestation or more, she is in labour for 8 hours or less; she achieves a normal delivery with an intact perineum; her baby has an Apgar score of 8+; and weighs more than 2.5kg; and she does not require or receive any further treatment and/or monitoring

CATEGORY II **Score = 7 – 9**

This is also a normal outcome, very similar to Category I, but usually with the perineal tear [score 2], or a length of labour of more than 8 hours [score 2]. IV Infusion [score 2] may also fall into this category if no other intervention. However, if more than one of these events happens, then the mother and baby outcome would be in Category III.

CATEGORY III **Score = 10 – 13**

Moderate risk/need such as Induction of Labour with syntocinon, instrumental deliveries will fall into this category, as may continuous fetal monitoring. Women having an instrumental delivery with an epidural, and/or syntocinon may become a Category IV.

CATEGORY IV **Score = 14 –18**

More complicated cases affecting mother and/or baby will be in this category, such as elective caesarean section; pre-term births; low Apgar and birth weight. Women having epidural for pain relief and a normal delivery will also be Category IV, as will those having a straightforward instrumental delivery.

CATEGORY V **Score = 19 *or more***

This score is reached when the mother and/or baby require a very high degree of support or intervention, such as, emergency section, associated medical problem such as diabetes, stillbirth or multiple pregnancy, as well as unexpected intensive care needs post-delivery. Some women who require emergency anaesthetic for retained placenta or suture of third degree tear may be in this category.

Category X women are those who are admitted to the delivery suite, but after assessment/monitoring are found not to be in labour or to need any intervention. These women are either sent home or transferred to the antenatal ward for observation.

Categories A1 & A2 women are those who require some intervention such as intravenous infusion and/or monitoring, e.g. antepartum haemorrhage, pre-eclampsia or premature labour. Such women often spend considerable time on delivery suite before being transferred to the antenatal ward or to another maternity unit with neonatal facilities. However, some women with moderate risk/needs will go home following assessment and treatment.

Category R women are re-admitted after delivery as postnatal cases, often requiring medical care.
Inductions of labour with prostins are recorded, as are escorted transfers to another maternity unit and the non-viable pregnancies.

1. Maternity support workers/care assistants

Due to changes in skill mix with the increasing use of support staff with a formal qualification in maternity services, there is a need to distinguish between those that can replace midwife hours, and other staff that support the midwife in care of women and their babies. Maternity Support Workers (MSW) refers to those support workers with a formal qualification such as Level 3 NVQ or Nursery Nurse, and who can replace midwife hours. The Maternity Care Assistant (MCA) is used to denote the more basic grade of support worker who supports the midwife. In all clinical areas the use of Care Assistants greatly aids the provision of maternity care, by releasing midwifery staff to be client, rather than ward centred.

Skill Mix Rationale

It is important to distinguish between the situations where support staff assist the midwife and where he/she replaces the midwife.

Birthrate Plus® (1996) makes it clear the ward and clinic staffing levels for midwives are based upon the premise that they are supported by MCA and clerical staff and these staff needs are assessed on a shift by shift basis.

The decision about the percentage of midwife time, which might be replaced, by MSW time must that of the local service managers.

Antenatal care: As this calls for midwife skills so it is not recommended to replace the midwives with an MSW, but units should ensure that midwives are well supported by clerical and MCA staff.

Intrapartum care: Birthrate Plus® does not recommend any replacement of midwife time by MSW time. To do so would undermine the basic quality standard of one to one care throughout labour plus the increased % of midwife time required for high needs categories.

Postnatal care in Hospital: Many services now suggest 20 - 25% of midwife time can be replaced by MSW input. Once a local decision has been made, the calculations of wte staff for each ward can readily be adjusted.

Postnatal Care in Community: Many services now suggest that 25% of midwife time can be replaced by MSW time. This would allow for full assessment and planning of care by the midwife, with a minimum of three visits and additional visits being undertaken by the MSW working under the direction of the midwife in charge of each woman's care.

Based on adjustments made by other maternity units, an average of 10% of the clinical total wte can be competent and qualified support staff usually being Bands 3 & 4.

The skill mix % is a rationale for having a sensible skill mix that does not reduce the midwifery establishment to an unsafe level and prevents flexibility of deployment to areas of high risk and needs. Some services are moving towards an 85/15% split with more MSWs working in community and increasing support staff on the p/n ward to work with transitional care babies.

Note: In addition, there is a need for Maternity Care Assistants in the Delivery Suite, Outpatient Services and Wards to provide support to women and their babies, but are in addition to the calculated clinical establishments. To assess the requirement of Band 2 support staff is on the numbers per shift in the various areas based on professional judgment and management decision. For example, 2 per shift on D/S at all times inclusive of the leave allowance.

Report To:	People Committee		
Date of Meeting:	12th October 2021		
Report Title:	Bi-Annual Staffing Review		
Report Author & Job Title	Su Monk, Deputy Director of Nursing and Quality, NHS England & Improvement Chief Nursing Officer Safe Staffing Fellow		
Executive/Non-executive Sponsor (presenting)	Helen Blanchard, Director of Nursing and Quality		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Committee is asked to: 1. Note the contents of this report which outlines the progress to date and further actions planned to ensure nurse staffing levels are safe to meet the needs of our patients, are effectively managed and are being published in accordance with the National Quality Board (2016), NHS Improvement (2018) Developing Workforce Safeguards recommendations, NHS Improvement (2018) Developing Workforce Safeguards recommendations, NICE guidance and self-assessment of the NHS Improvement recommendations for safe staffing 2. Receive assurance that the Director of Nursing and Quality has undertaken a formal annual review of safe staffing for all inpatient ward areas as detailed within the report with required changes to be included within workforce Business plans for each Division.		
Report History:	Six monthly review of Safe Staffing, last presented to Trust Board in June 2021		
Next Steps:	January 2022 SNCT and bi-annual report		

Executive Summary

The purpose of this paper is to provide the Board with a 6 monthly report on Nursing and Midwifery staffing and to provide assurance that the Trust has a clear validated process in place for monitoring and ensuring safe staffing in line with current national recommendations.

This report serves as the six monthly review of safe nursing staffing at North Bristol NHS Trust undertaken in August and September 2021 using the Safer Nursing Care Tool (SNCT) (Shelford 2013) with recommendations to be supported by workforce business plans and covers the period April to September 2021.

The purpose of this report is to share the results of the patient acuity and dependency data collected between 25th May and the 13th June 2021 across the adult inpatient areas to discuss the findings and make recommendations. Divisional Directors of Nursing have reviewed the results and triangulated the findings with professional judgement in reaching conclusions and making recommendations.

The Divisional Director of Nursing for ASCR has also completed a forward facing review of all Critical Care units in the context of changing capacity and Guidelines for the Provision of Intensive Care Services (GPIC's).

The Director of Midwifery has reviewed Midwife to Birth ratios as recommended and found within the

Birthrate Plus® tool and endorsed by the Royal College of Midwives. The ratios are reviewed monthly against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 29.5 births, Midwifery staffing continues to be reviewed alongside development of the continuity of carer model and will be presented in a separate report.

Prior to this safe staffing review as part of service restoration the Trist reconfigured the inpatient wards within the Brunel building to provide dedicated COVID/non-COVID patient pathways and to accommodate the recommencement of the elective care programme. This resulted in 12 inpatient wards changing location and/or the speciality they provide care for. Generally, funded establishments are appropriate to meet requirements across the Trust. With some areas identified for further review as detailed within Divisional reports and further data collection to be repeated in 2021 alongside a review of nurse establishments for all inpatient adult wards following ward and speciality reconfiguration to facilitate service restoration phase of the organisation's pandemic response.

The report informs the Board of the nursing and midwifery risks on the Divisional Risk Registers which are greater than 10.

The report includes the nursing and midwifery pay costs to date of the financial year 2021/22. The report highlights current staffing issues and explains actions taken to mitigate these concerns.

Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Experts in complex urgent & emergency care b. A Centre of Excellence for specialist healthcare **2. Developing Healthcare for the future** a. Training, educating and developing out workforce b. Invest in digital technology **3. Employer of choice** a. A great place to work that is diverse & inclusive b. Support our staff to continuously develop c. Support staff health & wellbeing **4. An anchor in our community** a. Developing in a sustainable way
Board Assurance Framework/Trust Risk Register Links	Risk to CQC registration if standards are not met Non-compliance with National Quality Board and NICE requirements on staffing Registered Nurse vacancies on the Risk Register
Other Standard Reference	NHS Developing Workforce Safeguards (2018) National Quality Board Requirements (Nov 2013, April 2016 and January 2018) NICE Guidelines (2014 and 2015) CQC Regulation 9: Person Centred Care CQC Regulation 12: Safe care and treatment CQC Regulation 18: Staffing CQC Regulation 19: Fit and proper persons employed
Financial implications	

Revenue	**Total £'000**	**Rec £'000**	**Non Rec £'000**
Income	Nil		
Expenditure	Nil		

North Bristol NHS Trust

	Savings/benefits: Nil **Capital**: Nil **Source of funding** : Option / [X] / Please provide additional information Existing budget Cost Pressure External Funding Other Resources and financial implications to be addressed as part of the annual Trust's Business Planning cycle and informed by the Divisional priorities
Other Resource Implications	Effective recruitment of sufficient band 5 Registered Nurses and Health Care Support Workers to fill the vacancy deficit
Legal Implications including Equality, Diversity and Inclusion Assessment	EDS2 Improved patient access and experience and represented and supported workforce
Appendices:	Nil

12.2

Contents **Page**

1. Executive Summary

The purpose of this paper is to provide the Board with a 6 monthly report on Nursing and Midwifery staffing and to provide assurance that the Trust has a clear validated process in place for monitoring and ensuring safe staffing in line with current national recommendations.

This report serves as the six monthly review of safe nursing staffing at North Bristol NHS Trust undertaken in May and June 2021 using the Safer Nursing Care Tool (SNCT) (Shelford 2013)., and was completed following the reconfiguration of 12 inpatient wards as part of service restoration

The purpose of this report is to share the results of the patient acuity and dependency data collected between 25th May and the 13th June 2021 across the adult inpatient areas to discuss the findings and make recommendations. The Divisional Heads of Nursing & the Director of Midwifery have reviewed the results and triangulated the findings with professional judgement in reaching conclusions and making recommendations. Trustwide Care Hours Per Patient Day (CHPPD) for in-patient wards has remained in line with national benchmarks.

The Divisional Director of Nursing for ASCR has also completed a forward facing review of all Critical Care units in the context of changing capacity and Guidelines for the Provision of Intensive Care Services (GPIC's).

The Director of Midwifery has reviewed Midwife to Birth ratios as this is recommended and found within the Birthrate Plus® tool and is also endorsed by the Royal College of Midwives. The ratios are reviewed monthly against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 29.5 births. The Trust commissioned a complete Birthrate Plus® review of staffing in October 2019 which was presented in February 2020 a further Birthrate Plus® review of Midwifery staffing levels has been commissioned by the Director of Nursing & Quality report has been completed and will report to separately. Midwifery staffing continues to be reviewed alongside development of the continuity of carer model.

No national workforce tool can incorporate all factors and therefore triangulation is essential to arrive at optimal staffing levels. The role of professional judgement and local intelligence should not be underestimated and should be applied to increase confidence in recommended staffing levels and provide assurance. Variables in terms of ward layout and number of side rooms have an impact on the number of nurses required but this is not reflected in the SNCT. The SNCT data whilst recommending staffing establishment figure does not replace professional judgment and it is recommended that very few single data collection period should form the basis of altering establishments, due to the seasonal variances that can be seen in acute care settings. In general, the funded establishments are appropriate to meet the requirements across the Trust. Areas where the SNCT data suggested an alternative establishment have been reviewed and no changes have been recommended at the current time. However, an outcome of the 6 monthly an outcome of the 6 monthly staffing review has identified priority areas requiring deeper review over the coming months:

- A further review of nurse establishments in January 2022 for all inpatient adult wards following ward and speciality reconfiguration to facilitate service restoration phase of the organisation's pandemic response.
- A further review of the staffing model for Acute Frailty Admission Unit gate 32A.

Daily safe staffing meetings occur between Divisions which are overseen by a Divisional Director of Nursing, where real time data of actual staffing levels and patient acuity can be viewed and staff redeployed as required. The staffing meetings assess the level of risk, identify areas where increased care hours are required and inform the movement of staff between clinical areas to balance the risk across the organisation.

2. Purpose

The purpose of this report is to share the results of the patient acuity and dependency data collected between 25th May and the 13th June 2021. The establishment review were delayed due to the organisation response to the Coronavirus pandemic and due to the nature of the patient case mix and speciality changes cannot be directly compared to previous years reviews.

3. Background

Following the Francis report, the National Quality Board (NQB) published guidance that set out the expectations for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for patients. The Lord Carter Review (2016) highlighted the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources.

The National Quality Board (NQB) publication *Supporting NHS Providers to Deliver the Right staff, with the Right skills, in the Right place at the Right time: Safe, Sustainable and Productive Staffing (2016)* outlines the expectations and framework within which decisions on safe staffing should be made to support the delivery of safe, effective, caring, responsive and well-led care on a sustainable basis.

In February 2020 the Trust was one off 11 organisations who participated in a Developing Workforce Safeguards review undertaken by NHS England & Improvement to assess compliance against the 14 recommendations for Nursing/ Midwifery, AHP and medical staffing groups.

3.1 Nursing

The Safer Nursing Care Tool (Shelford Group, 2013) is the most commonly used method (previously known as the AUKUH Acuity and Dependency Measurement Tool).

The Safer Nursing Care Tool (SNCT):

- Is an evidence-based tool which allows nurses to assess patient acuity and dependency. The data is collected and matched with pre-set staffing multipliers to ensure that nursing establishments reflect patient needs in acuity / dependency terms. The recommended number of staff following analysis is in whole time equivalent only (i.e. registered and unregistered staff and includes 21% uplift (holiday, sickness, study leave etc.). There is no reference to skill mix, allocation for a supervisory ward co-coordinator (if appropriate) or supervisory ward leader.
- Recommended staffing levels are based on an analysis of the actual patient acuity and dependency on the ward at the time of data collection
- The tool is appropriate for use in any acute hospital.

However, no national workforce tool can incorporate all factors and therefore triangulation is essential to arrive at optimal staffing levels. The role of professional judgement and local intelligence should not be underestimated and should be applied to increase confidence in recommended staffing levels and provide assurance. Variables in terms of ward layout and number of side rooms have an impact on the number of nurses required but this is not reflected in the SNCT. The SNCT data whilst recommending staffing establishment figure does not replace professional judgment and it is recommended that no single data collection period should form the basis of altering establishments, due to the seasonal variances that can be seen in acute care settings.

There are also a minimum number of nurses required to deliver safe care regardless of ward size, 11.5 whole time equivalent (wte) Registered Nurses (RN's) are required to provide 2 nurses 24/7. The SNCT data may indicate that smaller wards are over established however the reality is reductions in staffing levels would be inappropriate. Therefore caution is advised when interpreting results from smaller areas.

The Trust uses the Allocate SafeCare module to capture live acuity and dependency data to support daily deployment of nursing resource. SafeCare uses the SNCT (Shelford Group) Acuity and Dependency Measurement Tool and calculates the staffing requirement for each shift based on

this information. Data is provided as CHPPD and hours and is reviewed by the Senior Nursing Team to ensure that the right staff are in the right place to provide safe care.

SNCT is one of a few validated tools available to review and set nursing establishments as recommended by the Developing Workforce Safeguards (2018). In undertaking the bi-annual review the data has been produced using the SNCT tool to suggest numbers of staff required based on the patient acuity, bed occupancy and nurse sensitive indicators for May/June 2021.

3.2 Midwifery

The Trust regularly monitors and reports it Midwife to Birth ratios as this is recommended and found within the Birthrate Plus® tool and is also endorsed by the Royal College of Midwives. The ratios are reviewed monthly against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 29.5 births. The Trust previously commissioned Birthrate Plus® to undertake a review of midwifery staffing levels and was reported to the Board in February 2020. Midwifery staffing continues to be reviewed alongside development of the continuity of carer model and is detailed within a separate report completed by the Interim Head of Midwifery.

3.3 Neonatal Unit

The service specification from NHS England and the BAPM staffing standards, state that the minimum standards for nurse staffing levels for each category for care are:

- neonatal intensive care: 1:1 nursing for all babies
- neonatal high dependency care: 1:2 nursing for all babies
- neonatal special care: 1:4 nursing for all babies.

4. NQB Expectations: A Triangulated Approach to Staffing Decisions

The NQB three expectations (right staff, right skills, right place and time) support an approach to determining safe staffing levels based on patients' needs, acuity and risks, monitored from 'ward to board'. This triangulation approach to staffing decisions, rather than making judgments based solely on numbers or ratios of staff to patients, is supported by the CQC.

4.1 NQB Expectation One: right staff (Workforce Plans)

The bi-annual review of all divisional ward skill mixes was most recently undertaken in between August and September 2021. This review, led by the Director of Nursing and Quality, was to understand the baseline staffing position across the inpatient wards.

The methodology used for these reviews includes patient acuity, professional judgment, ward quality metrics and the national resource tools available and evidence-based guidance from Royal Colleges including the Royal College of Nursing. The Trust also compares local staffing with metrics available from an appropriate peer group within the Model hospital dashboard, recognising that the specific ward design for the Brunel Wards also needs to be appropriately benchmarked and considered.

4.1.1 Model Hospital Benchmarking

In line with all Trusts, NBT reports CHPPD on a monthly basis. CHPPD is calculated by adding the total monthly hours worked of registered nurses and health care assistants on the rosters (which includes the hours delivered by temporary staff) divided by the total patient bed days (sum of the patient count at midnight accumulated over a month). The scores across the organisation are accumulated to create a Trust score.

The data enclosed in the table below is May 2021 data, the latest data available through the Model Hospital. A more detailed breakdown of this metric per division is included in Expectation three: right place right time. This table below shows NBT in the
Third quartile of CHPPD at 9.4, an increase from October 2020
CHPPD which was 9.1 against a national average of 9.1 and a median of peer organisations of 8.4.

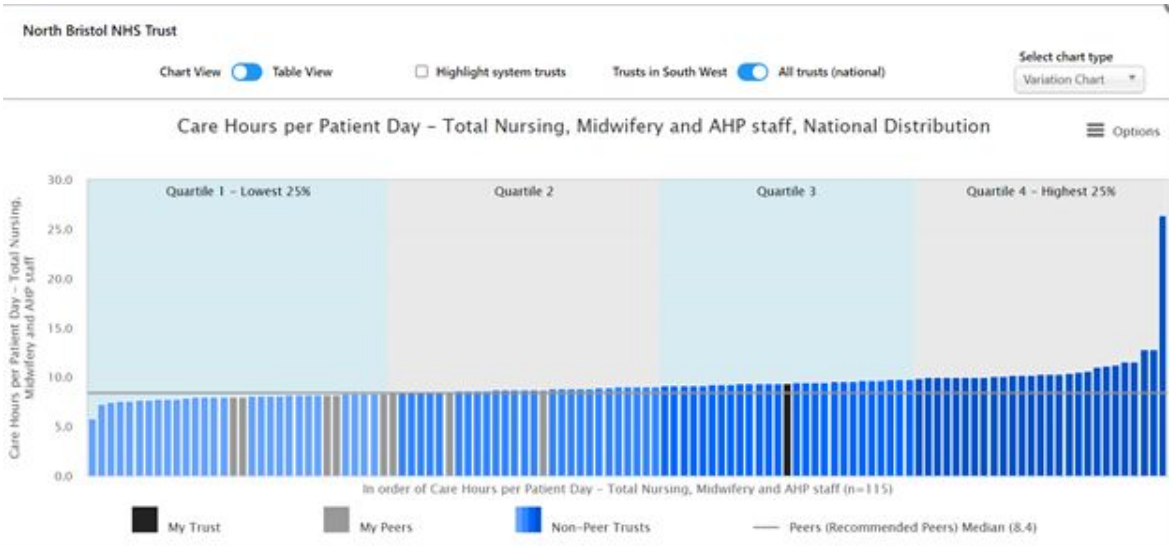


Table 1: CHPPD comparison, nationally (blue), peer (grey) and NBT in (black) May 2021.

The Model Hospital also uses a measure called Weighted Activity Unit (WAU) which shows the Trust spend on Nursing and Midwifery staff, based on ESR data (so excludes temporary staffing costs), compared to the total NHS clinical activity provided by the Trust within the 2019/2020 financial year (last year available). Table 2 shows the NBT position which is above the lowest quartile (lower being more cost efficient) with a WAU of £748 against a peer median of £932 amongst our peer organisations and a national median of £948.

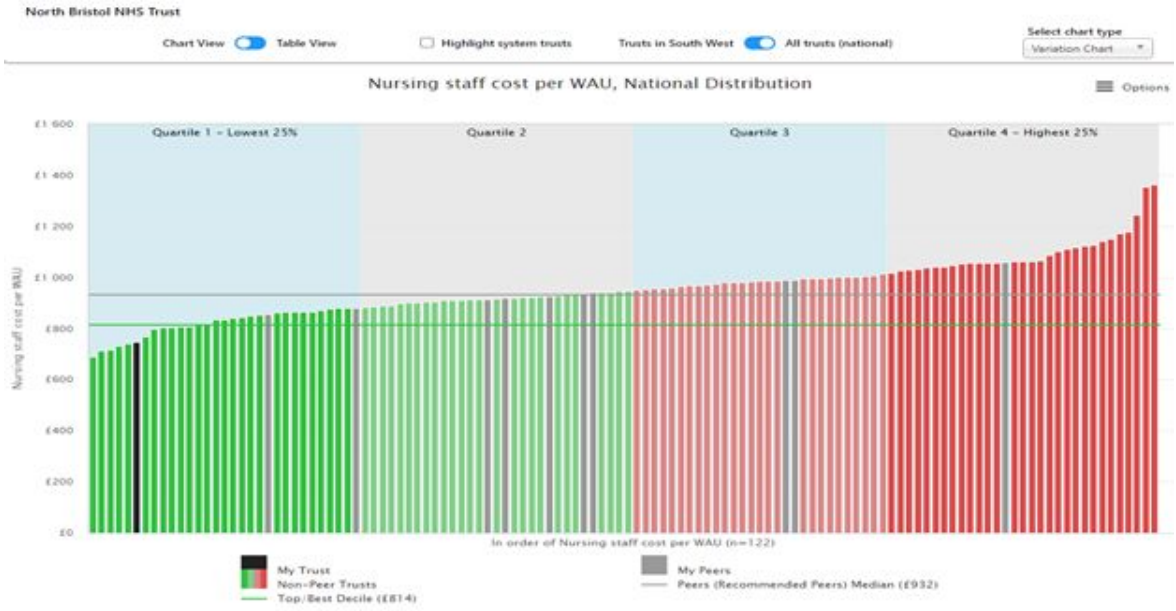


Table 2: WAU based on 2019/2020 financial position, NBT (black), national (green/red), peers (grey).

4.1.2 Winter bed model

During 2020 the organisation changed the way it planned for Winter bed model with the reconfiguration of inpatient wards to accommodate both COVID and non-COVID patient pathways for elective and emergency care. A reconfiguration of inpatient wards took place during April and May in 2020 as part of the organisations COVID service restoration phase to accommodate dedicated green elective care wards and cohorting of COVID/non-COVID patients. In Total 12 wards changed location and/or speciality. Staffing requirements are consistently discussed at the bed and staffing meetings and concerns can be escalated to the Divisional Directors of Nursing along with the Director of Nursing & Quality/Deputy Director of Nursing & Quality.

4.2 NQB Expectation Two: right skills

The Trust is committed to ensuring that clinical staff have the appropriate training and the right competencies to support the patient care within services.

The Trust has demonstrated a commitment to investing in new roles and skill mix reviews which enables registered nurses to spend more time to focus on clinical duties and decisions about planning and implementing nursing care.

The *Shape of Caring* report (2015) recommended changes to education, training and career structures for registered nurses and care staff. In light of this NBT has continued with the development of its workforce in support of this report. Assistant Practitioner roles have been well embedded within NBT and the role is continuing to be developed across the hospital with a number using it as a steppingstone into further education to commence degree level nurse education.

The NHS Improvement Resource recommends taking account of the wider multidisciplinary team who may or may not be part of the core ward establishment including allied health professionals, advanced clinical practitioners, administrative staff and volunteers. It is recognised that the range of specialist and advanced practitioners at NBT provide expert advice, intervention and support to ward based teams, along with the 'link nurse' model which is in place for certain specialties e.g. Tissue viability, Diabetes.

4.3 NQB Expectation Three: right place and time

Each month the Trust submits the ward planned and actual staffing levels including Care Hours per Patient Day (CHPPD) via Unify. The nursing and midwifery fill rates (showing the percentage of filled shifts) and CHPPD for the Trust for the since the last report in March 2020 can be viewed in Table 3.

Values	01/01/2021	01/02/2021	01/03/2021	01/04/2021	01/05/2021	01/06/2021	Grand Total
Sum of RN Day Fill	93.8%	90.1%	92.6%	95.8%	95.1%	93.2%	93.5%
Sum of RN Night Fill	97.6%	95.1%	92.1%	95.9%	96.4%	94.7%	95.3%
Sum of HCA Day Fill	85.3%	89.3%	91.9%	94.6%	92.6%	89.5%	90.5%
Sum of HCA Night Fill	97.0%	97.5%	97.6%	100.9%	101.5%	98.0%	98.8%
CHPPD	9.6	9.9	9.9	9.7	9.6	9.2	9.6

Table 3: Fill Rates and CHPPD June 2021

When there is a shortfall of registered nurses, on occasions unregistered staff are being utilised to ensure safe staffing. In addition the greater than 100% fill rates in Health Care Assistants (HCA) numbers are due to additional HCAs utilised to provide enhanced care. April 2020 saw

an increase in CHPPD related to reduced occupancy as part of the organisation's response to the pandemic and reduction in elective and planned care.

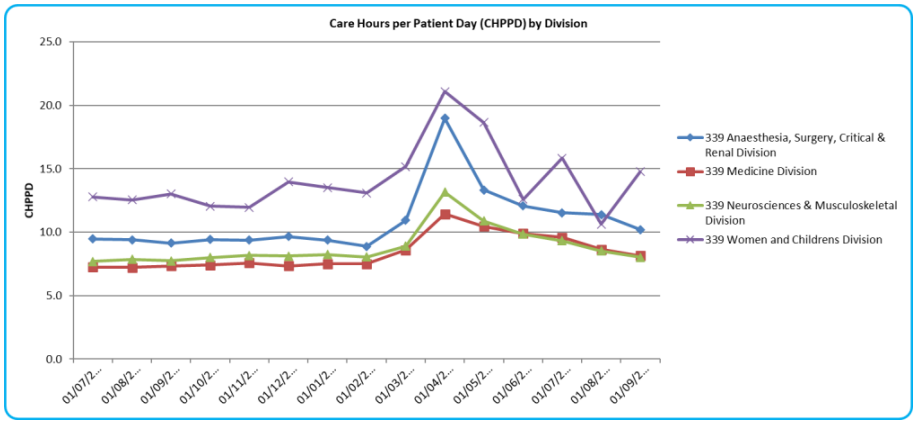


Table 4: Details the breakdown of the Model Hospital CHPPD metric by Division June 2021

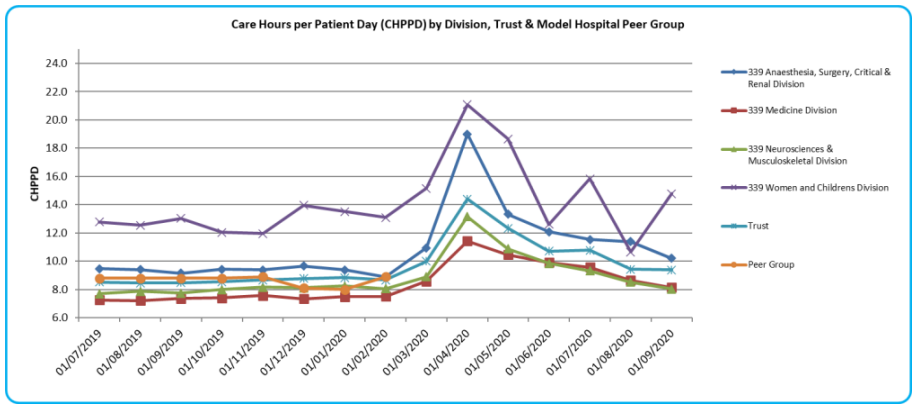


Table 5: Details the breakdown of the Model Hospital CHPPD metric Trust wide against peer group June 2021

This demonstrates that the care hours for medicine, ASCR, Medicine and NMSK have remained in line with national benchmarks with the biggest fluctuation being in Women & Children. Work to understand this fluctuation is ongoing but initially appears to be related to Cotswold Ward where women receive care and midnight census periods and do not reflect activity within the day and staffing in the midwifery led birth services as staff are rostered and available 24/7 but there may not be a woman in the unit at the midnight census. The ongoing work is to understand how other midwifery led units utilise this metric and why we appear to be an outlier.

4.3.1 Managing safe staffing every day

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

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

The triangulated approach uses three reference points:

- The Safe Care live Acuity tool which is available on Health Roster, to ensure that there is an appropriate system and process in place for the safe deployment of staff and to manage the organisational staffing resources on a day to day basis. This works on a RAG rating basis and identifies when there is a cause for concern (red). Safe Care works by taking the planned hours from the rota including any extra shifts filled and balances this against the Acuity and Dependency and results in a rating based on the utilisation of these 2 figures. This ranges from dark green where the acuity and dependency matches the hours available on the roster, to light green, amber and then red, which identifies a significant deficit in required care hours and places the area as high risk.

- Actual numbers of staff on a shift with a RAG rating identifying the agreed funded staffing levels (green) and the number of staff when there is a cause for concern (red) (see example below)

ASCR	RN	B4	HCA		RN	B4	HCA		RN	B4	HCA
8b											
Day	6	1	3		5	1	3		4	0	3
Night	5	1	2		5	0	2		4	0	2
32b SAU											
Day	6	1	3		5	1	3		4	1	2
Night	5	0	3		4	0	3		3	0	3

Table 6: An example of the skill mix numbers in the Safe Staffing Standard Operating Procedure showing funded numbers (Green) and numbers where there is a cause for concern and action may be required

- Professional judgement which is a discussion between the Nurse in Charge and Matron about the outcome of the Safe Care assessment and actual numbers of staff on a shift. There may be times when both metrics are red but care can be delivered safely to the patients and the other end of the spectrum where both metrics could be amber but not adequate to meet the safe care needs of the patients.

5. Governance

5.1 Multi-Professional Workforce Group

The Multi-Professional Workforce Group (MPWG) replaced the Nursing and Midwifery Workforce Group in January 2020 to provide robust monthly governance around safe staffing for Nursing, Midwifery and Allied health Professional staffing with actions being taken to address this including the introduction of new roles, workforce planning and recruitment and retention oversight for the professional groups included, band 2 – 4 competencies and skill matrix, and divisional staffing reports including workforce risks , E-Rostering metrics and opportunities for improvement.

5.2 New roles

The Director of Nursing and Quality has initiated a pre and post registration workforce group to provide ongoing governance to support the education and development of nursing, midwifery and AHP roles and oversee the development and design of new roles. This committee will report into Nursing, Midwifery & AHP workforce group and to upwards to the People and Digital Committee. There have been no new roles introduced since the last report in April 2020.

5.3 Demand & Supply Group

The Demand & Supply Group, this is attended by senior staff from Nursing, Midwifery and Allied Health Professional and People & Transformation team and is chaired by the Deputy Director of Nursing & Quality. The group was established to provide the MPWG (Multi-Professional Workforce Group) chaired by the Director of Nursing with assurance that there are robust and integrated mechanisms in place to ensure detailed consideration and oversight of the Trust's

Nursing, Midwifery & AHP workforce improvement plans and monitor and design recruitment and retention plans. This group was stood down during the pandemic response, but work has continued to be undertaken increasing both Registered and Unregistered nurse recruitment and utilising additional funding provided by NHS England as part of the 50K Nurses project.

5.4 Advanced Practice Steering Group
The steering group has been established to provide the MPWG (Multi-Professional Workforce Group) with ongoing planning updates regarding the development of Advanced practitioner Roles within NBT. The group oversees role development in line with Workforce planning demands for Nursing, Midwifery & AHP professions. The group also monitors nursing/midwifery/AHP service development plans for the future workforce, provides governance processes to support new roles such as Advanced Care Practitioners. Due to the previous chair having left their role the group has not formally since xx/xx, the chair of this group is being confirmed, while the subgroups have continued working on projects the wider group has been paused and is expected to reconvene in December 2021,

6. New Opportunities

6.1 Ward based therapists
A programme to include Occupational Therapists and Physiotherapists to supplement the band 5 ward nursing workforce is in development the Medicine Division in the Elgar re-enablement unit and the respiratory unit. A Quality Impact Assessment was completed for the programme and was approved by the Director of Nursing & Quality in April 2019.

6.2 ACP roles
Following NHSI support, a programme to implement the Advanced Care Practitioner (ACP) role into the Emergency Department is in progress. This brings a blended approach to senior clinical decision makers into Urgent and Emergency care to support vacancies in the medical rotas. These practitioners can be a either nurses and therapists educated to Masters Level and undertaking an approved Royal College of Emergency Medicine competency programme supervised by consultants in ED. Whilst this programme is in its infancy and will not release qualified practitioners for a number of years, it has been shown to have a positive impact on locum doctor spend and continuity of care in other Trusts in the country. The apprenticeship commenced at UWE in May 2019. In line with the Workforce Safeguards, the Divisional Director of Nursing for Medicine with the support of the People Partner has completed a Quality Impact Assessments for the development of the this new role which was discussed and ratified at the April Nursing & Midwifery Workforce Group by the Director of Nursing and Quality. The introduction of new and additional ACP roles is now overseen by the Multi-Professional Workforce Group.

6.3 Nursing Associates
In April 2017 the Trust as part of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan along with Bath became a pilot site for Trainee Nursing Associates. A QIA was completed and presented to the April 2019 Nursing & Midwifery Workforce group and a skills matrix developed to support their clinical practice. The Trust medicine management policy has been updated by the Deputy Director of Nursing and the Deputy Director of Pharmacy to ensure support registered NA's with administration of medications in accordance with their NMC registration and scope of practice. The first Nursing Associates completed their programme in April 2019 and the organisation now has 32 Registered Nurse Associates working within our clinical teams and 69 who are in training programmes, there is an ongoing commitment to support a minimum of 40 trainees per year.

There are considerable opportunities and benefits in deploying Nurse Associates within the nursing workforce and their implementation requires a structured systematic approach to planning, implementing and monitoring while deploying the role to ensure quality and safety for

patients and service users, and to provide the necessary assurance to the board, commissioners and regulators.

The NQB safe and sustainable and productive staffing guidance: *An improvement resource for the deployment of nursing associates in secondary care (2018)* recommends that as part of the governance process in implementing this new role into our skill mix, we assess the potential impact on quality through the completion of a Quality Impact Assessment (QIA). QIAs focus on systematically assessing and recording the likely impact on quality and safety of the implementation of this new role specifically, the impact on patients, service users and staff. This will involve anticipating, monitoring and measuring the consequences of activities and making sure that, as far as possible, any negative consequences are eliminated or mitigated, and any positive impacts are identified and maximised.

The organisation worked in collaboration with the University of Gloucester to develop an Assistant Practitioner to Nurse Associate conversion course supported financially by Health Education England, our first cohort of practitioners commenced in March 2020, although their programme was delayed during the initial pandemic response the programme is now nearing completion.

6.4 RN Degree Apprenticeship

As part of the Nursing & Midwifery programme of widening participation the organisation has successfully secured funding with the support of the Hospital Charity for a pilot to support 10 of our existing band 4 Nurse Associates / Assistant Practitioners to undertake a 2 year RN degree apprenticeship programme. The recruitment to these roles is being undertaken and the programme is due to commend late 2021.

7. Vacancies and turnover

Vacancies remain the biggest risk to the delivery of the 2021/22 service restoration programme for the organisation. The organisational vacancies are demonstrated in table 6 below broken down by Registered and Unregistered nurses and by division. The overall vacancies in Nursing & Midwifery have increased by 43 despite the previous improvements noted in since 2019. With a deterioration in retention with turnover rates noted from 14.2% in March 2020, 12.7% in September 2020 and 13.1% in June 2021 and with an overall vacancy rate of 7.4% which has deteriorated from 6.2% in March 2021.

New workforce models will continue to be explored to meet this gap and reflect the national profile of Registered Nurse vacancies. The rolling 12month turnover for the Trust is included at table 7 also broken down to reflect the divisional picture and shows a deteriorated position with turnover increasing from 12.7% to 13.1% in the period since September 2020 in registered and unregistered nursing. The impact of the Nursing and Midwifery retention programme whilst has been seen to have shown improvements in earlier years a review has been commissioned by the Deputy Director of Nursing & Quality through the Demand and Supply group and will report through the Multi-Professional Workforce Group.

Staff Group	Division	Vacancy WTE	Vacancy Factor %
Nursing and Midwifery Registered	339 Anaesthesia, Surgery, Critical & Renal Division	45.1	5.4%
	339 Core Clinical Services Division	5.5	11.2%
	339 Medicine Division	63.2	9.7%
	339 Neurosciences & Musculoskeletal Division	35.6	12.8%
	339 Women and Childrens Division	0.9	0.2%
Nursing and Midwifery Registered Total		**150.3**	**6.9%**
Unregistered Nursing and Midwifery	339 Anaesthesia, Surgery, Critical & Renal Division	10.1	3.5%
	339 Core Clinical Services Division	16.7	21.6%
	339 Medicine Division	24.7	6.1%
	339 Neurosciences & Musculoskeletal Division	37.9	17.3%
	339 Women and Childrens Division	2.7	2.2%
Unregistered Nursing and Midwifery Total		**92.0**	**8.3%**
Grand Total		**242.3**	**7.4%**

Table 7: The table above shows the Registered and Unregistered Vacancies in the Trust at the end of June 2021 expressed as WTE and as a percentage of the total workforce and by division

Staff Group	Division	Leavers WTE	R12M Turnover %
Additional Clinical Services	339 Anaesthesia Surgery Critical & Renal Division	29.3	11.4%
	339 Core Clinical Services Division	2.6	5.9%
	339 Medicine Division	38.8	10.5%
	339 Neurosciences & Musculoskeletal Division	32.2	19.1%
	339 Women and Childrens Division	10.5	8.5%
Additional Clinical Services Total		**113.5**	**11.7%**
Nursing and Midwifery Registered	339 Anaesthesia Surgery Critical & Renal Division	90.3	13.9%
	339 Core Clinical Services Division	4.0	19.5%
	339 Medicine Division	95.0	15.4%
	339 Neurosciences & Musculoskeletal Division	27.6	10.7%
	339 Women and Childrens Division	48.5	12.7%
Nursing and Midwifery Registered Total		**265.4**	**13.7%**
Grand Total		**378.9**	**13.1%**

Table 8: June 2021 leavers in the last 12 months and the rolling turnover broken down by Registered and Unregistered nurses and by division.

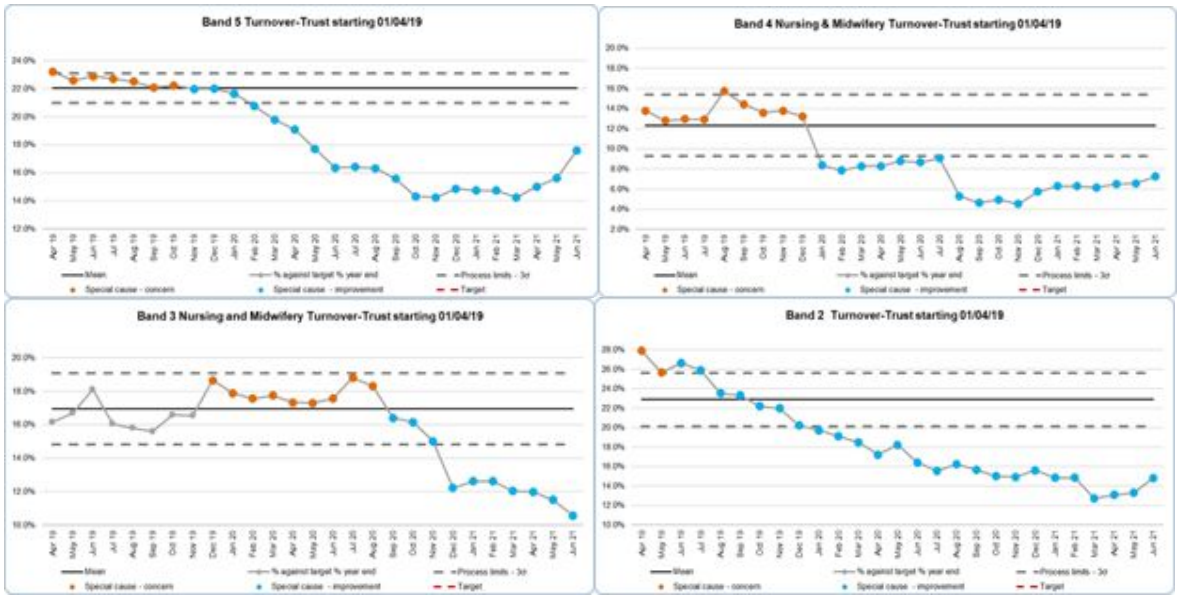


Table 9: Turnover reduction since in Bands 2 to 5 workforce groups June 2021

8. Recruitment and Retention

Over the past 6 months there has been a continued focus in the activity of both Registered and Unregistered Nurse recruitment including:

- Open days for Registered Nurses, continue to be successful and form a significant role in the Trust domestic recruitment programme. To continue our recruitment during the pandemic these events are now held virtually but continue to be well attended.
- Specialist Divisional national recruitment programmes are managed by the Trust Resourcing Team in collaboration with the Divisional Heads of Nursing and People Partners.
- International Recruitment programme is well established, and we continue to support our internationally educated nurses continue to have a 100% success rate with obtaining NMC registration through OSCE support programme. In total since the recommencement

of the internal recruitment programme in 2019 we have supported 158 internally educated nurses to register with the NMC and join our NBT nursing workforce. The projection for 2021/22 with the support of NHS England 50k project is to support the employment of a further 110 Internationally educated nurses.

Each Division has a detailed understanding of their vacancies and they track both recruitment and turnover closely to ensure that they are proactively recruiting and positively impacting on the retention of existing staff. With additional recruitment resource is in place in ASCR and Medicine given the ongoing use of agency staff in Theatres, Medirooms and Intensive Care to support the filling of vacancies and retention of staff. There is a Trust Wide Nursing Demand & Supply Steering Group in place with agreed actions and a number of ongoing projects in place supported by senior nurses, People Partners, Trust Workforce Planning Lead and the and Temporary Staffing Bureau managers, which reports to the Multi-Professional Workforce Group.

9. Adult inpatient wards benchmarking data

The general adult ward nursing staffing levels and skill mixes are reviewed annually for budget setting, providing assurance of the review completed between September and October 2020.

Recommended benchmarks

The national recommended benchmarks that have been used to support reviews of nurse staffing levels on inpatient wards are:

- NICE: Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommends that the Registered Nurse (RN) to patient ratio should not be greater than 8 patients per RN during the day shift

These national guides do not consider the development of the new band 4 Nurse Associate role. As described in the Workforce Safeguards, any implementation of new roles requires a detailed Quality Impact Assessment to determine the impact on patient safety and the delivery of high quality of care. From a regulatory perspective, the CQC stated their position in a briefing for providers in January 2019. Their perspective is that nursing associates are not registered nurses and they expect health and care providers to consider this when deploying them into their workforces. As with the introduction of any other new role, they will not be prescriptive about how we as a Trust deploy nursing associates, but they will require assurance that using them is safe and supports the delivery of high-quality care. More recently NHS Improvement have requested Nurse Associates are reported as an individual group in the Unify submission, we are working with our e-rostering system provider to identify this newly developed staff group from our RN and HCA workforce in our national reporting.

10. Ratio of Registered Nurses to patients

The budgeted ratio of one RN to eight patients during a day shift has been reviewed against funded staffing establishments in the 2021/22 budgets. NICE guidance for RN to patients is only recommended for the day shift where activity is increased, as opposed to the night shift. All inpatient ward establishments at NBT meet this RN to patient ratio on days. At night, all wards are funded to support 1RN to 10 patients Elgar 1 and 2 which are outside of this metric. These wards have increased healthcare assistant support at night in comparison to the other wards to ensure the delivery of safe care. The Divisional Director of Nursing and Matron have critically reviewed these wards and approved the staffing levels as being appropriate in Elgar 1 and 2, particularly as patients are medically fit for discharge and that the patient acuity, dependency support the agreed skill mix.

At present, the band 4 Assistant Practitioner roles in the ward establishments have been included in the unregistered HCA lines. However, as the band 4 Registered Nursing Associate role is implemented more widely into the organisation, consideration will have to be given to how these are integrated and reported in the workforce numbers. CQC's Regulation 18: Staffing, requires us to deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that we can meet people's care and treatment needs, and meet the other regulatory

requirements. This applies to nursing associates in the same way as employing other registered healthcare professionals.

11. SNCT Data 2021

Overall the Trust nursing establishments have been reviewed using the Safer Nursing Care Tool (SNCT) (Shelford, 2013) and the findings have been triangulated with existing establishment data, nurse sensitive indicators and professional judgement of the Divisional Director of Nursing/Midwifery within the staffing reviews. The Trust wide overall nurse staffing levels when compared against the SNCT data can be seen below in Table 10.

	Based on SNCT Data			Based on Funded Establishment in March excluding Headroom		
New Division	Required Registered	Required Unregistered	Required Total.	Establishment Registered	Establishment Unregistered	Establishment Total
339 Anaesthesia, Surgery, Critical & Renal Division	133.7	92.3	226.0	112.0	78.0	190.0
339 Medicine Division	344.4	320.6	665.0	311.2	282.3	593.5
339 Neurosciences & Musculoskeletal Division	165.5	175.3	340.8	161.5	170.9	332.3
339 Women and Childrens Division	7.4	5.5	12.9	13.7	10.2	23.9
Grand Total	**650.9**	**593.8**	**1244.7**	**598.3**	**541.5**	**1139.8**

Table 10: Trust wide SNCT establishment setting data June 2021

During June 2021 all inpatient wards were open and occupancy had returned to usual levels compared to March and September 2020 census period. Generally funded establishments are appropriate to meet requirements across the Trust. Noteworthy is the continued increase in level 1b acuity patients, this will form part of wider review of validation during the January 2022 SNCT data collection.

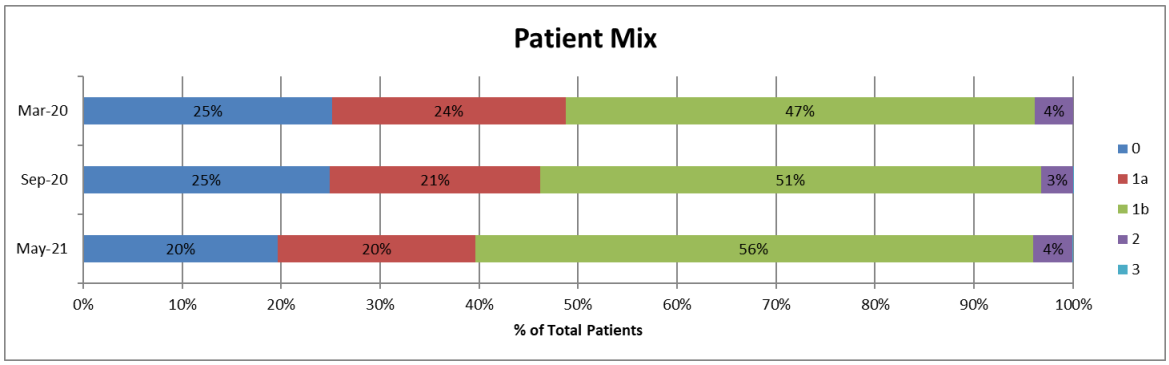


Table 11: Trust wide SNCT patient acuity data June 2021

12. Divisional safe staffing reports

Due to the large-scale changes that have taken place with the reconfiguration of the inpatient wards and speciality beds it is not possible to directly compare the below acuity detail against previous data collections periods. Within the Trust 12 wards changed their location and speciality to support the organisations response to the pandemic and to provide care for an increasing number of patients affected by COVID.

ASCR

ASCR funded establishments are generally appropriate to meet requirements across the Division.

		Based on SNCT Data			Based on Funded Establishment in March excluding Headroom		
Specialty	New Cost Centre	Required Registered	Required Unregistered	Required Total.	Registered Establishment	Unregistered Establishment	Total Establishment
General Surgery Services	339 14104 Ward 32B	28.6	22.0	50.7	26.6	20.4	47.0
	339 14222 Ward 26A Surgery	23.2	22.4	45.6	20.1	19.4	39.6
General Surgery Services Total		**51.9**	**44.4**	**96.3**	**46.7**	**39.9**	**86.6**
Renal Wards	339 14411 Ward 8B (Renal - 38 Bed)	25.3	17.7	43.0	21.6	15.1	36.7
Renal Wards Total		**25.3**	**17.7**	**43.0**	**21.6**	**15.1**	**36.7**
Surgical Wards	339 14221 Ward 33A Surgical	26.5	9.9	36.4	21.3	8.0	29.3
	339 14324 Ward 33B Urology	30.0	20.4	50.4	22.3	15.1	37.4
Surgical Wards Total		**56.5**	**30.3**	**86.8**	**43.6**	**23.1**	**66.7**
Grand Total		**133.7**	**92.3**	**226.0**	**112.0**	**78.0**	**190.0**

Table 12: ASCR SNCT data June 2021

The Divisional Director of Nursing for ASCR has completed a forward facing review of Critical Care units in the context of changing capacity and Guidelines for the Provision of Intensive Care Services (GPIC's) and no changes are required at this time. With the unit staffing complying with 1:1 nursing for ITU level care and 1:2 nursing for HDU level care.

Divisional Staffing Risks

There are no risks related to nursing workforce within the ASCR Divisional risk register rated above 10.

The Division has particular challenges related to vacancies in Registered Nurses in Critical Care, Medirooms and Anaesthetic Nursing, an enhanced resourcing plan is being delivered by the division's recruitment and retention lead supported by the Trust resourcing team.

Medicine

Medicine funded establishments are generally appropriate to meet requirements across the Division with the division undertaking a review of both Elgar and 32a to understand the model of care going forward for both wards.

		Based on SNCT Data			Based on Funded Establishment in March excluding Headroom		
Specialty	New Cost Centre	Required Registered	Required Unregistered	Required Total.	Establishment Registered	Establishment Unregistered	Establishment Total
Cluster 1 - Specialist Medicine	339 14031 Acute Medical Unit Gate 31A&B	67.8	29.8	97.6	67.5	29.7	97.2
Cluster 1 - Specialist Medicine Total		**67.8**	**29.8**	**97.6**	**67.5**	**29.7**	**97.2**
Medicine Cluster 3	339 14410 Ward 8A (Flex Capacity)	22.5	17.7	40.2	24.5	19.3	43.8
Medicine Cluster 3 Total		**22.5**	**17.7**	**40.2**	**24.5**	**19.3**	**43.8**
Medicine Cluster 2	339 14103 Ward 32A	31.2	35.9	67.1	24.3	27.9	52.2
	339 14501 Ward 9B Flex Capacity	22.2	28.4	50.7	20.1	25.8	45.9
	339 14502 Ward 28B (Complex)	22.6	28.9	51.5	20.1	25.8	45.9
	339 14503 Ward 9A	22.3	28.5	50.8	20.1	25.8	45.9
	339 17003 EEU	41.7	62.2	103.9	31.7	47.2	78.9
Medicine Cluster 2 Total		**140.0**	**183.9**	**323.9**	**116.4**	**152.4**	**268.8**
Medicine Cluster 4	339 14402 Ward 27A	30.9	18.9	49.8	26.0	15.9	41.8
	339 14403 Ward 28A Respiratory	30.5	22.5	53.1	28.9	21.3	50.1
	339 14520 Ward 27B	31.0	22.6	53.6	27.8	20.2	47.9
Medicine Cluster 4 Total		**92.5**	**63.9**	**156.4**	**82.6**	**57.3**	**139.9**
Medicine Cluster 1	339 14325 Ward 26B	21.6	25.3	46.9	20.1	23.6	43.8
Medicine Cluster 1 Total		**21.6**	**25.3**	**46.9**	**20.1**	**23.6**	**43.8**
Grand Total		**344.4**	**320.6**	**665.0**	**311.2**	**282.3**	**593.5**

Table 13: SNCT Data Medicine In-Patient Wards June 2021

Further work is required regarding funding requirements for the change of use of the Gate 32a as a Frailty Admissions Unit deescalating pressures on AMU and the Emergency Zone, this will be reviewed as part of the Divisional annual business planning.

Divisional staffing risks

Division	ID	What is the risk?	Rating (current)
Medicine	770	If a high number of substantive / bank staff are unable to attend work due to confirmed Coronavirus or self-isolating (as per PHE guidelines), we will be unable to provide high quality care due to decreased workforce.	12

Table 14: Medicine highest staffing risk related to COVID and all staff groups regarding potential staff absence.

NMSK

The acuity and dependency of NMSK patients varies significantly due to the emergency nature of the specialities and the requirement for enhanced observation in patents. To support this variation there is an element of funding for temporary staffing within the funded establishment which enables care hours to be increased in response to patient need.

However, NMSK division have reviewed the provision of enhanced care and due to the consistent requirement and these roles have now been included in ward the establishment, this conversion of temporary bank roles has resulted in an increase in substantive whole time equivalent roles.

At a divisional level funded care hours are generally sufficient to maintain safe care, but these are monitored on a ward basis to identify changes in dependency trends.

	Based on SNCT Data			Based on Funded Establishment in March excluding Headroom		
ew Cost Centre	Required Registered	Required Unregistered	Required Total	Establishment Registered	Establishment Unregistered	Establishment Total
39 14211 Ward 7A	20.7	20.1	40.8	30.9	30.0	60.9
39 14241 Ward 6B	28.4	23.0	51.4	26.6	21.5	48.0
	49.1	43.1	92.2	57.5	51.5	109.0
39 14242 Ward 25B	25.3	27.2	52.6	20.1	21.6	41.8
39 14311 Ward 7B	20.4	19.4	39.7	17.0	16.1	33.1
39 14312 Ward 25A	25.5	27.2	52.7	20.1	21.5	41.6
	71.2	73.8	145.0	57.3	59.1	116.5
39 14302 Ward 34B	23.7	28.7	52.3	26.6	32.2	58.8
39 14303 Ward 34A	21.5	29.8	51.3	20.1	27.9	48.0
	45.2	58.5	103.6	46.7	60.1	106.8
	165.5	175.3	340.8	161.5	170.9	332.3

Table 15: SNCT Data NMSK In-Patient Wards June 2021

There are no risks related to nursing workforce within the NMSK Divisional risk register rated above 10.

Women's and Children's Division

Cotswold Ward

Cotswold Ward has a total of 28 beds. However currently it is funded and staffed to provide care for 15 Gynaecology patients and 4 beds allocated to surgical specialities. The bed modelling supported by the divisional team and executive team was taken to admit suitable surgical patients from ASCR at times of Trust escalation and 4 beds were allocated for this. Cotswold Ward also has a 10 bed 'Day Case' unit, with the majority of gynaecology procedures being performed as a Day Case or in Outpatients, this area is currently being used to support maternity services.

The ward is staffed according to the acuity / enhanced care needs of the patient, and increases its staffing numbers accordingly, an example being a patient with medical termination of pregnancy requiring 1:1 nursing care. Generally, funded establishments are appropriate to meet requirements across the ward.

		Based on SNCT Data			Based on Funded Establishment in March excluding Headroom		
Specialty	Cost Centre	Required Registered	Required Unregistered	Required Total.	Establishment Registered	Establishment Unregistered	Establishment Total
Gynae Services	339 01269 Cotswold Ward	7.4	5.5	12.9	13.7	10.2	23.9
Gynae Services Total		**7.4**	**5.5**	**12.9**	**13.7**	**10.2**	**23.9**
Grand Total		**7.4**	**5.5**	**12.9**	**13.7**	**10.2**	**23.9**

Table 18: SNCT Data Cotswold In-Patient Ward

Neonatal Intensive Care Unit (NICU)
An ongoing concern was staff vacancies in NICU and following successful recruitment programmes just 44% of all staff are Qualified in Specialty (QIS) trained with the British Association of Perinatal Medicine (BAPM) standard being 70%. The 9 month programme usually commences after 1 – 2 years in post, taking 3 – 5 years to reach QIS level and up to 5 years to achieve the competencies and confidence of a neonatal nurse in ITU. The remaining 2 cots opened as planned in 2021 returning the unit to full occupancy of 34 cots.

The Division have been in discussion with the specialist commissioners at NHSE to resolve the additional investment in nursing capacity required for NICU to re-open the 4 closed cots. This has resulted in the successful re-opening of 2 cots with the remaining 2 cots scheduled to open in 2021. This has been delayed due to the pandemic and adhering to space requirements during service restoration. The Division has been working collaboratively to review local NICU service review with University Hospitals Bristol & Weston NHS Foundation Trust and further updates will follow in future reports.

Nurse staffing is monitored and managed closely by the Divisional Management team. Three times daily an SBAR is completed which help inform decisions about the staffing requirements in line with acuity of babies. There is an escalation process in place for staff to be used from other areas and the supervisory ward sister and matron provide additional support. Gaps are covered by bank and agency when required.

The service specification from NHS England and the BAPM staffing standards, state that the minimum standards for nurse staffing levels for each category for care are:

- neonatal intensive care: 1:1 nursing for all babies
- neonatal high dependency care: 2:1 nursing for all babies
- neonatal special care: 4:1 nursing for all babies.

There are no risks related to nursing workforce within the W&C Divisional risk register rated above 10.

Midwifery
Many influences on safe staffing in maternity services affect the number of specialists required to keep staffing safe and sustainable. Examples are population mix, social care needs, health inequalities, specific health needs, health complexities, safeguarding children and vulnerable adults services, and a fluctuating birth rate. Increasing complexities in health have led to an increase in obstetric, anaesthetic and neonatal interventions driven by concerns for patient safety. Maternity settings face many workforce challenges because pregnant women with co-morbidities and complexities require more specialist input from obstetric, anaesthetic, neonatal and midwifery professionals.

Midwife to Birth ratio
The Trust regularly monitors and reports its staffing of Midwife to Birth ratios as this is recommended and found within the Birthrate Plus® tool and is also endorsed by the Royal College of Midwives. The ratios are reviewed monthly against the recommended mean national ratio of one whole time equivalent (WTE) midwife per 29.5 births and these benchmarks are reported to Board on the monthly IPR. A review of the Maternity unit staffing was undertaken by BirthRate Plus ® in October 2019 and a f review of midwifery safe staffing presentation to People committee in October 2021.

13. Trust Wide Nursing and Midwifery staffing
A detailed breakdown of the WTE and finance against the funded position for the whole nursing and midwifery workforce is enclosed below. It is broken down by funded (Black), substantive (Blue), bank (orange) and agency (Grey).

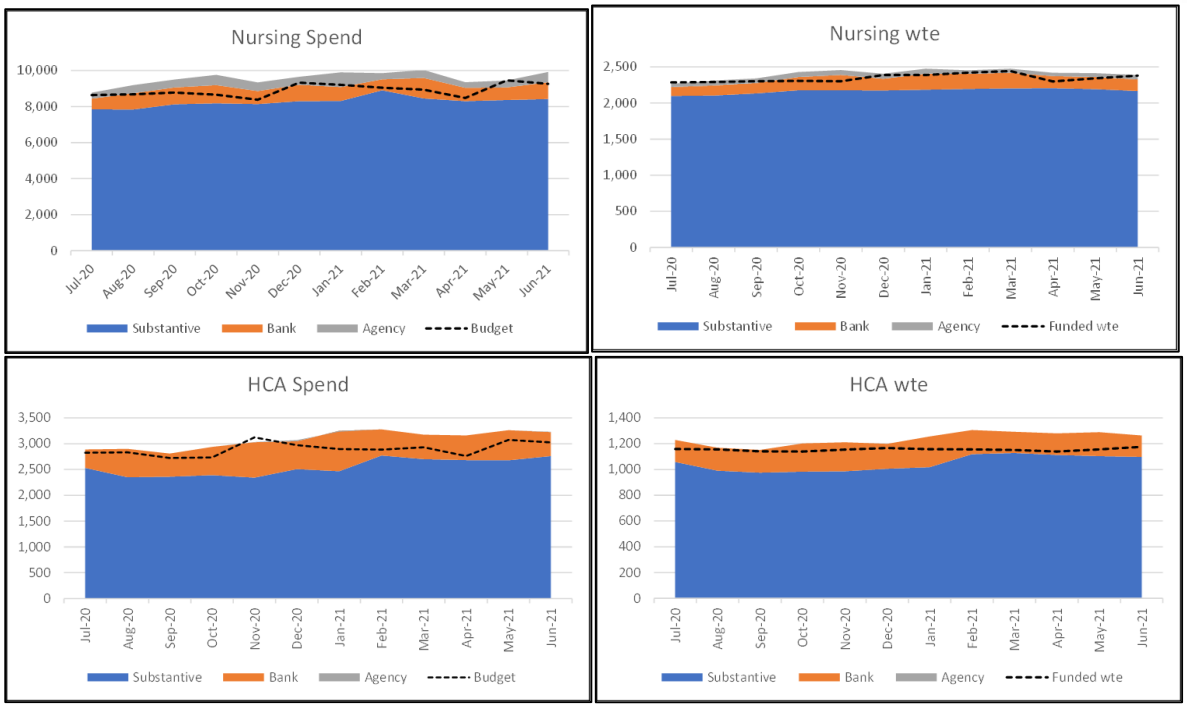


Table 19: Trust wide profile of worked WTE and spend compared to funded establishments

The overall Trust position shows the impact of the vacancies on temporary staffing use. Whilst the WTE worked more for both registered and unregistered is more closely aligned to that of the funded position as a result of the controls in place, the impact of the cost of agency to fill the vacancies remains a significant concern.

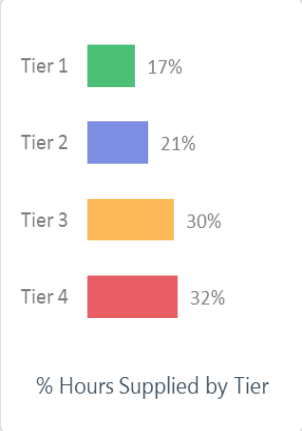
14. Temporary Staffing
Bank usage
The recruitment of both registered and non-registered nurses to the temporary staffing bank continues and staff are supported by the Clinical Lead to ensure new starters and existing staff are supported with revalidation and maintaining of high professional standards. The bank remains unable at present to meet the demands due to the number of vacancies across the organisation. Table 19.

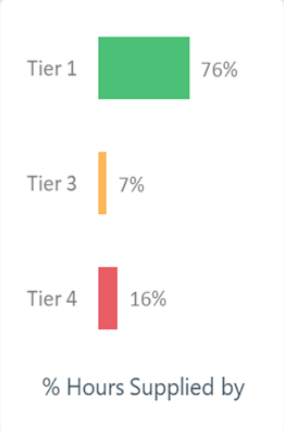
Agency usage
Table 19 above details the WTE volumes of agency nursing.

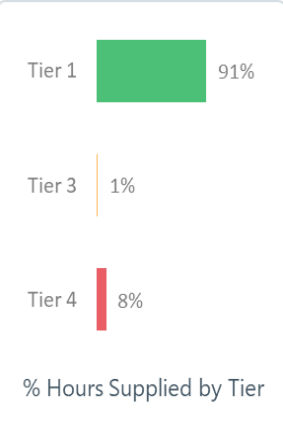
NBT has clear plans in place and is working towards an ongoing reduction in the use of agency nursing staff in line with the NHS Improvement agency rules. Tier 4 agency nurse approval is via the Director of Nursing & Quality and Deputy Director of Nursing & Quality or on call Executive out of hours.

In November 2017 across BNSSG the use of a neutral vendor was implemented in order to further reduce agency spend through improved pay rates below the NHSI cap, with framework agencies. The current arrangements were reviewed by Directors of Nursing across BNSSG and in September 2019 a change to the way agencies were commissioned and engaged by GRI was undertaken by the Directors of Nursing across BNSSG and Bath, the removal of Tier 2 with a revised tariff and merger of Tiers 1 and 2 and increased controls put in operation within each organisation for the use of Tier 3 and Tier 4 agencies.

The Safe Staffing SOP supports the consistent decision making required for managing non-framework agency usage. Over the last 6 months we have seen an increase in the fill rates for agency nursing shifts from Tier 1 agencies, with 89% of our current fill in June 2021 at Tier 1 compared to 17% in April 2019 within cap, 10% of our supply continues to be from Tier 4 agencies which are non-framework as can be seen in Tables 21, 22, 23 & 24.







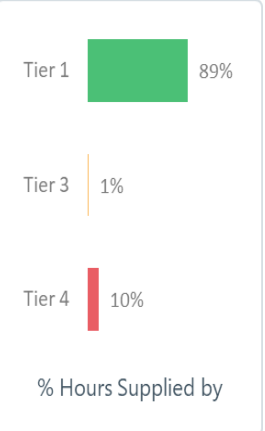


Table 21	**Table 22**	**Table 23**	**Table 24**
April 2019	March 2020	September 2020	June 2021

15. Patient quality measures

Current analysis of patient feedback is via complaints, concerns, letters of appreciation and friends and family feedback. Staff are encouraged to report unsafe staffing incidents via electronic reporting which are reviewed at the Nursing and midwifery Workforce Group, the use of the 'happy app' in certain areas and via the 'Freedom to Speak up Guardians'. A new quality dashboard is in development, a first draft was completed as part of Clinical Governance Improvement Programme in April 2019 and triangulates nurse sensitive quality metrics including patient feedback with workforce data to triangulate the patient experience and outcomes with nurse staffing to ensure delivery of quality patient care and experience. Further development of the dashboard is scheduled for 2021 as part of the continued improvement programme led by the Director of Nursing and Quality.

16. Effect of the Pandemic

Between June and August 2021, the organisation has noted an increase in absence due to sickness amongst both registered and unregistered nursing workforce. This has been noted alongside an increasing in turnover and an increased demand for temporary staffing. In the completion of this report it has been acknowledged that the Divisional risk registers do not reflect the current risks related to nurse staffing the Director of Nursing and Quality has commissioned a deep dive into the issue. The Deputy Director of Nursing and Quality is working closely with the Divisional Directors of Nursing to complete the review which will report to the Multi-professional workforce group and to the People Committee in the upward report.

17. Conclusion

This paper has reviewed the approach North Bristol NHS Trust takes to manage safe nurse staffing. This includes the triangulated approach of the NQB expectations (July 2016) for safe staffing and has demonstrated the outcomes of the actions which have progressed over the past 6 months. Current actions to support recruitment and retention and how staffing is managed daily to support safe and quality patient care is also included. Nurse staffing will continue to be

reviewed daily by the Divisional Directors of Nursing and a further review SNCT data collection will be undertaken in January 2022. The onward data collection is planned to return to SNCT guidance for data collection in January and June.

18. Recommendations

This report has demonstrated to the Trust Board that the Annual assessment of nurse staffing in line with business planning and against the triangulated approach to staffing of the NQB expectations has taken place.

The Trust Board is asked to:

1. Note the contents of this report which outlines the progress to date and further actions planned to ensure nurse staffing levels are safe to meet the needs of our patients, are effectively managed and are being published in accordance with the National Quality Board (2016), NHS Improvement (2018) Developing Workforce Safeguards recommendations, NHS Improvement (2018) Developing Workforce Safeguards recommendations, NICE guidance and self-assessment of the NHS Improvement recommendations for safe staffing

2. Receive assurance that the Director of Nursing and Quality has undertaken a review of safe staffing for all inpatient ward areas as detailed within the report with a further review planned for January 2022.

Report To:	Trust Board		
Date of Meeting:	25 November 2021		
Report Title:	Integrated Performance Report		
Report Author & Job Title	Lisa Whitlow, Associate Director of Performance		
Does the paper contain	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
	N/A	N/A	N/A
Executive/Non-executive Sponsor (presenting)	Executive Team		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
		X	
Recommendation:	The Trust Board is asked to note the contents of the Integrated Performance Report.		
Report History:	The report is a standing item to the Trust Board Meeting.		
Next Steps:	This report is received at the Joint Consultancy and Negotiation Committee, Operational Management Board, Trust Management Team meeting, shared with Commissioners and the Quality section will be shared with the Quality and Risk Management Committee.		

Executive Summary	
Details of the Trust's performance against the domains of Urgent Care, Elective Care and Diagnostics, Cancer Wait Time Standards, Quality, Workforce and Finance are provided on page six of the Integrated Performance Report.	
Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services c. A Centre of Excellence for specialist healthcare d. A powerhouse for pathology & imaging **2. Developing Healthcare for the future** a. Training, educating and developing our workforce b. Increase our capability to deliver research c. Support development & adoption of innovations d. Invest in digital technology **3. Employer of choice** a. A great place to work that is diverse & inclusive

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

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NHS North Bristol NHS Trust

North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

November 2021 (presenting October 2021 data)

Exceptional healthcare, personally delivered

CONTENTS

North Bristol Integrated Performance Report

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Trend	Benchmarking (in arrears except A&E & Cancer as per reporting month)		
																			Peer Performance	Rank	Quartile
Responsive	A&E 4 Hour - Type 1 Performance	R	95.00%	65.00%	82.07%	77.95%	73.21%	68.51%	73.33%	81.05%	74.26%	72.71%	64.38%	54.36%	61.47%	61.75%	60.82%		52.73%	1/9	
	A&E 12 Hour Trolley Breaches	R	0	0	12	3	52	206	7	0	6	0	4	97	14	38	29		0-278	5/9	
	Ambulance Handover < 15 mins (%)		100%	-	68.07%	67.70%	57.77%	54.95%	60.97%	58.17%	50.28%	51.07%	48.46%	39.75%	37.84%	41.26%	36.18%				
	Ambulance Handover < 30 mins (%)	R	100%	-	93.50%	93.76%	88.44%	83.80%	92.75%	89.36%	79.42%	80.43%	73.44%	60.62%	66.21%	64.67%	56.60%				
	Ambulance Handover > 60 mins		0	-	33	26	82	180	57	83	272	199	346	636	471	418	622				
	Stranded Patients (>21 days) - month end				247	141	145	124	129	136	272	116	122	277	145	151	151				
	Right to Reside: Discharged by 5pm	R	50.00%		-	-	28.52%	30.53%	29.43%	30.89%	35.87%	31.83%	33.53%	33.25%	28.27%	29.70%	27.84%				
	Bed Occupancy Rate			93.00%	94.19%	92.38%	95.10%	95.86%	92.74%	92.49%	95.25%	95.23%	96.63%	95.96%	95.32%	97.20%	97.26%				
	Diagnostic 6 Week Wait Performance		1.00%	32.64%	27.47%	26.73%	32.37%	33.04%	27.20%	24.72%	29.45%	31.99%	36.13%	38.91%	42.55%	42.83%	41.80%		31.47%	8/10	
	Diagnostic 13+ Week Breaches		0	0	1697	1427	1487	1420	1358	1364	1513	1779	2054	2183	2180	2724	3029		37-2895	9/10	
	Diagnostic Backlog Clearance Time (in weeks)				0.9	0.8	1.0	1.0	0.8	0.8	0.9	1.1	1.3	1.3	1.4	1.6	1.5				
	RTT Incomplete 18 Week Performance		92.00%	-	74.00%	74.35%	73.18%	71.62%	70.65%	71.64%	73.59%	74.29%	74.98%	73.78%	73.16%	71.87%	70.37%		61.82%	3/10	
	RTT 52+ Week Breaches	R	0	-	1092	1249	1418	1817	2108	2088	1827	1583	1473	1544	1770	1933	2068		79-10804	5/10	
	RTT 78+ Week Breaches	R		-	-	-	-	-	-	-	363	424	448	532	656	659	577		1-5112	4/10	
	RTT 104+ Week Breaches	R		-	-	-	-	-	-	-	5	12	19	28	34	55	93		0-656	4/10	
	RTT Non-Admitted Clock Stops			-	5979	5975	5402	5361	5463	6769	5633	5975	6828	6025	5278	6145	5983				
	RTT Admitted Clock Stops			-	2618	2395	2097	1761	1882	2607	2153	2387	2486	2312	2088	2272	2332				
	RTT New Starts			-	11413	9974	9619	9399	9495	11500	10911	10901	12082	11687	10948	11648	11307				
	Other Stops					2186	2141	2129	2193	2260	1562	2034	1470	1981	2103	2238	2511				
	Total Waiting List	R		-	30214	29632	29611	29759	29716	29580	31143	31648	32946	34315	35794	36787	37268				
	RTT Backlog Clearance Time (in weeks)				2.3	2.1	2.2	2.3	2.5	2.5	2.7	3.3	2.6	1.8	1.5	1.7	1.7				
	Cancer 2 Week Wait	R	93.00%	65.47%	89.01%	78.65%	63.72%	60.03%	70.87%	63.24%	39.53%	36.58%	36.44%	53.40%	66.58%	51.22%	-		74.73%	10/10	
	Cancer 2 Week Wait - Breast Symptoms		93.00%	38.37%	87.76%	61.07%	33.77%	49.64%	36.17%	15.20%	6.18%	9.21%	17.19%	71.23%	84.35%	74.64%	-		55.83%	5/10	
	Cancer 31 Day First Treatment		96.00%	87.39%	92.68%	97.01%	95.47%	89.84%	95.96%	96.62%	94.40%	97.38%	95.48%	95.77%	93.00%	91.89%	-		93.36%	7/10	
	Cancer 31 Day Subsequent - Drug		98.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95.45%	-		97.93%	9/10	
	Cancer 31 Day Subsequent - Surgery		94.00%	81.40%	87.76%	91.95%	92.22%	77.66%	84.44%	85.48%	81.18%	86.73%	84.62%	90.80%	72.84%	80.90%	-		80.69%	7/10	
	Cancer 62 Day Standard	R	85.00%	80.06%	72.87%	75.76%	77.39%	65.91%	74.34%	76.09%	75.00%	77.11%	62.74%	68.59%	68.60%	56.98%	-		68.12%	8/10	
	Cancer 62 Day Screening		90.00%	86.96%	77.14%	76.92%	86.36%	78.57%	86.79%	68.18%	73.68%	54.72%	73.33%	86.36%	52.54%	75.00%	-		70.11%	3/10	
	28 Day Faster Diagnosis	R	75.00%		-	-	-	-	-	-	66.39%	54.73%	43.56%	65.46%	66.77%	56.07%	-		68.67%	10/10	
	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%		84.21%	83.71%	82.92%	81.52%	83.63%	84.73%	84.48%	82.56%	83.29%	82.99%	83.13%	81.80%	81.90%				

North Bristol Integrated Performance Report

Domain	Description	Regulatory	National Standard	Current Month Trajectory (RAG)	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Trend
Quality Patient Safety & Effectiveness	5 minute apgar 7 rate at term			0.90%	0.64%	0.73%	0.70%	0.50%	0.51%	0.43%	0.70%	0.95%	0.69%	1.51%	1.15%	0.62%	1.26%	
	Caesarean Section Rate			28.00%	36.42%	31.16%	41.92%	35.13%	38.69%	40.28%	37.44%	33.11%	40.09%	39.36%	34.88%	38.74%	37.35%	
	Still Birth rate			0.40%	0.00%	0.23%	0.64%	0.46%	0.23%	0.00%	0.43%	0.22%	0.00%	0.20%	0.00%	0.57%	0.39%	
	Induction of Labour Rate			32.10%	36.62%	39.77%	37.55%	39.81%	33.80%	33.81%	35.24%	37.14%	35.29%	37.35%	35.31%	33.40%	29.05%	
	PPH 1500 ml rate			8.60%	3.39%	4.42%	2.83%	3.26%	3.94%	3.23%	3.07%	4.03%	5.17%	2.00%	2.11%	2.10%	3.94%	
	Never Event Occurrence by month		0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	
	Commissioned Patient Safety Incident Investigations				-	-	-	-	-	-	-	-	-	2	2	3	0	
	Healthcare Safety Investigation Branch Investigations				-	-	-	-	-	-	-	-	-	1	2	-	0	
	Total Incidents				1210	1054	1062	1240	877	1006	1039	1071	1029	1061	927	936	0	
	Total Incidents (Rate per 1000 Bed Days)				50	49	49	57	45	46	46	44	43	44	38	39	0	
	WHO checklist completion			95%	99.60%	99.40%	99.95%	99.69%	99.84%	100.00%	99.84%	99.84%	99.93%	99.80%	99.70%	99.75%	99.15%	
	VTE Risk Assessment completion	R		95%	95.12%	94.61%	95.44%	95.28%	95.10%	95.38%	95.46%	95.46%	95.38%	95.52%	94.83%	94.29%	-	
	Pressure Injuries Grade 2				28	17	17	17	27	7	9	10	15	17	22	24	19	
	Pressure Injuries Grade 3			0	1	0	0	0	0	0	0	0	0	0	0	0	0	
	Pressure Injuries Grade 4			0	0	0	0	1	0	0	0	0	0	0	0	0	0	
	PI per 1,000 bed days				0.85	0.42	0.60	0.52	0.82	0.19	0.30	0.30	0.48	0.51	0.72	0.75	0.51	
	Falls per 1,000 bed days				9.57	8.85	8.55	9.54	8.63	8.44	8.33	8.70	8.53	8.36	7.83	7.23	7.19	
	#NoF - Fragile Hip Best Practice Pass Rate				77.27%	75.61%	63.64%	42.86%	69.05%	78.38%	57.78%	53.49%	68.00%	68.18%	76.32%	42.11%	-	
	Admitted to Orthopaedic Ward within 4 Hours				67.44%	53.66%	57.14%	39.68%	54.76%	44.68%	71.88%	54.05%	42.86%	52.50%	13.64%	42.11%	-	
	Medically Fit to Have Surgery within 36 Hours				86.05%	80.49%	79.59%	58.73%	80.95%	89.36%	71.88%	51.35%	80.95%	70.00%	81.82%	47.37%	-	
	Assessed by Orthogeriatrician within 72 Hours				93.02%	95.12%	79.59%	80.95%	97.62%	97.87%	56.25%	18.92%	90.48%	95.00%	100.00%	89.47%	-	
	Stroke - Patients Admitted				86	79	80	70	61	96	91	100	91	75	92	83	53	
	Stroke - 90% Stay on Stroke Ward			90%	84.62%	81.97%	80.88%	58.18%	83.33%	81.08%	98.26%	86.76%	80.82%	87.30%	80.00%	58.33%	-	
	Stroke - Thrombolysed <1 Hour			60%	72.73%	50.00%	33.33%	50.00%	44.00%	78.00%	100.00%	50.00%	70.00%	85.71%	90.91%	50.00%	-	
	Stroke - Directly Admitted to Stroke Unit <4 Hours			60%	61.73%	63.64%	47.83%	35.59%	60.00%	48.68%	47.89%	52.00%	49.33%	46.20%	39.73%	32.00%	-	
	Stroke - Seen by Stroke Consultant within 14 Hours			90%	86.00%	89.71%	85.92%	87.30%	91.55%	90.00%	85.14%	90.36%	92.11%	95.45%	89.19%	98.08%	-	
	MRSA	R	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	
	E. Coli	R		4	4	5	3	3	1	6	4	5	4	1	5	3	8	
	C. Difficile	R		5	7	5	7	4	9	4	10	6	10	6	2	5	4	
	MSSA			2	4	6	2	3	3	0	4	1	5	2	5	4	1	
Quality Caring & Experience	Friends & Family - Births - Proportion Very Good/Good				-	-	-	-	-	94.26%	95.51%	95.51%	94.74%	92.68%	95.95%	91.30%	98.53%	
	Friends & Family - IP - Proportion Very Good/Good				-	-	93.24%	94.06%	95.72%	93.68%	92.90%	94.52%	91.79%	92.85%	91.94%	92.16%	92.25%	
	Friends & Family - OP - Proportion Very Good/Good				-	-	95.60%	95.71%	95.29%	94.63%	94.90%	95.09%	94.40%	94.65%	94.54%	93.77%	94.80%	
	Friends & Family - ED - Proportion Very Good/Good				-	-	90.96%	87.49%	89.21%	87.24%	84.86%	82.00%	73.19%	71.84%	72.87%	74.81%	73.94%	
	PALS - Count of concerns				73	99	66	62	71	79	108	88	127	127	123	123	100	
	Complaints - % Overall Response Compliance			90%	94.44%	92.68%	94.64%	81.48%	84.38%	85.11%	79.07%	83.33%	77.03%	85.71%	88%	77.36%	69.12%	
	Complaints - Overdue				2	2	0	0	0	0	0	0	0	2	1	8	10	
	Complaints - Written complaints				48	39	23	37	43	42	56	67	51	65	48	52	55	
Well Led	Agency Expenditure ('000s)				875	900	1043	1234	544	1042	#N/A	816	1029	1374	1061	1492	1576	
	Month End Vacancy Factor				3.83%	3.38%	4.59%	3.80%	3.65%	3.62%	#N/A	4.81%	#REF!	6.52%	6.55%	6.28%	6.53%	
	Turnover (Rolling 12 Months)	R		12.00%	12.78%	12.74%	12.73%	12.89%	12.56%	12.36%	13.37%	13.60%	13.81%	12.97%	14.21%	13.92%	15.35%	
	Sickness Absence (Rolling 12 month -In arrears)	R		-	4.41%	4.44%	4.38%	4.47%	4.48%	4.42%	4.32%	4.31%	4.31%	4.36%	4.42%	4.46%	-	
	Trust Mandatory Training Compliance				86.45%	86.07%	85.79%	85.90%	85.91%	85.40%	85.17%	84.95%	84.55%	82.82%	82.58%	82.32%	82.12%	

EXECUTIVE SUMMARY
September 2021

Urgent Care
Four-hour performance deteriorated slightly in October with performance of 60.82%; the Trust ranked first amongst 9 reporting AMTC peer providers. The Trust had 622 ambulance handover delays over one hour and 29 12-hour trolley breaches in month which saw over 7,000 nationally. Four hour performance and Ambulance handover times were impacted by greater bed occupancy at an average of 97.26% for the month as a result of rising COVID-19 admissions, increased LoS and poor complex discharge levels. Trust wide internal actions are focused on improving the timeliness of discharge, a relaunch of internal professional standards, maximising SDEC pathways and weekend discharge rate improvements. The low level of complex discharges for the next quarter remains a risk; BNSSG Healthier Together Executive agreed recurrent funding plans for increased community investment in November. In October, to provide immediate capacity for emergency admissions, the Trust has converted elective capacity, cancelling all Priority 4 activity and running a limited Priority 3 programme; which will result in further waiting list backlog growth.

Elective Care and Diagnostics
The overall RTT waiting list continued to grow in October resulting from reduced elective capacity, due to capacity pressures on the bed base, but continues to compare favourably with combined national Acute provider growth. There were 2,068 patients waiting greater than 52-weeks for their treatment in October, 577 of these were patients waiting longer than 78-weeks and 93 were waiting over 104-weeks. This was the fourth consecutive month that the Trust has reported an increase in long waiting patients, although breaches have not yet increased to the peak level of 52-week breaches seen in February 2021. The residual risk of 104-week breaches at the end of March 2022, based on the H2 planning assumptions, is 44 patients awaiting treatment predominately in T&O plus 20 patients choosing to defer their treatment. Reductions are already being seen in the cohort of patients at risk of breaching 104 weeks at year-end. When compared nationally, the Trust remains in the third quartile for all long waiting patient cohorts and compares reasonably with model hospital peers. The Trust continues to treat patients based on their clinical priority first followed by length of wait. Diagnostic performance improved slightly in October with performance of 41.80%. The Trust is sourcing additional capacity for several test types to support recovery of diagnostic waiting times.

Cancer Wait Time Standards
Performance for the TWW standard has deteriorated in September at 51.21% compared to the previous month (66.58%) continuing to be impacted by issues in Breast, Skin and Endoscopy. The 31-Day standard was 91.89%. The reported 62-Day performance for September deteriorated on the previous month with performance of 56.98%. Due to the level of performance against the CWT targets, the Trust is being supported by National and Regional colleagues until at least January 2022, with an internal Task Force established to focus on delivery of remedial actions. On the live PTL (11/11/21) there are 154 patients waiting over 104-Days. Instances of clinical harm remain low month-on-month and the Trust has only identified one moderate harm in the last 12-months as a result of delays over 104-Days.

Quality
For Maternity, areas of excellence are identified in relation to implementing a ground-breaking drug therapy for COVID-19 positive pregnant women. There have been no reported Grade 3 or 4 pressure injuries in October and none for 2021-22 year to date. There were no MRSA cases reported in October 2021 however, MSSA and C Difficile cases remain above targeted trajectories. The IPC central team has been actively involved with Infection Prevention Week teaching at ward level and participating at Regional / National events. There are no current Mortality Outlier alerts for the Trust and continued high completion rates of mortality reviews are demonstrated. There has been a 36% increase in the actual number of incidents involving a high risk medicine in October compared to September, demonstrating that these incidents are occurring more frequently.

Workforce
Temporary staffing demand grew by 3% in October with bank hours worked increasing by 7%; the first time in 2021/22 that bank growth has been greater than overall temporary staffing demand growth. The Trust vacancy factor increased in October, predominantly driven by an increase in Estates and Ancillary vacancies. Turnover remains lower than this point pre-pandemic but there was an increase across all staff groups in October compared with September moving from 13.90% to 15.35%. Sickness absence also increased in September to 4.46% from 4.42% in August, with *stress/anxiety/depression/other psychiatric illnesses* remaining higher than would ordinarily be anticipated for the period.

Finance
The financial framework for both H1 and H2 of 2021/22 requires the Trust to deliver core operations within an agreed financial envelope and, in addition, to recover costs incurred in dealing with the COVID-19 pandemic in line with the required and prescribed national guidance. The financial performance for the year 2021/22 remains to breakeven as set out in the Board approved budget paper. The H2 financial plan has been developed and shows a plan to breakeven. This plan includes non-recurrent income and expenditure. The actual result for Month 7 is a breakeven position. The forecast outturn is that the Trust will achieve the breakeven plan at year end as well as delivering the capital plan.

RESPONSIVENESS
SRO: Chief Operating Officer
Overview

Urgent Care

The Trust reported four-hour performance of 60.82% in October. Ambulance handover delays deteriorated significantly with 622 handovers exceeding one hour reported in month; the Trust had 29 12-hour trolley breaches. Bed occupancy varied between 93.81% and 99.89% against the core bed base. Ambulance arrivals remained consistent with pre-pandemic levels and continued to be particularly challenged due to multifactorial issues including the impact of COVID-19 admissions on flow and capacity, low morning discharge rates and reduced discharges to post acute community and domiciliary care. There is a Trust-wide plan in place to improve emergency flow which focusses on the actions that can be taken within the Trust and includes increased use of SDEC pathways, focus on early discharges and improvement in weekend discharging.

Planned Care

Referral to Treatment (RTT) – The number of patients exceeding 52-week waits in October was 2,068, the majority of breaches (1,151; 55.66%) being in Trauma and Orthopaedics. For the fourth consecutive month, the Trust has reported an increase in 52-week wait breaches; the overall proportion of the wait list that is waiting longer than 52-weeks is 5.55% which is relatively static on the previous month. The Trust is focussing on the treatment of patients who are waiting over 104-weeks or are at risk of waiting that long for their treatment; this is whilst maintaining timely access to treatment for those with the greatest clinical need.

Diagnostic Waiting Times – Diagnostic performance improved slightly in October with performance of 41.80%, though failed to meet the improvement trajectory of 32.64%. The number of patients waiting longer than 13-weeks in October increased to 3,029 compared to 2,724 in September. CT performance improved significantly however Echocardiography and Endoscopy have both experienced backlog growth. Modalities of significant underperformance have action plans in place to provide additional capacity through a combination of insourcing and outsourcing of activity. A high level review continues to be completed for patients exceeding 13-weeks to ensure no harm has resulted from the extended wait times. In September NBT ranked 8th amongst 10 peer providers for 6-week and 13-week performance.

Cancer

The TWW and 62-Day CWT standards and trajectories saw a decline on last month's performance. The Trust continues to carry backlogs in Skin, Breast, and Endoscopy which is impacting on TWW and 62-Day pathways. Breast services continue to struggle to maintain activity, insourcing services have been secured to support the front end and the surgical element of the pathway. Recruitment within Cancer Services has been successful and agency support has been secured to improve patient tracking activity. Following a National and Regional review of the Trust's compliance with Cancer High Impact Actions we obtained positive feedback with regards to governance procedures and performance management but there are areas for improvement especially in the faster diagnosis pathway compliance. We will continue to be in special measures for the remainder of this quarter.

Areas of Concern

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

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

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

Improvements

Maternity : The Perinatal Quality Surveillance Monitoring (PQSM) data provides a framework for Maternity quality and safety review. Actions taken and currently in progress are summarised in response to the key areas flagged in relation to workforce, staff and service user involvement, projected achievement of the 2022 Maternity Incentive Scheme and Continuity of Carer. Areas of excellence are identified in relation to implementing a ground-breaking drug therapy for Covid positive pregnant women and community oxygen saturation monitoring for our Covid positive pregnant population.

Pressure Injuries - There have been no reported Grade 3 or 4 pressure injuries in October and none for 2021-22 year to date. For October there has been a reduction in total pressure injuries, which bucks the recent trend and is subject to ongoing monitoring to establish whether this improvement is sustained.

Infection control: There were no MRSA cases reported in October 2021 (last one for Trust reported in February 2021).

Mortality Rates/Alerts: There are no current Mortality Outlier alerts for the trust and continued high completion rates of mortality reviews are demonstrated, with Medical Examiner reviews and referrals into Trust governance processes also operating effectively to address family concerns and integrate with coronial cases. A development programme re-looking at the Trust' s approach to mortality reviews has concluded with enhancements to the approach now being developed, including through NHSE/I regional engagement.

Areas of Concern

Infection control: MSSA and C Difficile cases remain above targeted trajectories. The IPC central team has been actively involved with Infection Prevention Week teaching at ward level and participating at Regional / National events. Specifically relating to C-Difficile, the Southwest C Diff HCAI collaborative has held initial shared learning sessions to look at reduction of infection, focusing on Antimicrobial Stewardship .

Medication Incidents: There has also been a 36% increase in the actual number of incidents involving a high risk medicine in October compared to September, demonstrating that these incidents are occurring more frequently. The team are working on identifying causes for the increase in incidents involving high risk medicines in collaboration with ward teams.

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

Corporate Objective 4: Build effective teams empowered to lead

Vacancies

The vacancy factor increased to 6.53% in September (from 6.28% in September). Increases in Estates and Ancillary staff vacancies.

Turnover

Staff turnover increased to 15.35% in October. Excluding the COVID-19 and mass vaccination workforce, the turnover rate decreases to 14.53%, however still shows an increase from 13.90% in September. and remains lower than pre-COVID levels (October 2019 - 14.29%).

Prioritise the wellbeing of our staff

Sickness absence increased to 4.46% in September from 4.42% in August. Days lost to *Stress/anxiety/depression/other psychiatric illness* continue to be higher than any other reason, however initial view of October absence position show a 9.18% reduction in days lost compared with August and September.

Continue to reduce reliance on agency and temporary staffing

Temporary staffing demand increased in September by 3% (37.84 wte) and for the first time this year bank hours worked increased at a greater rate, 7% (+37.20 wte). There was a small reduction in agency use across registered nursing and midwifery, administrative and clerical and scientific and allied health professional staff groups. Tier 4 RMN use saw a reduction (+3.28 wte) but was partially offset by an increase in RN tier 4 use (+2.32 wte).

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

Theme	Action	Owner	By When
Vacancies	Health care support worker assessment centres have increased for the remainder of the year to support closing vacancies gaps and increases in turnover. Additional interventions currently being worked up	Head of Resourcing	Mar-22
Turnover	Nursing & Midwifery Demand and Supply group agreed retention interventions and will monitor progress	Head of People	Nov-21
Health and Wellbeing	Staff support proposal going to H2 Programme Board (Hot food and drink, extending free car parking & staff security campaign)	Head of People Strategy	Nov-21
Health and Wellbeing	Calm rooms, wellbeing pods & restroom improvement proposals developed into business case for approval	Head of People Strategy	Dec-21
Temporary Staffing	Delivering campaign to encourage inactive workers to participate and contacting staff who have left within the last 12 months to register on our bank	Head of Resourcing	Nov-21
Temporary Staffing	System wide review of Waiting List Initiative Rates to support capacity management across system	Director of People and Transformation	Dec-21

FINANCE
SRO: CFO
Overview

The actual result for the Month 7 and year to date is a breakeven position.

Key drivers at month 7 are:
The Trust has recognised Elective Recovery Fund (ERF) non-recurrent income of £8.9m for the year to date.

The income reported in M7 is based on notified allocations from BNSSG system.

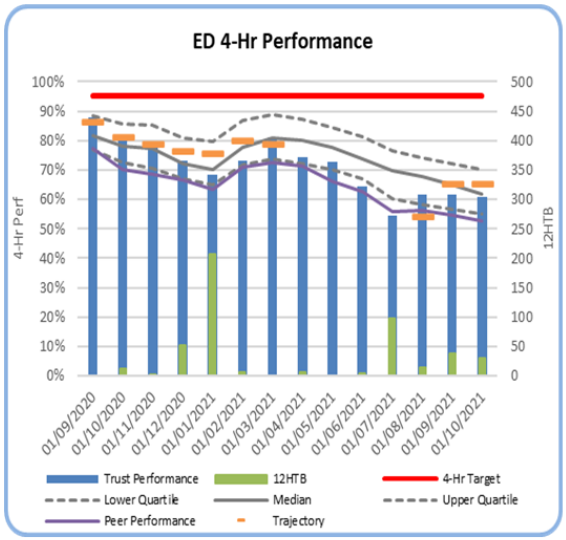
Cash at 31 October amounts to £104.3m.

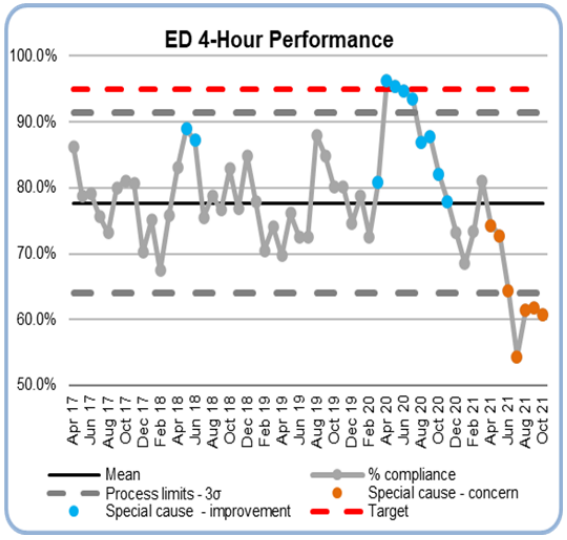
Total capital spend to date is £10.5m, compared to a plan of £12.6m for the first 7 months of the year.

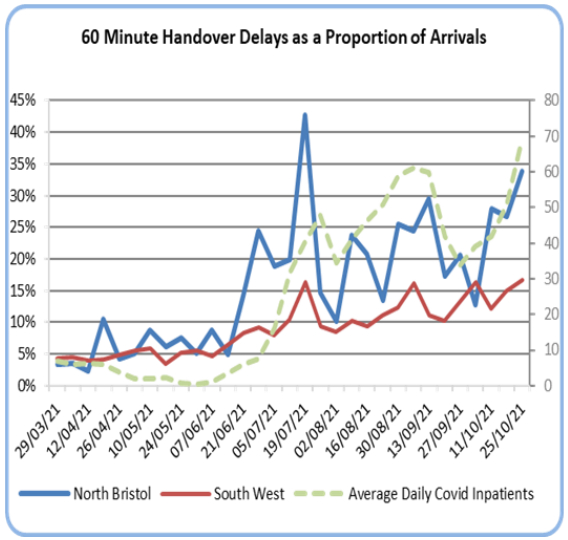
The forecast outturn is that the Trust will achieve the breakeven plan at year end as well as delivering the capital plan.

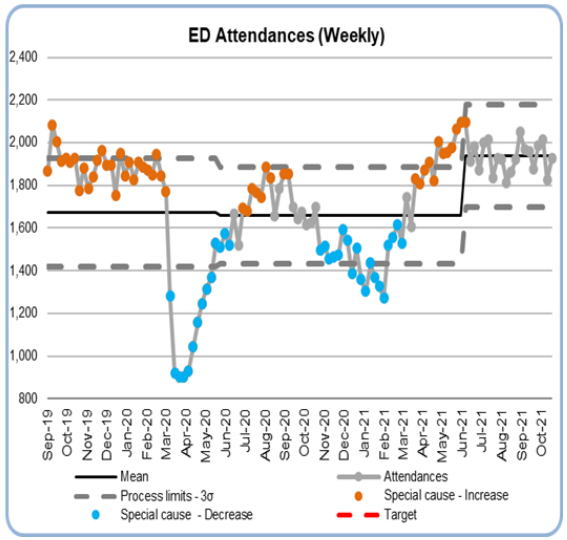
Responsiveness

Board Sponsor: Chief Operating Officer
Jon Scott









Urgent Care

What does the data tell us?

Four-hour performance deteriorated slightly in October with performance of 60.82%. Trust performance exceeded that of our AMTC peers, ranking first out of nine reporting centres. When compared nationally, the Trust remains in the third quartile. ED performance for the NBT Footprint stands at 69.31% and the total STP performance was 70.83% for September.

ED attendances were slightly higher when compared to 2019/20 levels. There was a decrease in 12-hour trolley breaches in October compared to September with the Trust recording 29 in month; nationally there were 7059 with 23 Trusts reporting over 100.

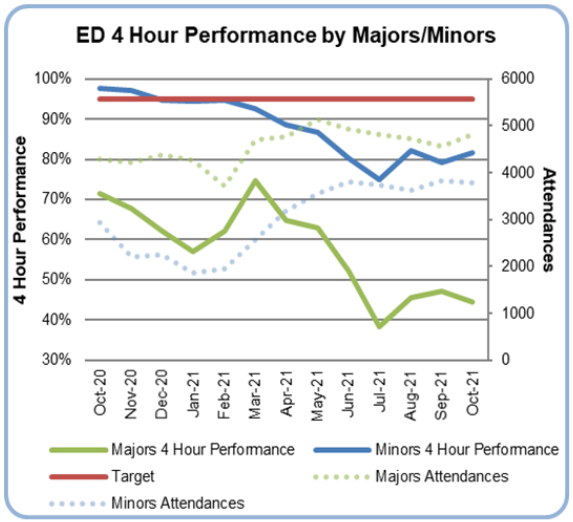
Ambulance handover times continued to be challenged and deteriorated on last month with the Trust recording 622 ambulance handover delays over one-hour. Rising numbers of COVID-19 inpatients (October peak of 75) and increased LoS has resulted in compromised flow as the Trust moved to create further cohort areas for Blue (COVID-19 positive) patients. Green (COVID-19 negative elective) capacity has reduced as elective beds were converted to COVID-19 negative non-elective beds to manage emergency pressures. The lower elective throughput will result in a growth to the elective backlog.

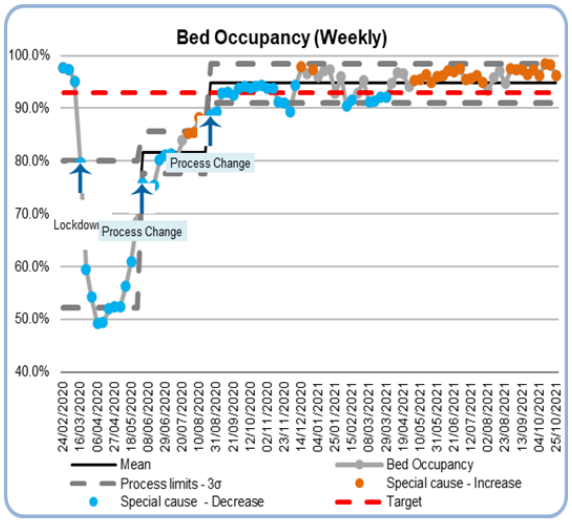
What actions are being taken to improve?

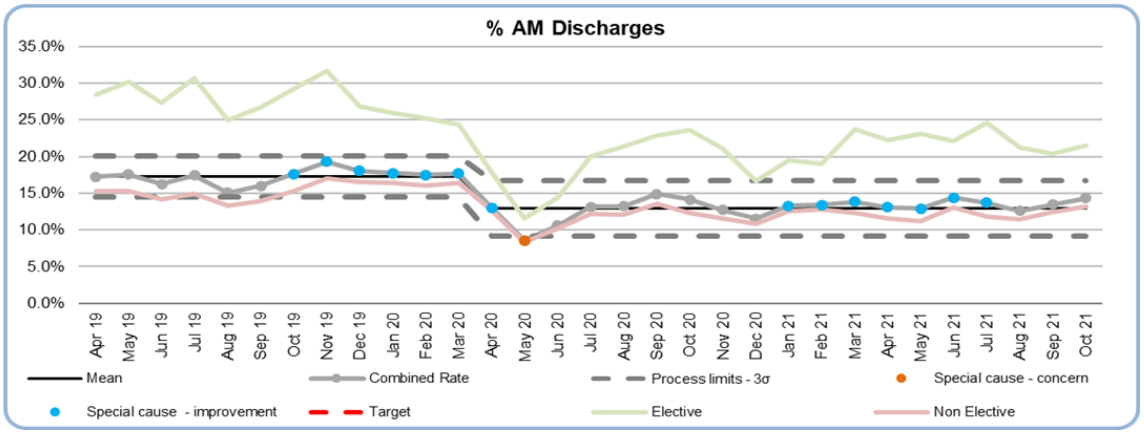
A Trust Ambulance improvement plan including BNSSG and SWASFT actions for out of hospital care has been presented to Region. An internal performance trajectory will be presented to the next Finance and Performance Committee for approval.

The Emergency Flow Plan aimed at improvements in three areas (emergency portals, time in hospital, and discharge) has been incorporated into the Urgent Care Board. A system wide project to provide reduction of 20% of ED minors patients through enhanced streaming is underway; although there has been slippage due to workforce availability.

Improvements in time of day discharge is being seen with increased use of the discharge lounge before 10am. Weekend discharge improvements are slower to implement due to staffing challenges.







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

4-Hour Performance

What does the data tell us?

In October, Minors performance improved slightly to 81.76%, whilst Majors performance deteriorated to 44.38%.

For the eighth consecutive month, the predominant cause of breaches at 50.13% was waiting for assessment in ED, whilst 19.56% of breaches were caused by waiting for a medical bed.

Bed occupancy remained challenged, varying between 93.81% and 99.89% in October against the core bed base. Bed occupancy was impacted by rising COVID-19 admissions and increased length of stay resulting from greater complexity of need and system staffing pressures increasing the number of patients delayed in discharge to post-acute care.

In October, 14.25% of patients were discharged between 08:00-12:00; which was up on the previous month.

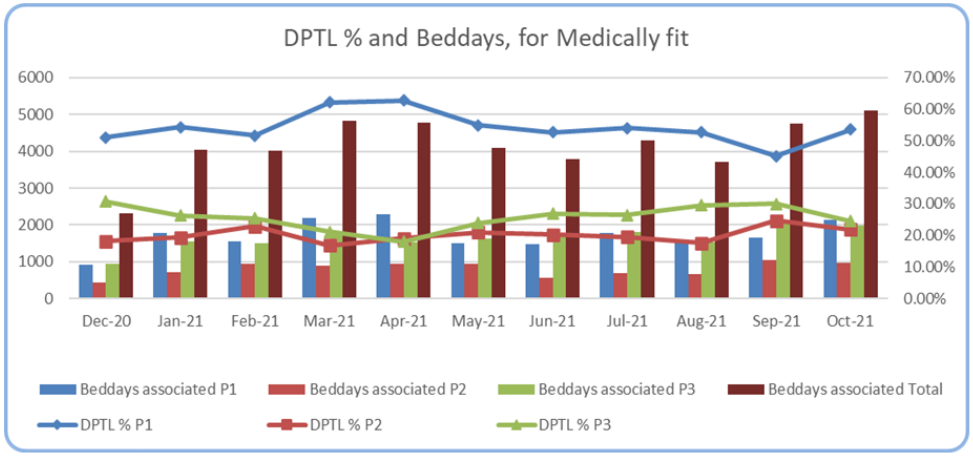
What actions are being taken to improve?

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

1. Emergency Portals (incl. Ambulance Turnaround Plan), decompressing ED and increasing use of SDEC pathways.

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

3. Discharges including implementation of the "Hospital Discharge and Community Support policy and operating model" and addressing BNSSG shortfalls in complex discharge rates (especially in P1 Home First capacity).



Criteria to Reside

What does the data tell us?

In October, the number of delayed bed days for medically fit patients awaiting Pathway 2 and 3 remained the same as September. The delayed bed days for Pathway 1 rose significantly by 438 bed days.

P1 discharges remain impacted by insufficient staff capacity for Local Authority (LA) domiciliary care. Patients are delayed in Sirona P1 Discharge to Assess (D2A) waiting discharge for long term packages of care meaning they cannot pull patients from NBT. There are insufficient community beds for patients with dementia and perceived behavioural challenges, also stroke patients with high care needs.

At the point of reporting 238 patients were ready for discharge on a complex pathway of which 189 were waiting for external reasons (60 patients waiting P1, 30 patients waiting P2 and 53 patients waiting P3). 20 patients were awaiting repatriation and 19 patients referred to the community were awaiting a pathway decision, 4 patients were homeless. During October some care homes and rehab units remained closed to admission due to COVID-19 adding to delayed discharge bed days. 49 patients were awaiting internal actions (18 waiting therapy review, 25 waiting referral submission, 4 a medical decision, 1 due to COVID-19 and 1 delay reason not recorded).

What actions are being taken to improve?

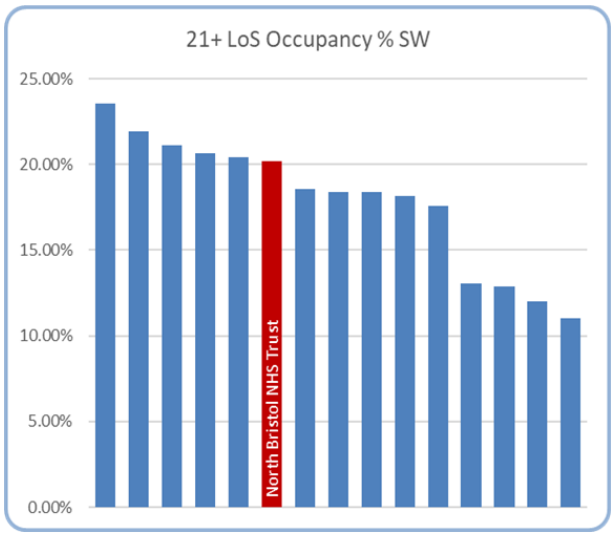
In September, additional transitional bed capacity for S. Glos (10 in total) and 5 additional Bristol and S. Glos shared capacity at Quarry House was commissioned by BNSSG, these were soon full. Further beds will come on line in November to facilitate discharge of patients waiting Pathway 1 QDS packages of care.

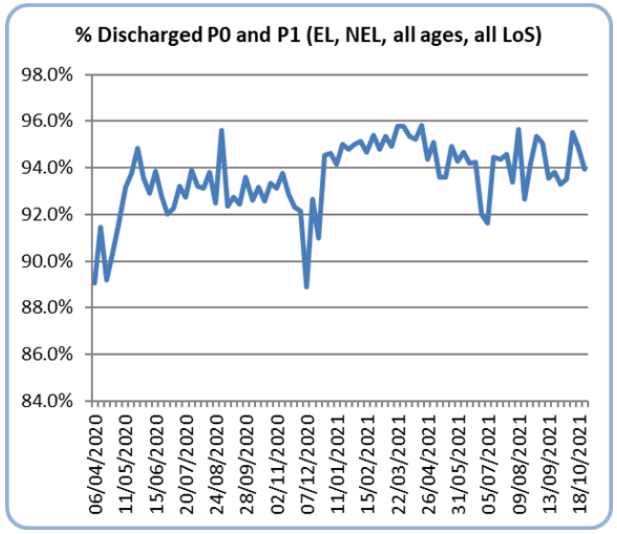
Domiciliary care capacity is a key capacity gap impacting all discharge pathways. Sirona and care agencies continue undertaking proactive campaigns to source care workers and holding recruitment stands in local shopping centres.

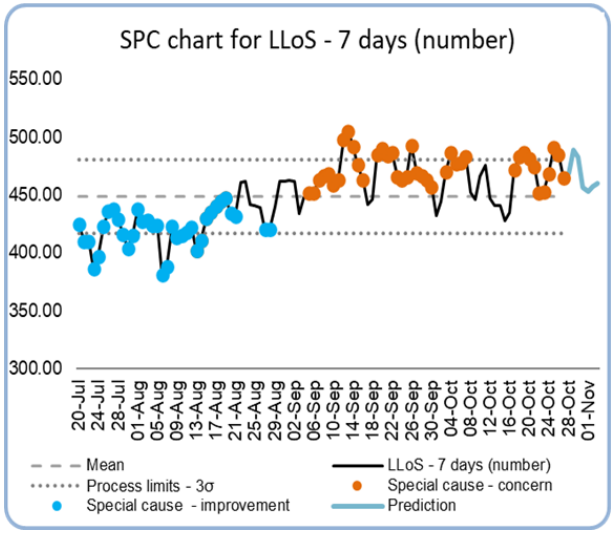
The SRF improvement project, overseen by the Urgent Care Delivery Group, commenced in early October targeting one ward in each division (26A; 9A and 26B). 26A has had the most significant improvement with 40% of ward staff undertaking SRF training. Early results demonstrated a reduction in admission to SRF submission saving 4 beds overall vs an in month target of 11 beds. A further 2 wards will go live in November with an on-going roll out programme across the winter.

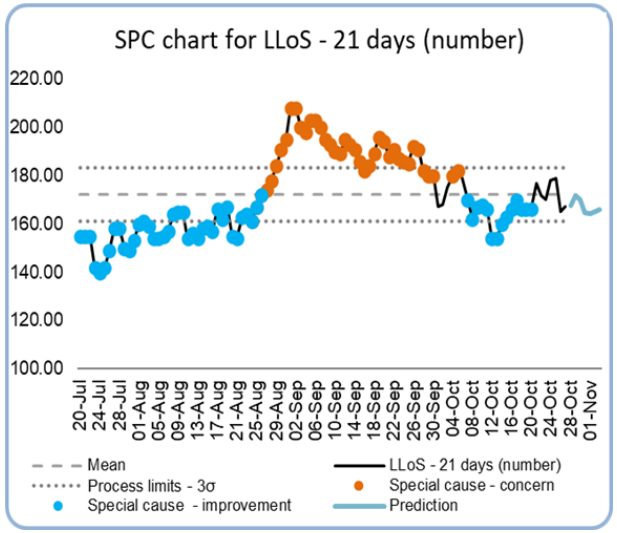
With the increasing wait for Pathway 1, a process has been introduced to engage family support with care at home whilst waiting confirmed pathway commencement. Bed day savings will be monitored and reported in November.

The IDS has appointed a 12 month fixed term Contract homeless discharge case manager commencing January 2022 funded by the Department for Health and Social Care and linked to the Bristol homeless health and care project.









Stranded Patients

What does the data tell us?

21+ day long stay patients reduced in volume throughout October to 20% (was 23% in September) however stays over 7 days increased, given the mix of patient acuity and delayed P1, 2 and 3 discharges this is to be expected.

The Trust's positioning for 21+ days improved again from the third highest percentage in the South West Region in September to 6th highest. NBT continued the focus on reducing 21+ stay patients throughout October.

Weekly complex discharge levels remain below the target levels (expected weekly target 121 across P1, 2 and 3). In October 349 patients were discharged on these pathways (46 more than September) against a target of 535 discharges, 65% of expected discharges. P0 non complex discharge is the main pathway from hospital and the highest volume of monthly discharges and total 5065 in September.

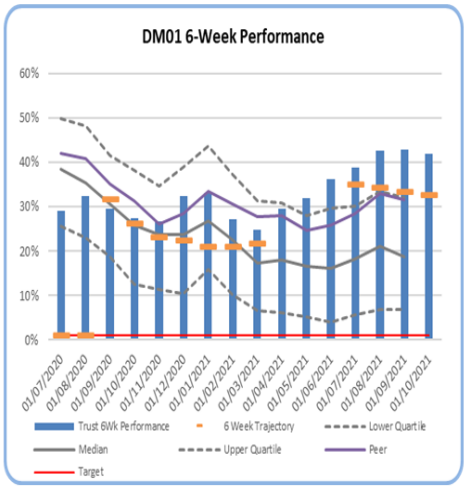
What actions are being taken to improve?

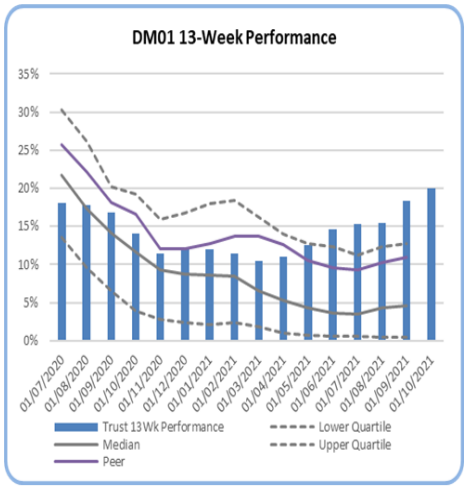
The IDS Team have established a weekly schedule of proactive patient tracking huddles to check the progress of patients on a complex discharge pathway and escalate actions where required to assure the discharge is as timely as possible. The focus is on all patients medically ready for discharge not just those becoming stranded, and is contributing to the 21+ LoS reduction.

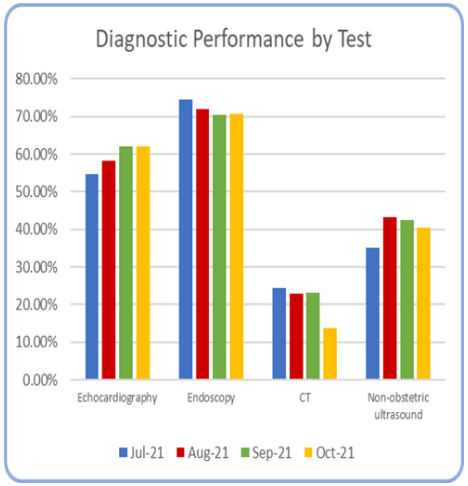
This approach is being enhanced with the embedding of the Cluster IDS Team model and the Band 7 IDS Team leads monitoring case manager caseloads and giving oversight on discharge plans.

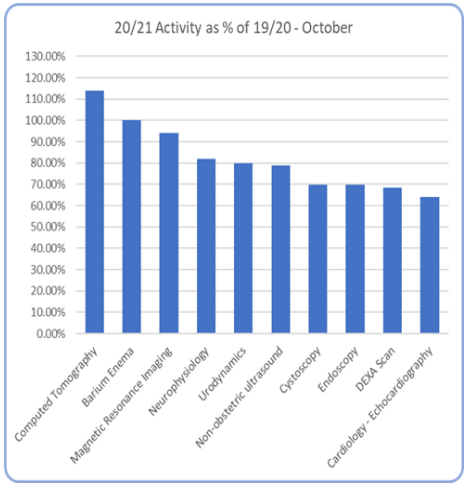
The BNSSG system Discharge to Assess (D2A) business case to Healthier Together Executive has been approved in November. The risk associated with workforce and increasing staffing for delivery still remains.

Data Source: South region NHSI UEC dashboard, w/e 31st October 2021









Diagnostic Wait Times

What does the data tell us?

In October, diagnostic 6-week performance improved slightly at 41.80%, though failed to meet the improvement trajectory of 32.64%. The improvement was driven by wait list growth with the backlog remaining static. 13-week performance deteriorated more significantly with an increase of 11.20%. There was a 2.42% increase in the overall wait list in October whilst activity levels reported below 80% of 2019/20 levels for 50% of test types.

Endoscopy and Echocardiography have both experienced backlog growth. Echocardiography performance continues to be impacted by capacity constraints; insourcing has been limited so far with staffing issues within the insourcing company, partially offset by additional agency support. CT has experienced the most significant improvement in month with planned actions starting to positively impact on performance.

In September, NBT ranked eighth amongst 10 peer providers for 6-week performance and ninth for 13-week performance. Nationally, Trust positioning was static for 6-week performance whilst 13-week position deteriorated, both remaining in the fourth quartile.

What actions are being taken to improve?

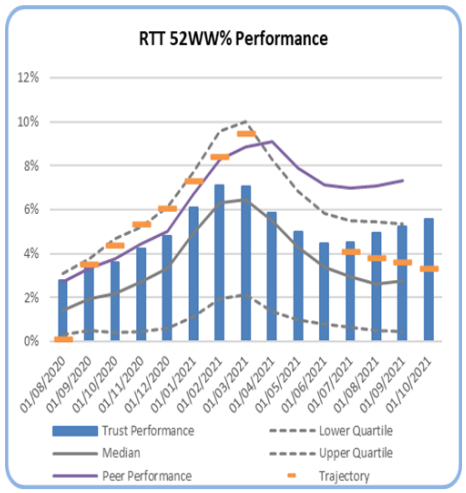
Endoscopy – There has a been a significant focus on re-establishing both insourcing and outsourcing of activity, which has been delivered, although staffing shortages have impacted the effectiveness of this mitigation. Focus continues on the internal capacity gap including a business case for prospective list cover, efficiency opportunities as a result of the new IT system for scheduling and exploring a system-wide shared Endoscopy PTL to ensure the most equitable use of available outsourcing capacity.

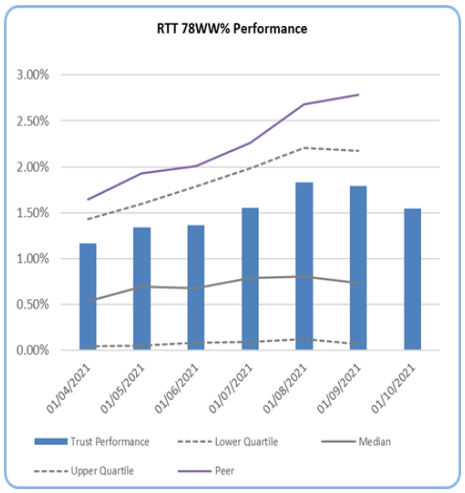
Non-Obstetric Ultrasound – The Contract has been signed for the insourcing of additional capacity in order to support backlog clearance. However, the provider currently has workforce shortages and therefore, the benefit will not be as great as 60 slots per week. In the meantime, following a review of IPC measures, it is anticipated that in-house productivity will improve following a reduction in requirements for cleaning between patients. In addition, the Trust continues to send 45 patients every other week to Emersons Green Treatment Centre.

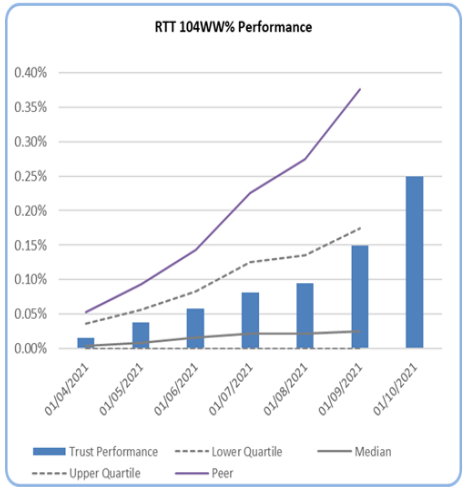
CT – Additional capacity has commenced using the demountable CT scanner based at Weston General Hospital. Positive impacts are also being seen from the new scanner at Cossham and good uptake of WLIs in October. November WLIs have all been booked and improved performance is expected to be sustained.

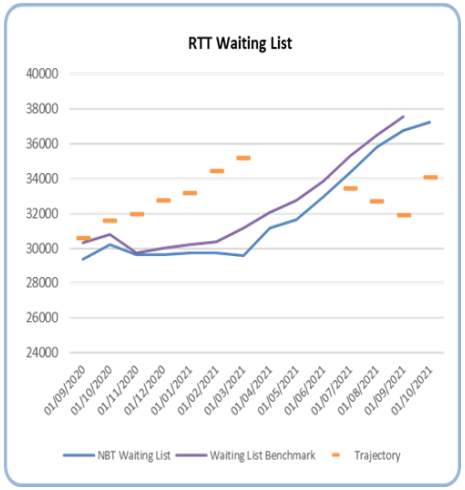
MRI – The Trust has extended the contract with the BioBank MRI research facility for additional MRI capacity for support throughout the winter period to March 2022. Productivity gains from changes in IPC measures are also being reviewed.

Echocardiography – The insourcing plan to increase Echocardiogram capacity is currently delayed due to staffing issues within the insourcing company. However, it is anticipated that a return to plan can still result in backlog clearance by year-end – this is dependent on the insourcing company providing the full capacity plan alongside the additional agency staffing being sought.









Referral to Treatment (RTT)

What does the data tell us?

In October, the Trust reported an increase in the waiting list to 37268, as anticipated in the H2 plan. The Trust has reported an increase in 52-week wait breaches for the fourth consecutive month with 2068 patients waiting greater than 52-weeks for their treatment; 577 of these were patients waiting longer than 78-weeks and 93 were waiting over 104-weeks. The majority of 52 and 104-week breaches (1151; 55.66%) are in Trauma and Orthopaedics and typically have the lowest level of clinical prioritisation against the national guidance (P4).

Increased waiting times and wait list growth is the result of an elective demand and capacity imbalance. Cancellations resulting from increasing COVID-19 admissions, non-elective demand and bed pressures has resulted in challenged elective inpatient capacity. Coupled with consistent demand at pre-pandemic levels since March 2021, this has resulted in wait list growth and longer waiting times. The residual risk of 104-week breaches at the end of March 2022, based on the H2 planning assumptions, is 44 patients awaiting treatment predominately in T&O plus 20 patients choosing to defer their treatment. Reductions are already being seen in the cohort of patients at risk of breaching 104 weeks at year-end.

When compared nationally, Trust waiting list growth continues to compare favourably to national waiting list growth for Acute providers. However, Trust positioning for long waiting patients continues to report within the third quartile for all cohorts (52, 78 and 104-weeks).

What actions are being taken to improve?

An Elective Care Recovery Board has been established and has developed a comprehensive plan to manage the waiting list to required levels.

The Trust is undertaking regular patient level tracking and proactive management of long waiting patients and specific engagement with patients at risk of exceeding 104-week waits.

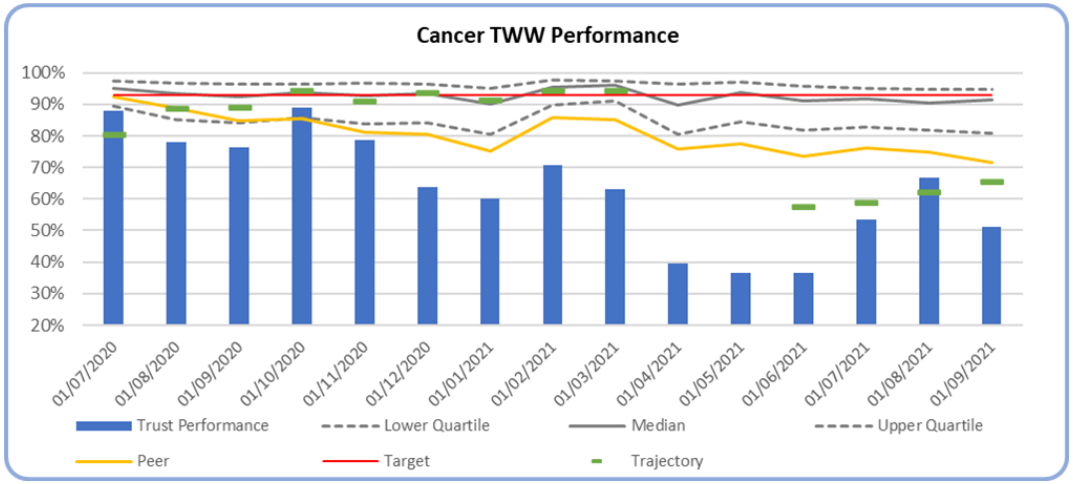
Options for Independent Sector (IS) transfer are limited to patients meeting IS treatment criteria. The Trust is exploring the transfer of further patients into available capacity within an IS Provider in a neighbouring system.

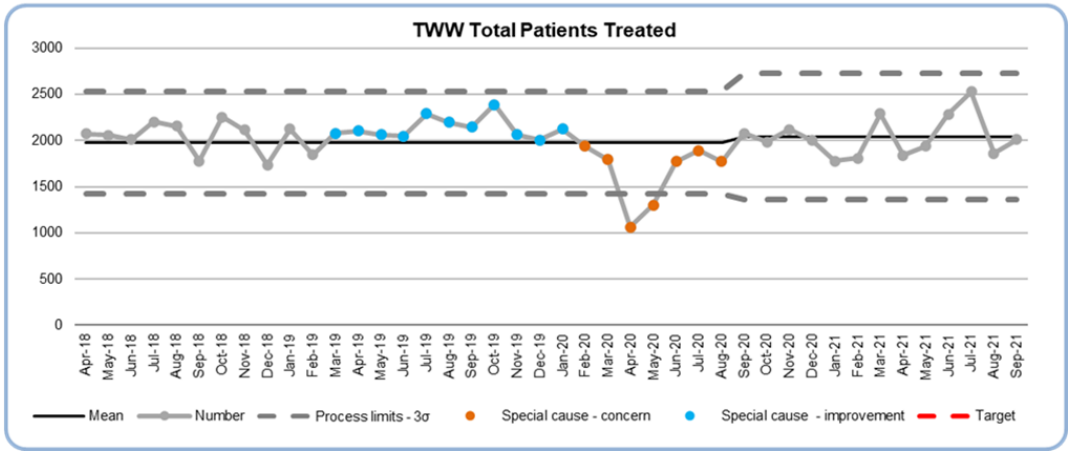
Continued application of review recommendations from Get It Right First Time (GIRFT) reports, Model Hospitals and the British Association of Day Surgery (BADS) are undertaken to ensure efficient use of the available capacity is maximised.

The Trust is exploring a number of further actions both internally and across the BNSSG system to increase capacity including engagement of further external staffing resource, specialists in theatre utilisation improvements and shared resources with UHBW.

Clinical validation of the longest waiting T&O patients has commenced and a review of patients suitable for transfer to the IS has taken place.

All patients bar one on a non-admitted pathway, at risk of breaching 104 weeks at year-end, have the next steps in their treatment plan booked in November/December.





Cancer: Two Week Wait (TWW)

What does the data tell us?

The Trust reported a performance of 51.22% in September compared to 66.58% in August which is a 23% decrease in performance. Urology, and Brain were the only specialties to achieve the standard. The Trust saw 2013 patients in September compared to 1863 patients in August. Of the 2013 patients seen, 984 patients breached the TWW target, the average day to 1st appointment in August was 26 days.

Breast had performance of 68.75% compared to the August performance of 85.20%. They saw 544 patients in September with 170 of those seen in a breach position. Colorectal continues to be of concern; their performance dropped again this month from 63.99% to 62.63%. The service continues to experience OPD capacity issues due to workforce pressures, Endoscopy capacity issues and CT reporting delays.

Skin service continues to clear their backlog and as a result they had poor TWW performance of 6.61% in September, an expected deterioration on last month's position. . The skin service saw 711 patients in September of these, 664 patients were seen in a breach position.

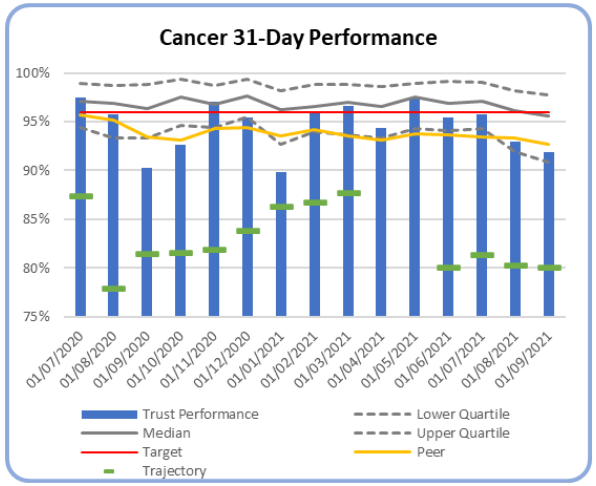
What actions are being taken to improve?

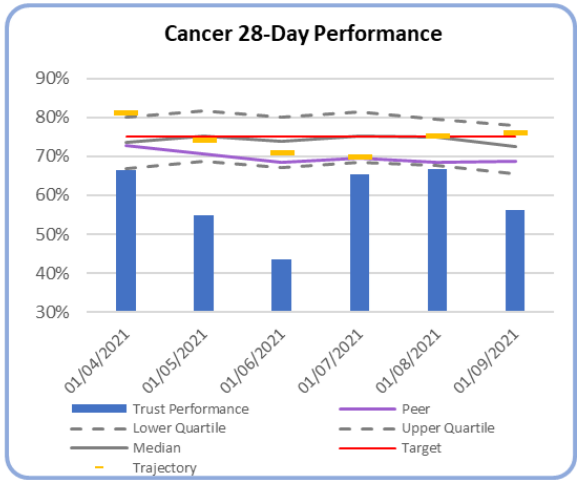
The cancer taskforce meetings have been established and now include Colorectal and Gynaecology. We continue to work with the Regional cancer team on assurance and improvement plans that provide assurance to the Executive.

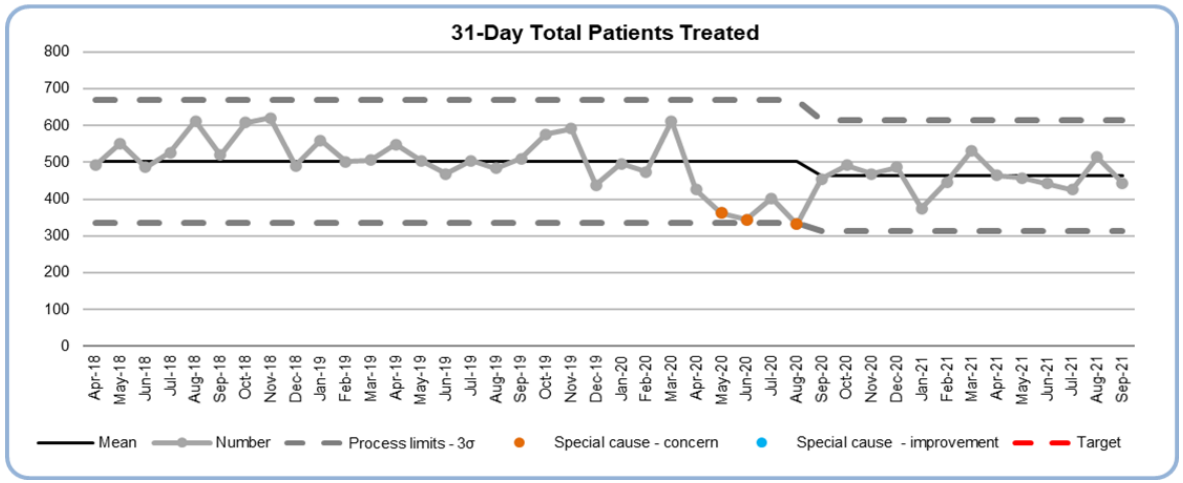
External support for Breast is being worked up to provide additional one stop and surgical capacity in late November / early December.

For Skin, backlog clearance is on track to be cleared by the end of November with additional capacity being secured to support the surgical element of the pathway.

Delays in Endoscopy continue to affect the performance of Colorectal; recovery plans are in place and expected to improve the TWW position by the end of Quarter 3.







Cancer: 31-Day Standard

What does the data tell us?

In September, the Trust missed the first treatment standard of 96.00% with a performance of 91.89% compared to the 93.00% in August. 277 patients were treated this month; 21 of them within a breach position.

The Trust continues to report in the third quartile for this standard when compared nationally.

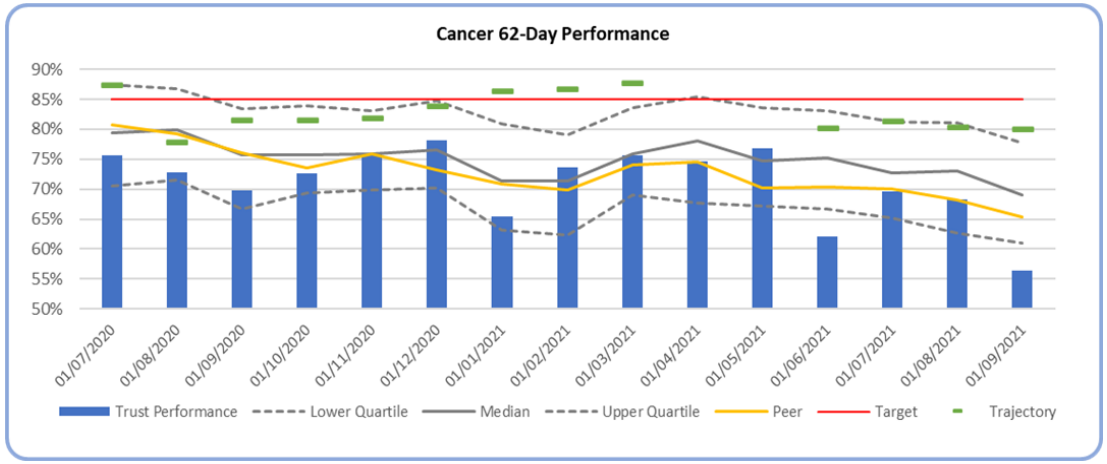
All specialties except for Breast (85.48%) and Urology (87.725) achieved above 90% this month.

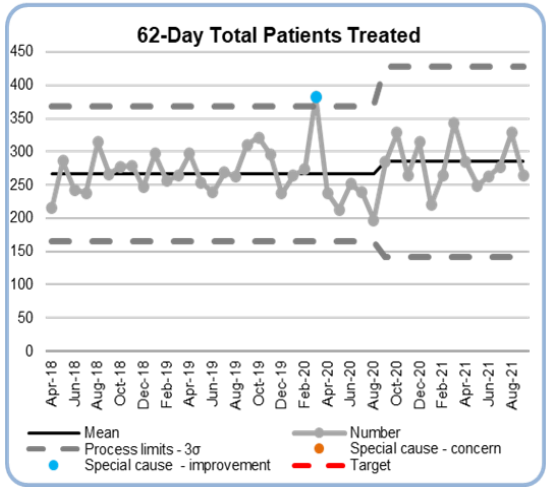
28-Day Performance – the Trust saw a deterioration this month with a performance of 56.07% compared to 66.77% in August. 1706 patients were seen and 819 of them breached the 28-Day standard. It is expected that the Trust can expect to see a recovery of this standard as backlogs are cleared and pathway delays in Endoscopy are reduced.

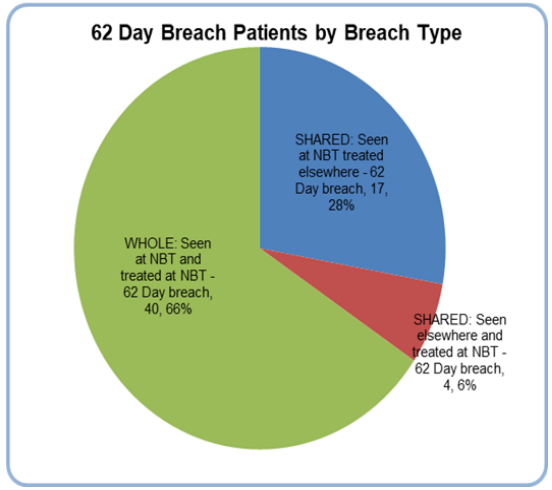
What actions are being taken to improve?

One of the factors adversely affecting performance against this standard is the reduction in tracking staff within Cancer Services. The recruitment programme has been completed and new staff on site with an extensive training programme in place .

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







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

Cancer: 62-Day Standard

What does the data tell us?

The reported 62-Day performance for September was 56.98% which is a decline compared to the August position of 68.60%. In September, of the 133 patients treated, 78 patients were treated within the standard.

Colorectal, Sarcoma, Upper GI and Haematology require improvement as they have remained in the lower quartile for performance at NBT for three consecutive months and will be included in the work of the cancer taskforce and Regional scrutiny. Improvement plans are being worked up and
specialty meetings are in place.

Gynaecology saw an improvement this month; they achieved performance of 50.00% compared to the 28.57% in August. They treated 4 patients, 2 of them in a breach position.

Urology's performance of 50.72% was disappointing, a further drop from their August performance of 61.73%. The service saw 34.5 patients with 17 breaches. They failed to achieve CWT standards of 85% and they failed to achieve their trajectory of 87.9%. Most of the delays were due to complex pathways. The service continues to have delays in the pathway due to oncology capacity prior to decision to treat.

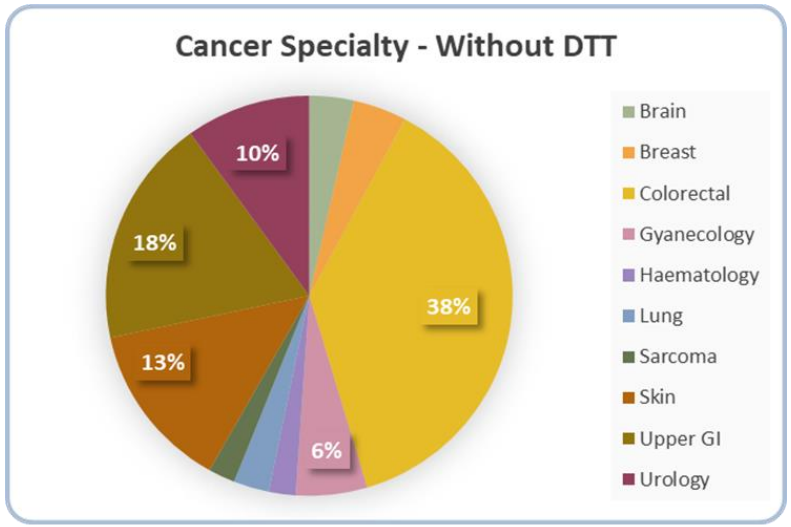
What actions are being taken to improve?

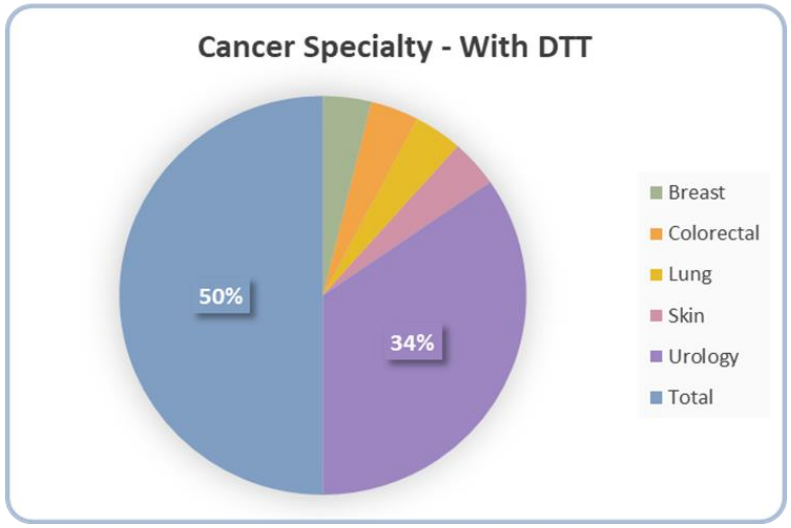
A series of taskforce meetings have been established to manage the Cancer pathways and ensure plans for improvement are in place.

Most of the September breaches were caused by the known delays at the front end of the pathway within TWW. The performance against the 62-Day standard will continue to show improvement as backlogs are cleared. Pathway reviews are ongoing.

A remedial action plan has been requested from Urology to support their 62-Day recovery.

Progress against the H2 PTL trajectory is being tracked via the H2 Recovery Board.





Cancer: 104-Day Patients

What does the data tell us?

August uploaded position
The Trust had one 104-Day breach this month that required Datix compared to the ten last month. This is the lowest position NBT has had since December 2020. Two were in Urology and one in Breast, all of which were due to system delays and complex pathways.

The Urology 104-Day breaches continue to remain low and are usually unavoidable due to late transfers from other providers.

Live PTL snapshot as of 11/11//2021
There are 154 patients waiting over 104-Days which is an increase of 1 in the last month of September. Colorectal patients are currently accounting for 35% of the total number of patients waiting over 104-Days, 141 are currently without a decision to treat.

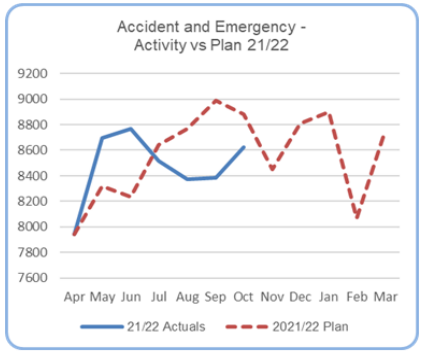
Instances of clinical harm remain low month-on-month and the Trust has only identified one moderate harm in the last 12-months as a result of delays over 104-Days.

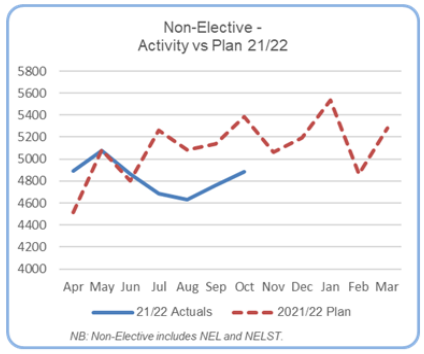
We have sustained the overall 104-Day numbers again this month, we are continuing to work on the PTL tracking backlog and this work will be completed within the next two weeks which will help with the overall 104-Day position.

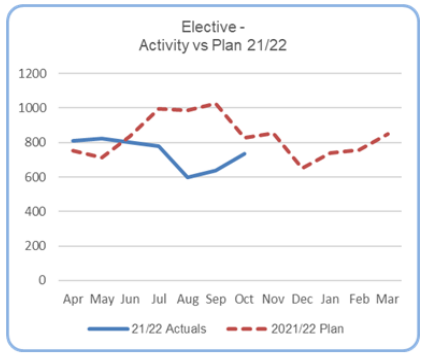
What actions are being taken to improve?

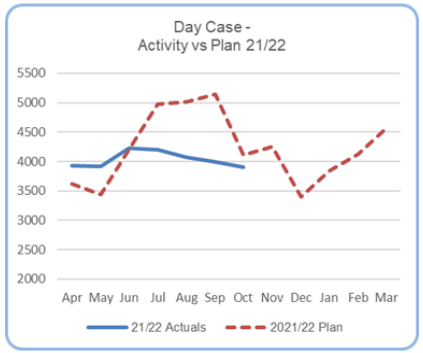
Recruitment has been completed with most of them starting in November, however the impact on tracking will continue until they are trained fully.

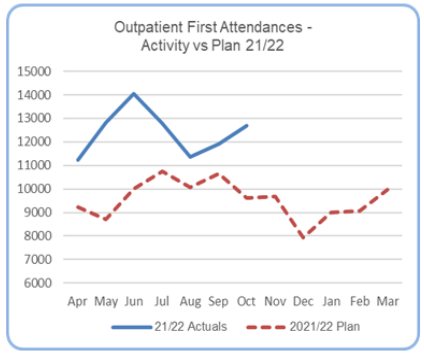
A series of taskforce meetings have been established to manage the Cancer pathways and ensure plans for improvement are in place which will also help to reduce the 104-Day delays.

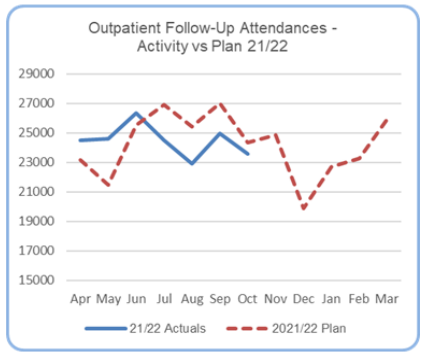


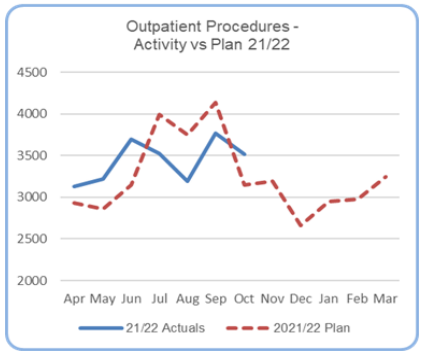


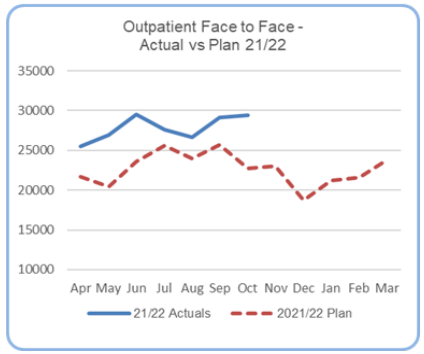


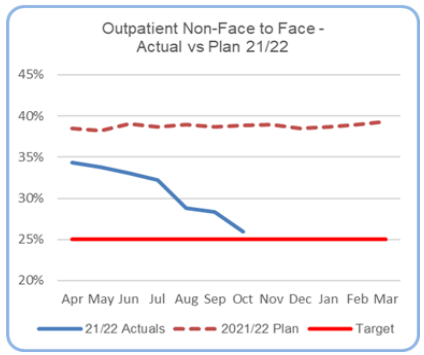












Activity vs Plan

What does the data tell us?

ED Attendances reported 3.73% above plan for Quarter 1 with a decline against plan from July, reporting -4.24% adverse variance against plan for Quarter 2 and a -2.93% adverse variance against plan for October.

Non-Elective Inpatients reported 3.01% above plan for Quarter 1 with a decline from July reporting -9.08% adverse variance against plan for Quarter 2 and a -9.22% adverse variance against plan for October.

Elective Inpatients reported above plan for April and May with a decline from June onwards. Quarter 1 reported 5.61% variance against plan, with June's underperformance being offset by the over performance in April and May. Quarter 2 reports -33.00% adverse variance to plan and a -11.20% adverse variance against plan for October.

Day Case activity reports a decline against plan from July. Quarter 1 reported 7.27% variance against plan, reporting above plan for each month. Quarter 2 reports an underperformance of -18.88%, and an underperformance of -5.10% for October.

Outpatient First Attendances have consistently reported above plan this year to date, reporting 36.38% variance in Quarter 1 and 14.63% variance in Quarter 2. For October, a 31.86% variance above plan was reported.

Outpatient Follow-Up Attendances reported above plan consistently through Quarter 1 with an overall variance of 7.57%. Achievement against plan has deteriorated in Quarter 2 reporting -8.90% adverse variance to plan, and for October a -3.23% adverse variance to plan.

Outpatient Face-to-Face attendances have reported consistently above plan this year to date with virtual attendances reporting below plan. Despite virtual attendances reporting adverse variance to plan, the 25% target has been achieved in all months this year to date.

Safety and Effectiveness

Board Sponsors: Medical Director and Deputy Chief Executive and Director of Nursing and Quality
Tim Whittlestone and Helen Blanchard

NBT - PQSM

	Target	Jun-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	TREND
Perinatal Morbidity and Mortality inborn												
Total number of perinatal deaths		2	1	0	2	1	0	2	2	4	3	
Number of stillbirths 16 to 23+6 weeks excl. TOP		0	0	0	0	0	0	1	2	0	2	
Number of stillbirths (>=24 weeks excl. TOP)		2	1	0	2	1	0	0	0	2	1	
Number of neonatal deaths : 0-6 Days		0	2	1	0	0	2	0	0	1	0	
Number of neonatal deaths : 7-28 Days		1	0	1	0	0	0	1	0	1	0	
Suspected brain injuries in inborn neonates (no structural abnormalities) grade 3 HIE 37+0 (HSIB)		0	0	0	0	0	0	0	0	0	1	
Maternal Morbidity and Mortality												
Number of maternal deaths (MBRRACE)		0	0	0	0	0	0	0	0	0	0	
Number of women who received level 3 care		0.2%	0.2%	0.0%	0.0%	0.2%	0.0%	0.2%	0.0%	0.4%	0.2%	
Insight												
Number of datix incidents graded as moderate or above (total)		3	1	2	1	2	2	3	0	1	2	
Datix incident moderate harm (not SI, excludes HSIB)		2	0	0	0	2	2	0	0	0	1	
Datix incident SI (excludes HSIB)		1	1	2	1	0	0	0	0	1	0	
New HSIB SI referrals accepted		0	0	0	0	0	1	3	0	1	1	
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0	1	1	0	0	0	
Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0	0	0	0	
Workforce												
Minimum safe staffing in maternity services: Obstetric cover (Resident Hours) on the delivery suite		83	83	83	83	83	83	83	83	83	83	
Minimum safe staffing in maternity services: Obstetric middle grade rota gaps		1	1	1	0	0	0	0	0	0	1	
Minimum safe staffing in maternity services: Obstetric Consultant rota gaps		0	1	1	1	1	1	1	0	1	1	
Minimum safe staffing in maternity services: anaesthetic medical workforce (rota gaps)		Data Not Available (DNA)				0	0	0	0	1	1	
Minimum safe staffing in maternity services: Neonatal Consultants workforce (rota gaps)		Data Not Available (DNA)				1	1	1	1	1	1	
Minimum safe staffing in maternity services: Neonatal Middle grade workforce (rota gaps)		Data Not Available (DNA)				2	2	1	1	1	1	
Minimum safe staffing: midwife minimum safe staffing planned cover versus actual prospectively (number unfilled bank shifts).		Data Not Available (DNA)				11%	13.5%	10.7%	10.7%	15%	14%	
Vacancy rate for midwives (black = over establishment, red = under establishment		14.5	10.5	15.9	15.9%	14.0%	5.7%	10.0%	2.0%	2.5%	2.9%	
Minimum safe staffing in maternity services: neonatal nursing workforce (% of nurses BAPM/QIS trained)		Data Not Available (DNA)				47%	47%	43.0%	47.0%	35%	42%	
Vacancy rate for NICU nurses		Data Not Available (DNA)				7.7	7.7	7.7	10	10	10	
Datix related to workforce (service provision/staffing)		5	12	33	14	21	27	16	14	11	8	
MDT ward rounds on CDS (minimum 2 per 24 hours)		Data Not Available (DNA)				57%	57%	57%	67.7%	70%	71%	
One to one care in labour (as a percentage)		Data Not Available (DNA)				98.6%	99.6%	98.2%	98.6%	98.5%	98.9%	
Compliance with supernumerary status for the labour ward coordinator	100%	Data Not Available (DNA)				DNA	DNA	DNA	DNA	97.8%	95%	
Number of times maternity unit attempted to divert or on divert		0	1	0	0	0	1	2	3	1	4	
Number of consultant non-attendance to 'must attend' clinical situations		Data Not Available (DNA)				DNA	DNA	DNA	DNA	0	0	
Involvement												
Service User feedback: Number of Compliments		12	8	12	29	39	10	12	27	56	66	
Service User feedback: Number of Complaints		8	12	14	21	15	9	25	36	6	5	
Staff feedback from frontline champions and walk-abouts (number of themes)		3	3	2	0	4	3	5	6	6	3	
Improvement												
Progress in achievement of CNST/10		7	8	8	9	10	10	10	10	7	7	
Training compliance in maternity emergencies and multi-professional training (PROMPT)	90%	45%	40%	53%	58%	72%	76%	76%	76%	76%	42%	
Fetal Monitoring training compliance core competency 4, personalised	90%	25.1%	36.0%	40.1%	46.8%	51.1%	42.9%	42.9%	42.9%	42.9%	7%	
Continuity of Carer (overall percentage)		Data Not Available (DNA)				DNA	DNA	DNA	DNA	DNA	DNA	
		19.7%	20.6%	16.9%	21.1%	18.9%	16.7%	19.7%	13.9%	13.6%	16%	

Maternity - Perinatal Quality Surveillance Monitoring (PQSM) Tool

NHS North Bristol NHS Trust

What does the data tell us?

The PQSM provides oversight on locally collected safety intelligence. The areas of focus from October's data are identified below:

- 1 x new HSIB referral. 1 x moderate harm report relating to post partum;

WORKFORCE

- ***Midwifery*** Internal and external funding is supporting the recruitment of an additional 22.5 wte clinical midwives. Recruitment is ongoing for 28 wte, which takes into account vacancies.
- ***Obstetrics***: External funding uplift now obtained via Ockenden monies to support Consultant led MDT ward rounds.
- ***Neonatal Consultants***: Currently 2 Consultant Rota gaps. Middle grade tier now full. Plan to create a partial gap as SAS doctor plans to act up to cover Consultant rota gaps.
- ***Neonatal Nursing***: Vacancy currently sits at 10 WTE with 42% unavailability for October 2021, compounded by increasing maternity leave. Focused recruitment is in progress
- **Diverts:** On 4 occasions, Cossham Birth Centre was placed on divert due to deployment of available staff to CDS and other inpatient settings.

Staff and Service users Involvement: Planned presentation of the Maternity Picker Report to be shared with Division 22nd of November and actions to be agreed with the involvement of the Maternity Voices Partnership. Staffing across the perinatal service continues to be the most frequently raised safety concern by staff. The staffing mitigations are described in further detail above.

The last 2 months have seen a significant reduction in the number of complaints; this is due in part to the improvements in the capacity of the sonography service.

Maternity Incentive Scheme (MIS): Revised change to the MIS Year 4 as of October 2021. For October, NBTs compliance confidence forecast remains at 7 out 10. 3 areas require more work to secure compliance: Safety Action 2 – Maternity Services Data Set; Safety Action 6 - Saving Babies lives; SA 7 - Maternity Voices Partnership (MVP).

Continuity of Carer: New national technical guidance published October 2021. Service strategy in response being developed.

Training: Progress towards the compliance with the training elements for Safety Action 6 (fetal monitoring) and Safety Action 8 MDT emergency skills training are being monitored through Maternity Speciality Governance. Currently we are on target to meet the minimum requirements by April 2022.

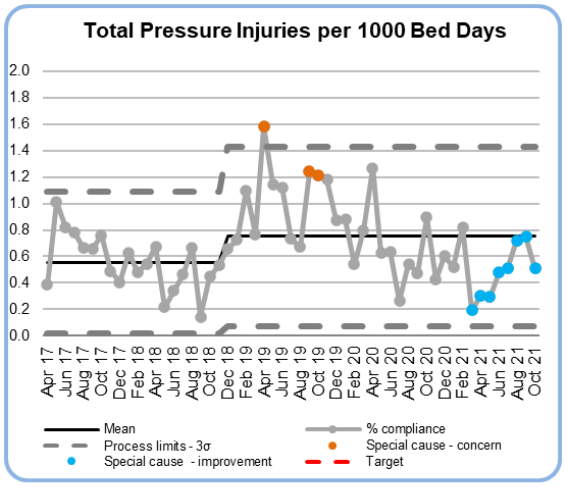
Areas of excellence: Leading the way in response in developments to support patient safety in the Covid-19 pandemic, including implementing a ground-breaking drug therapy for Covid positive pregnant women and community saturation monitoring for our Covid positive pregnant population.

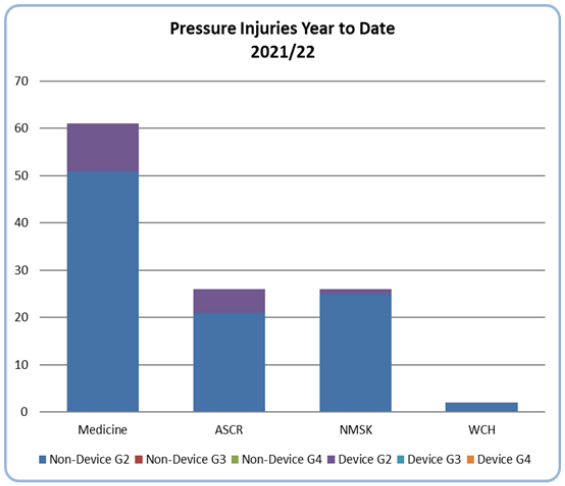
COVID-19 Maternity: There were 11 positive cases of COVID-19 in maternity in October.

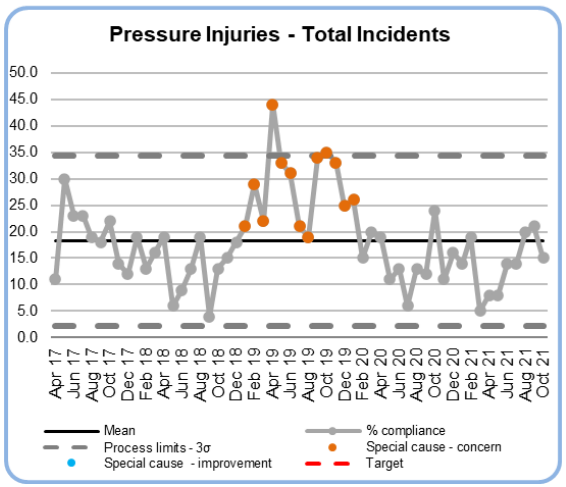
What actions are being taken to improve?

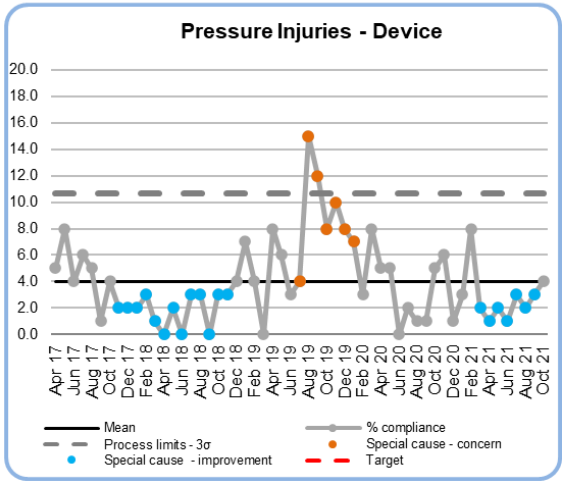
- ***Midwifery workforce***: Ongoing work within Division to address identified clinical midwifery staffing issues, including Birth Rate plus reassessment and development of business cases.
- ***Obstetric Workforce***: Review of existing job plans finalised and business case to be completed for further uplift. Business case submitted for O&G consultant expansion; Funding approved for fetal medicine consultant now out to advert.
- ***Workforce - Diverts***: A full Birthrate+ exercise is planned to explore both NBT's individual service needs and BNSSG system wide requirements to meet full CoC service delivery.

QP2









Pressure Injuries

What does the data tell us?

In October, there was a decrease in the number of Grade 2 pressure injuries and a slight increase in the number of medical device related Grade 2 pressure injuries, which is above the mean rate for devices.

The Trust ambition for 2021/22 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 3 or 4 pressure injuries in October.
19 Grade 2 pressure injuries were reported of which 4 were related to a medical device.
One unstageable pressure injury was validated to Gate 37 – the After-Action Review process has been undertaken in line with the Patient Safety Incidence Response Framework.

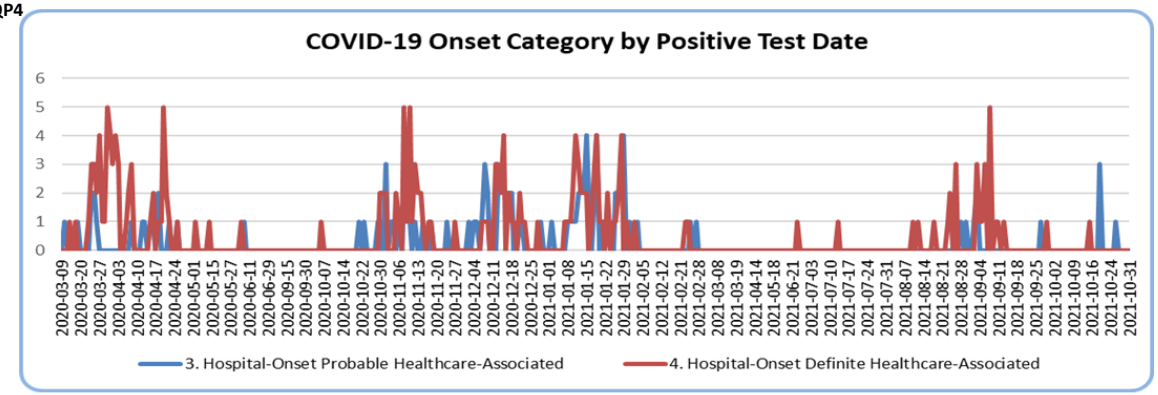
The incidence summary for October is as follows:
Medical Devices: 21%
Heels: 32%
Sacrum/ Buttocks: 26%
Foot/ Spine: 21%

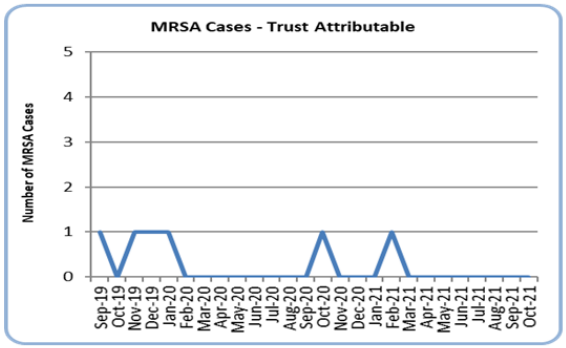
What actions are being taken to improve?

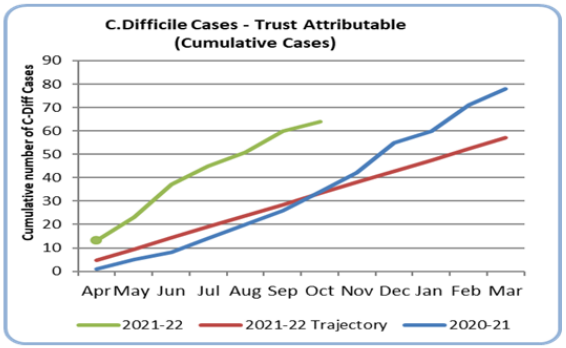
This month, the Tissue Viability team have been undertaking face to face teaching as well as the ongoing monthly MS team webinars relating to specific themes and trends identified through learning reviews.

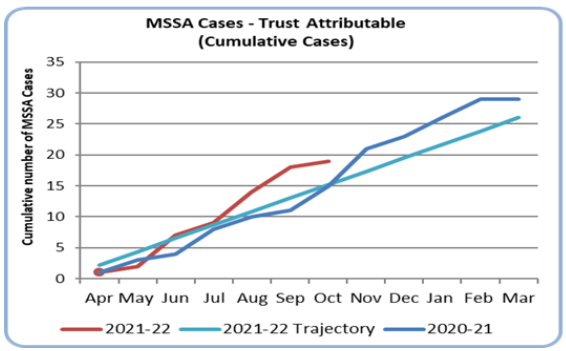
To assist the introduction of the 'RAG rating' support system which will be implemented in November to each inpatient clinical area, collaborative working with the wider MDT has been undertaken, including the QI and Patient Safety team. The support system will ensure an individualised review of the clinical area to develop sustainable action plans to reduce hospital acquired pressure injuries.

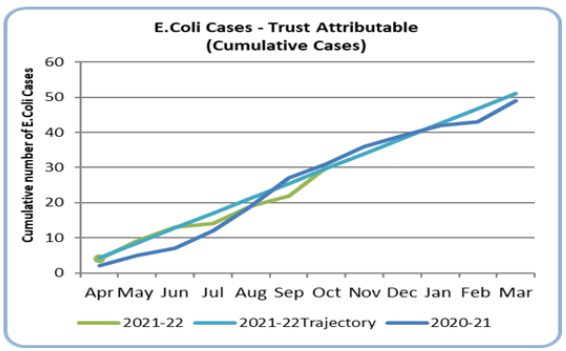
QP4











Infection Prevention and Control

What does the data tell us?

COVID-19 (Coronavirus)
Regionally there had been a peak in a Covid surge; above the national prediction. These patients have the highly contagious Delta + Variant. This resulted in a move to 2 full blue wards at one stage .We have seen a lower number of ITU admissions, with an increase in the use of high flow O2 at ward level. We have continued to see a reduction in outbreaks.

MRSA
Last bacteraemia was reported in Feb 2021.

C. difficile
C. difficile trajectory 2021/22 has been set at 52. The remains higher than trajectory – note slight reduction of cases in the last 2 months.

MSSA
MSSA cases continue to be higher than trajectory.
Gram –ve

Trajectory set for a 5% reduction of cases for 21/22 based on 2019/20 figures.

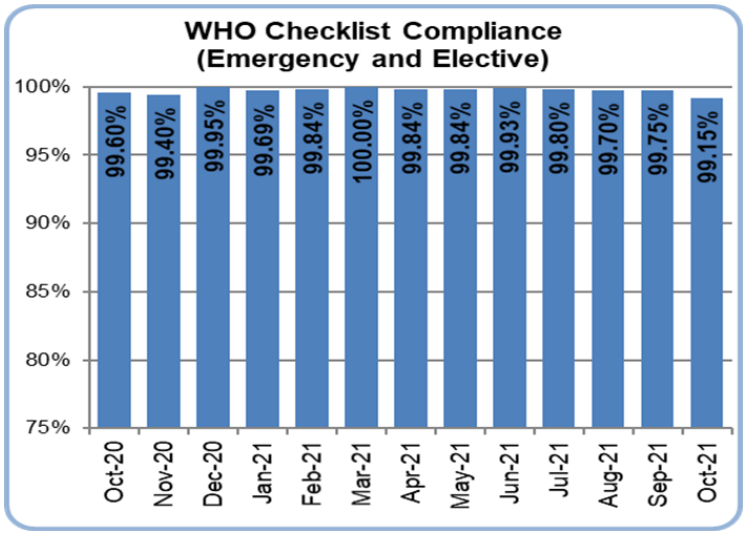
IPC teams have continued to support and educate teams managing Pandemic response as well as other infections, Ongoing VRE outbreak and NICU Pseudomonas increased incidence. The team has also supported the staff vaccination tent along with colleagues from Tissue Viability .

What actions are being taken to improve?

HCAI reduction – Teams have been actively involved with Infection Prevention Week teaching at ward level and participating at Regional / National events .

C Diff - Southwest C Diff HCAI collaborative has held initial sessions with shared learning and plans to look at reduction of infection, focusing on Antimicrobial Stewardship .

QP2

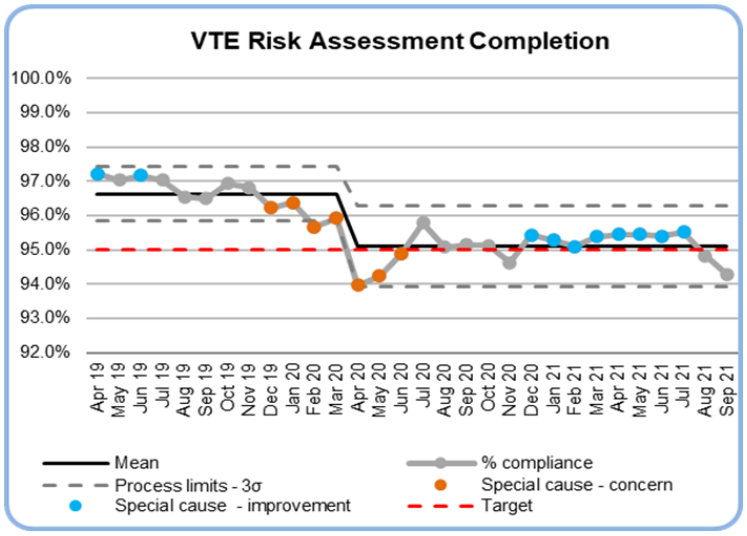


WHO Checklist Compliance

What does the data tell us?

In October, WHO checklist compliance was 99.15%. The Board expects that a WHO surgical safety checklist will be completed and documented prior to each operation in theatres.

The IPR report of less than 100% is due to issues with data capture. All cases where WHO was not recorded electronically are reviewed to ensure that checklist compliance was recorded in the paper medical records, therefore meaning that the correct checks were undertaken in practice.



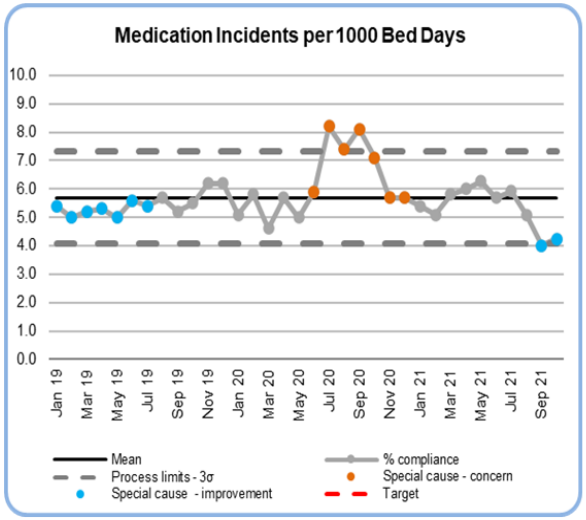
VTE Risk Assessment

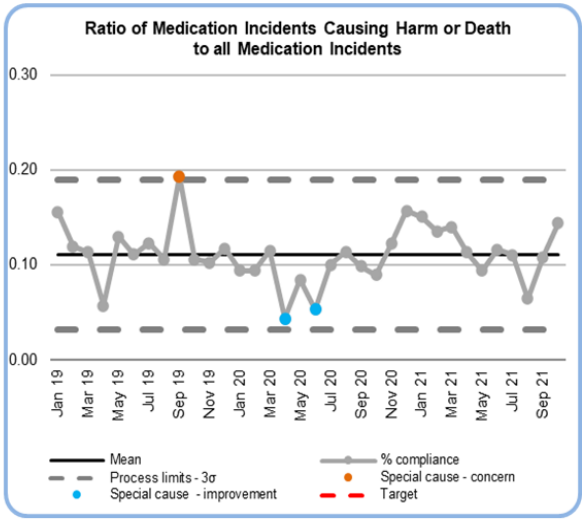
What does the data tell us?

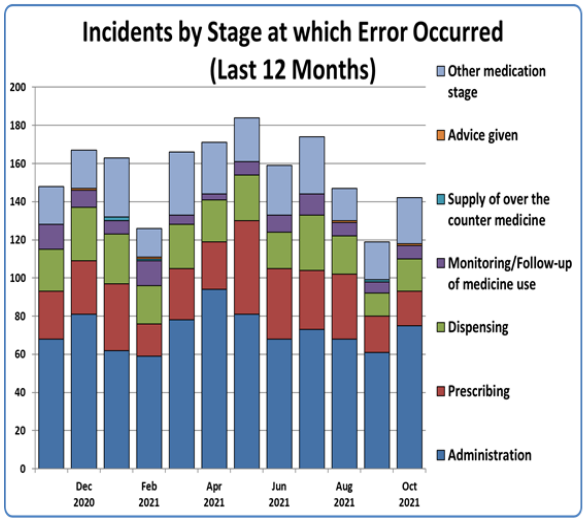
In September, the rate of VTE Risk Assessments performed on admission was 94.29%. VTE risk assessment compliance is targeted at 95% for all hospital admissions.

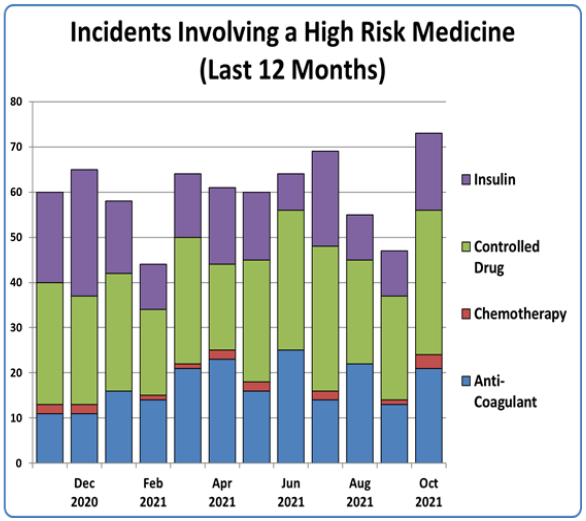
Compliance with this target fell during 2020/21, the Thrombosis committee reviewed the reasons and remedial actions had restored this to acceptable levels during 2021/22.

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









Medicines Management Report

What does the data tell us?

NBT had a rate of 4.2 medication incidents per 1000 bed days. This is lower than the mean average over the last 6 months. The organisation was under significant operational pressure during October so it is unclear if this reduction is due to a change in reporting practices or a genuine reduction.

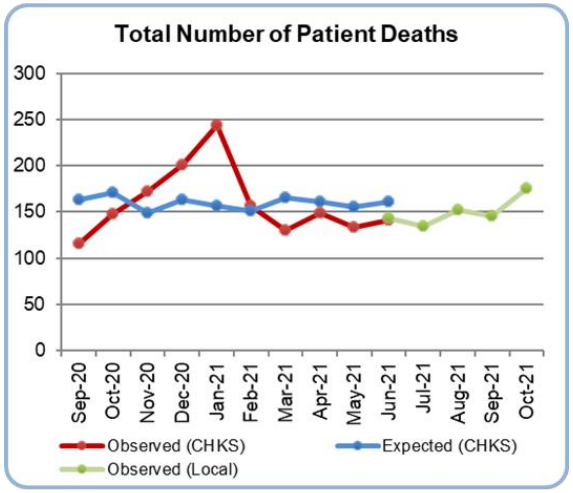
Ratio of Medication Incidents Reported as Causing Harm or Death to all Medication incidents
During October 2021, c.14% of all medication incidents are reported to have caused a degree of harm (depicted here as a ratio of 0.14). This is the highest percentage in the last 6 months. However, the actual number of incidents reported as causing any degree of harm is consistent with the last 6 months, therefore this indicates a reduction in the reporting of incidents causing 'no harm'. 'No harm' incidents accounted for 86% of all NBT reported medication incidents.

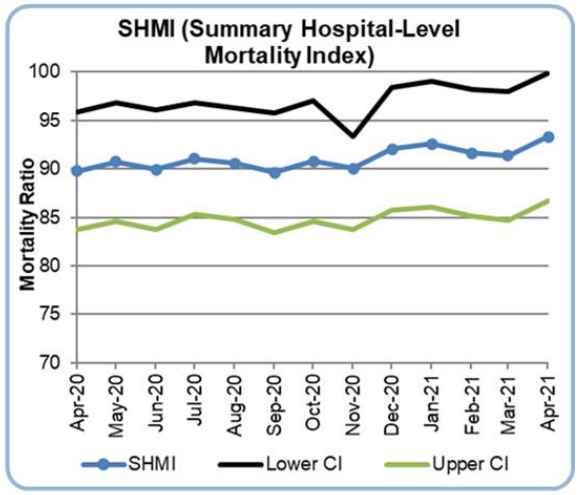
Incidents by Stage
Incidents occurring at the 'administration' stage accounted for c.53% of all medication incidents in October 2021, with the next most frequent stage being 'other', where c.17% of incidents occurred. This is consistent with the last 6 months.

High Risk Drugs
During October 2021, c.53% of all medication incidents involved a high risk medicine, which is an increase of 10% on September and 18% on August. There has also been a 36% increase in the actual number of incidents involving a high risk medicine in October compared to September, demonstrating that these incidents are occurring more frequently.

What actions are being taken to improve?

The Medicines Governance Team continue to encourage reporting of all incidents via divisional channels.
The team are working on identifying causes for the increase in incidents involving high risk medicines in collaboration with ward teams.
Validation of incidents by stage is a priority to ensure work streams are directed to the most appropriate areas.





Mortality Review Completion

Sep 20 – Aug 21	Completed	Required	% Complete
Screened and excluded	986		
High priority cases	267		
Other cases reviewed	662		
Total reviewed cases	1915	1976	96.9%

Overall Score	1=very poor	2	3	4	5= Excellent
Care received	0.0%	4.8%	24.6%	43.9%	26.7%

Date of Death	Sep 20-Aug 21
Scrutinised by Medical Examiner	1205
Referral to Quality Governance team	131

Mortality Outcome Data

What does the data tell us?

Mortality Outcome Data
An increase in deaths was seen in December 2020 and January 2021 which is likely to have been the result of increasing COVID-19 infections and has since reduced.
There are no current Mortality Outlier alerts for the trust.

Mortality Review Completion
The current data captures completed reviews from Sep 20 – Aug 21. In this time period 96.9% of all deaths had a completed review, which includes those reviewed through the Medical Examiner system.

Of all "High Priority" cases, 93% completed Mortality Case Reviews (MCR), including 20 of the 20 deceased patients with Learning Disability and 24 of the 27 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 95% (score 3-5). There have been 16 mortality reviews with a score of 1 or 2 indicating potentially poor, or very poor care which undergo a learning review through divisional governance processes.

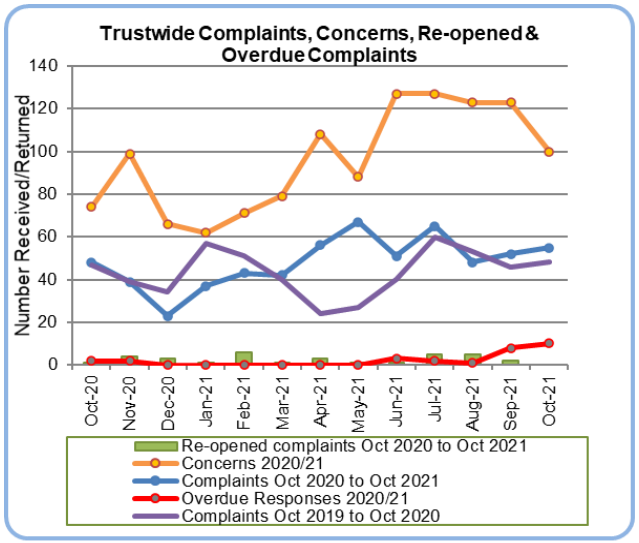
What actions are being taken to improve?

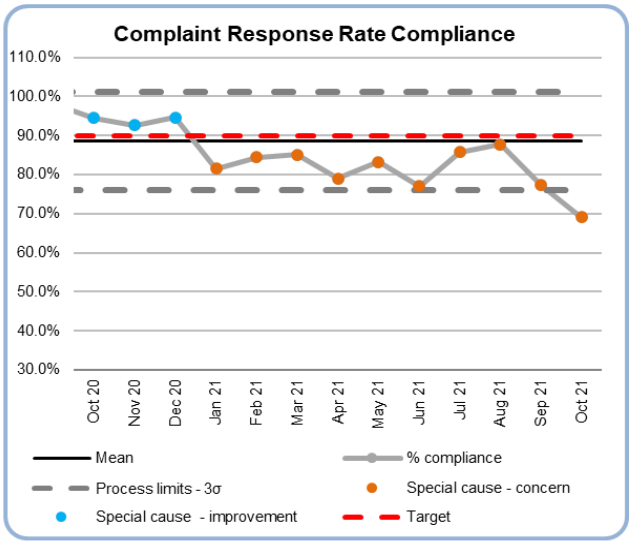
The Learning from Deaths Development Sessions have concluded, which focused on further enhancements to promote a learning culture that leads to improvement as an outcome from these reviews. To ensure that principles agreed within these sessions are appropriately considered and taken forward, an end of programme report will be tabled at the Clinical Effectiveness and Audit Committee in January 2022, with input from Specialty Mortality Leads including actionable next steps.

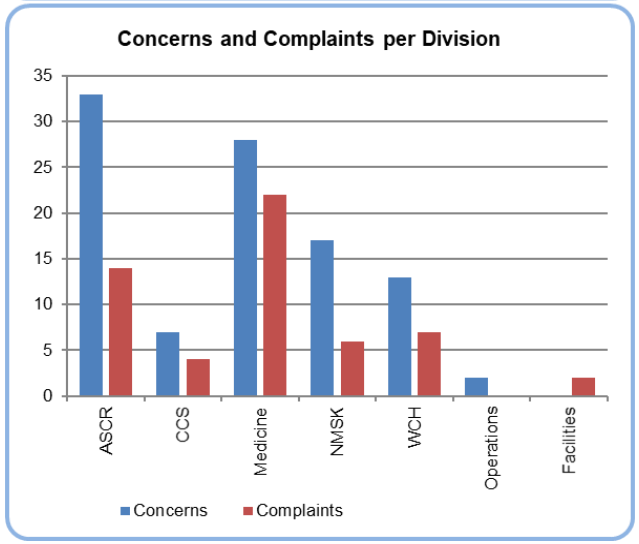
The development sessions also engaged one of the NHSE/I regional quality leads with an expertise in mortality and Learning From Deaths and we will imminently be discussing this with Royal Cornwall Hospital, aligned to work they are currently undertaking of a similar nature to share thinking and potential improvements.

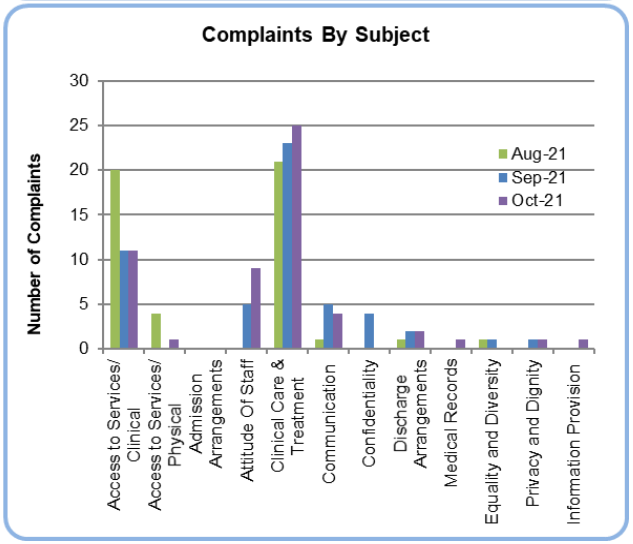
Patient Experience

Board Sponsor: Director of Nursing and Quality
Helen Blanchard









Complaints and Concerns

What does the data tell us?

In October 2021, the Trust received 55 formal complaints. The most common subject for complaints remains 'Clinical Care and Treatment'.

The 55 formal complaints can be broken down by division: (the previous month total is shown in brackets)

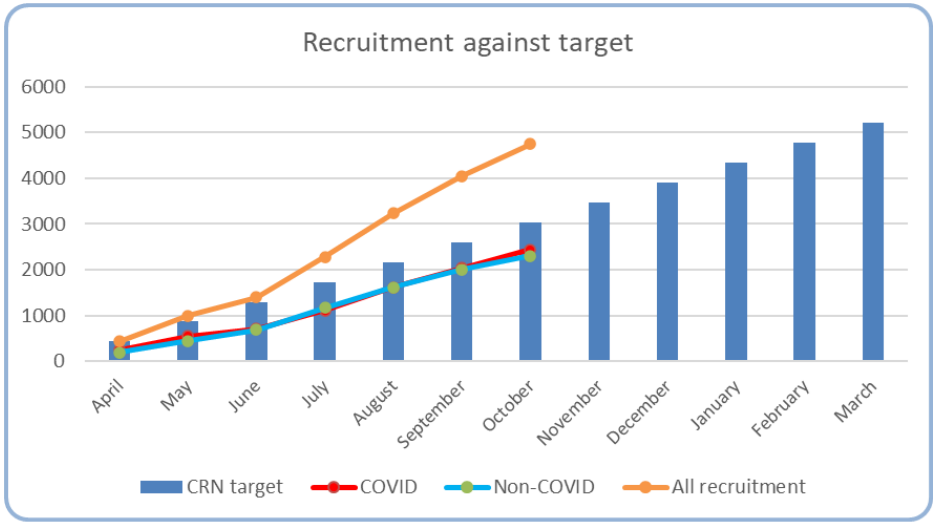
ASCR	14	(10)	CCS	4	(2)
Medicine	22	(19)	NMSK	6	(8)
WCH	7	(10)	Operations	2	

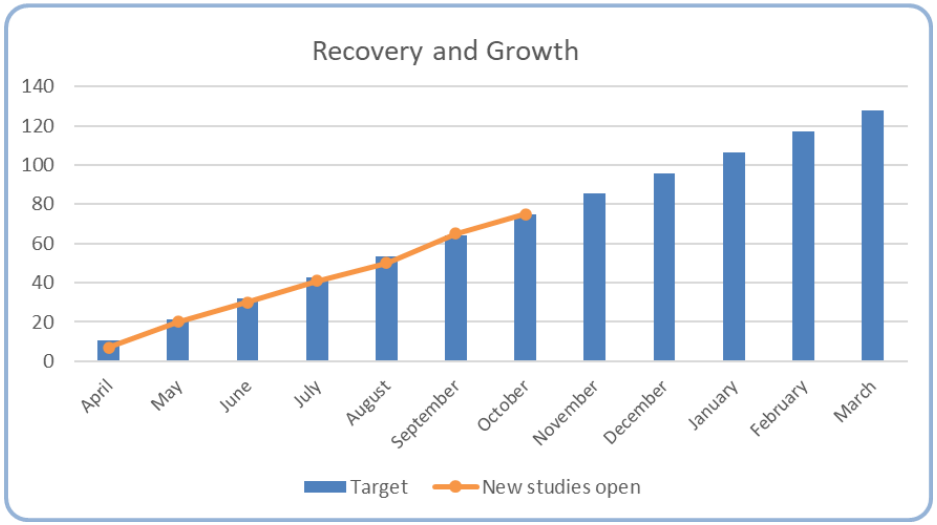
The number of PALS concerns received by the Trust remains high. In October, 100 PALS concerns were received, this is down slightly on the previous few months however the number of enquires was up from 65 in September to 72 in October.

The response rate compliance for complaints was 69% in October. This is a further fall in performance from September and is well below the Trust target of 90%. In addition to this, we have a concerning number of overdue complaints for the second month. At the time of reporting there are 10 overdue complaints. 6 of the overdue complaints are in Medicine, 3 in ASCR and 1 in WaCH. This is an ongoing problem with staffing in the Divisional Patient Experience Teams in Medicine and ASCR, and capacity of clinical staff to address complaints and attend LRMs. The risk has been added to the risk register.

What actions are being taken to improve?

- Weekly validation/review of overdue complaints by Patient Experience Manager (ongoing)
- Active recruitment to vacant posts
- Central complaints team assisting by sending holding letters to complainants to advise when their complaint is with the Chief Executive Office for sign off.





Research and Innovation

What does the data tell us?

NBT is showing strong performance in rebuilding our research portfolio and recruiting participants to trials. Recruitment is currently at 159% target to date, with an increasing performance in non COVID research activities.

In addition to restarting many of our studies paused to recruitment during COVID in 20-21 we have opened 75 new studies year to date, this matches study set up rates seen in previous years.

NBT Research Strategy is due to be updated in 2022. R&I are starting the engagement programme and will be reaching out to all our stakeholders over the next 2-3 months to ensure our strategy for 2022-2027 reflects the needs and aspirations of the Trust and our communities.

NBT currently leads 60 externally funded research grants, to a total value of £27.2m. This includes 31 prestigious NIHR grants, across a range of specialities, which total £25.7m. Our NIHR funding success rate for 2021 is now at 83% (far higher than the ~25% national average). In addition NBT is a partner on 55 externally-led research grants, to a total value of £10.3m to NBT.

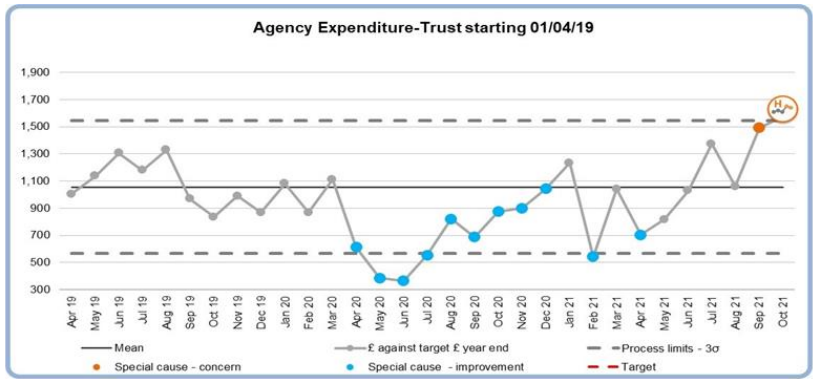
The Southmead Hospital Charity has very kindly agreed to provide additional funding to permit NBT to run two SHC Research Funding calls per annum. The SHC Research Fund welcomes research applications from all NBT staff members to undertake a small pump-priming research project (up to a maximum of £20k) in any subject area. Round 13 is currently open for applications with a deadline of 24th November 2021.

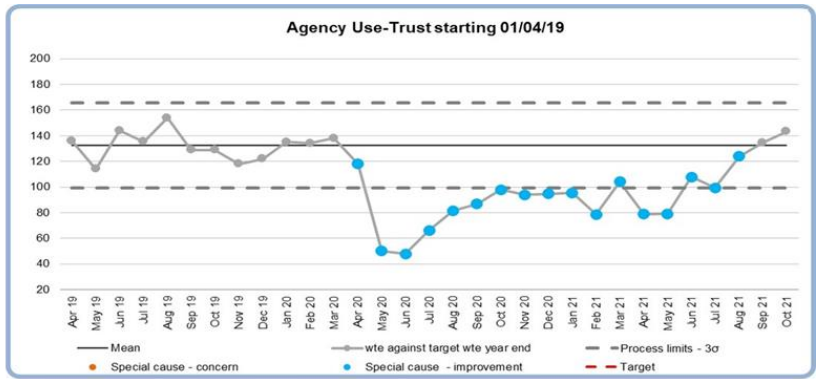
In addition, with support from Southmead Hospital Charity, R&I are piloting a SHC Infrastructure call this year; welcoming applications from across NBT, for research facilitator staff to be embedded within NBT teams, departments, divisions to develop research themes and pipelines of research grants applications (up to £100k). This call will open w/c 15th November 2021.

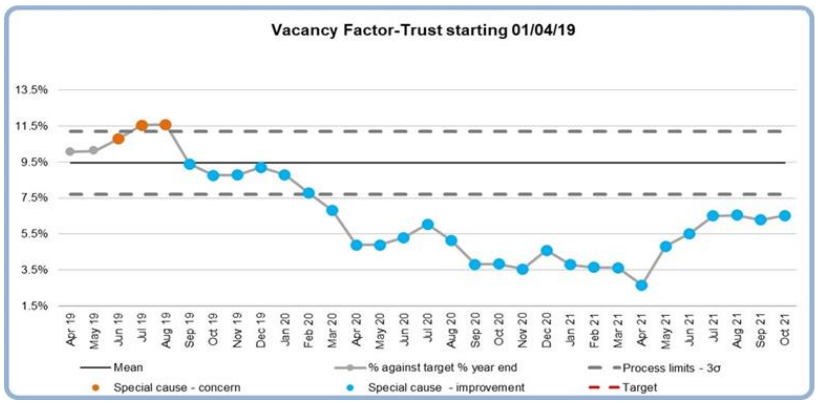
Well Led

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

Workforce







What Does the Data Tell Us – Vacancies Nursing and Midwifery

Band 2 and 3 saw a net increase of 17 wte vacancies with band 2 seeing an increase and band 3 a decrease. The band 2 position is being driven by increasing turnover. **Resourcing position:**

- Offered 17 new candidates band 2 and 3 roles in October and saw 9 new starters.
- Continue to advertise for Band 2 staff on rolling basis but application quality has dipped for the last few months.
- Latest band 3 role has just closed with 35 candidates to shortlist.

Band 5 vacancies decreased further in October (ongoing intake of newly qualified staff) to 135.8 with a vacancy factor of 10.36%. **Resourcing position:**

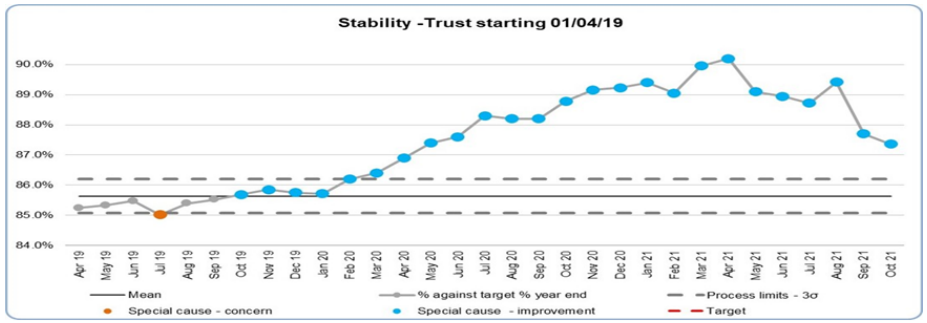
- 80 band 5 candidates in our pipeline with 23 booked to start in the next 3 months.
- Attended the RCNi careers fair in Birmingham in October meeting over 50 new candidates
- Nursing Careers Webinar was attended by 33 candidates and we made 16 offers over 2 days

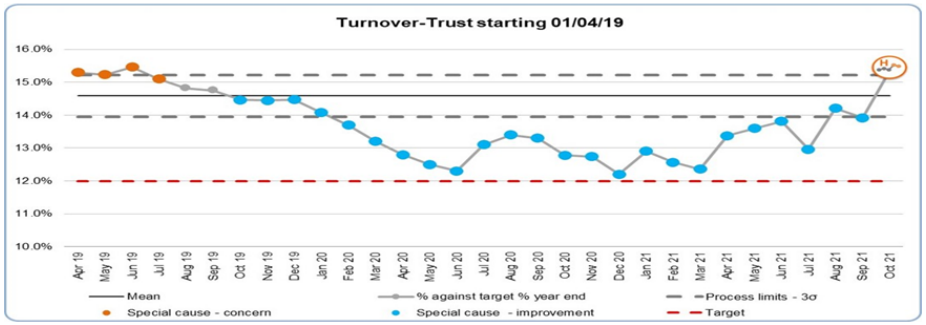
Actions – Vacancies and Temporary Staffing

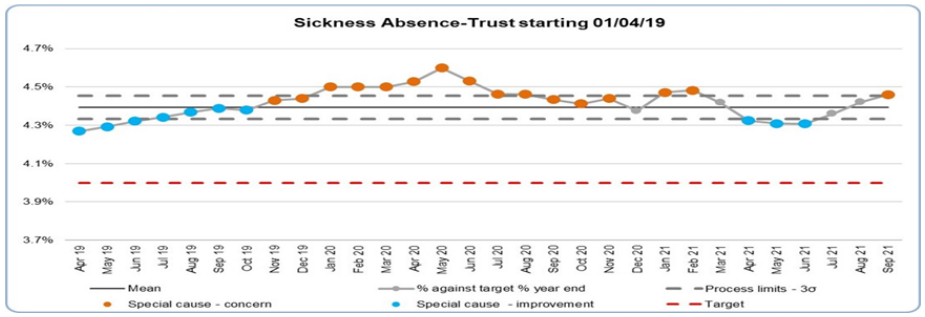
Head of Resourcing

- Working with Learning and Development to engage more bank only staff to convert to substantive via apprenticeship route – **Dec-21**
- Wider, paid for advertising to counter labour market challenges for band 2 toles – **Dec-21**
- Bank recruitment activity has been increased in all staff groups – **Ongoing**
- Agency approvals have been provided in advance, to improve agency fill rates where appropriate – **Oct-21 and ongoing**

Engagement and Wellbeing







What Does the Data Tell Us - Turnover and Stability

Whilst the October 2021 turnover position is more positive than the same point pre-Pandemic turnover continues to rise across all staff groups.

A key risk between now and April 22 is the potential to lose more staff due to the compulsory requirement for NHS staff to be Covid vaccinated.

Actions - Turnover and Stability

Head of People

- Nursing and Midwifery Supply and Demand group has formally commissioned the Retention Task and Finish group to prioritise and progress the retention actions agreed in October. New analysis of Q2 leavers data has occurred and is being fed in. **Action:** Progress to be reviewed at next Supply and Demand meeting **- Nov-21.**

- Work has started to develop a NBT and system-wide response to this through the establishment of key workstreams. **Actions:**

    - Weekly meetings implemented, aligned to workstreams. Regular updates to occur via Silver and Gold cells and BNSSG governance structures **– Nov-21**

    - Turnover to be closely monitored and 'Compulsory Vaccination' as a reason for leaving to be added to our NBT leaver's questionnaire **– Nov-21**

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

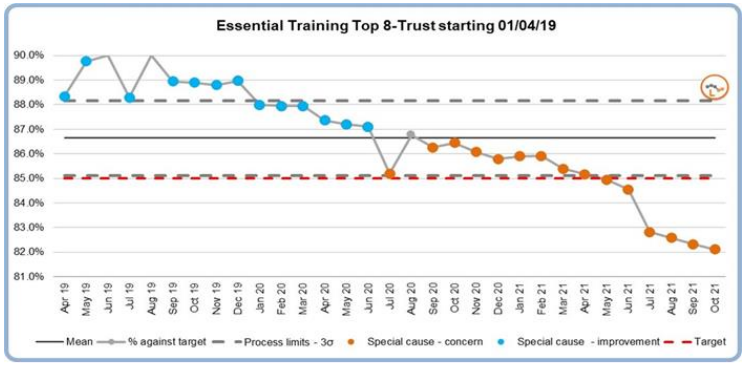
In addition to the adverse position with *Stress/anxiety/depression/other psychiatric illness, Cough/cold/influenza* saw the greatest increase with an 86.71% increase in October compared to September (September saw a 96.72% increase compared with August)

Actions - Sickness and Health and Wellbeing

Head of People and Head of People Strategy

- Our new draft sickness policy (more supportive and simple in style and practical application); has been discussed and agreed at JUC. **Action**: Submission to JCNC sub-group for next stage of sign off - **Dec 21**

- Financial Support for staff proposal being developed – **Dec 21**



Training Topic	Variance	Sep-21	Oct-21
Child Protection	-0.4%	83.0%	82.7%
Adult Protection	-0.5%	84.2%	83.7%
Equality & Diversity	0.2%	85.4%	85.6%
Fire Safety	-0.3%	82.9%	82.6%
Health &Safety	-0.8%	85.3%	84.5%
Infection Control	-0.8%	89.8%	89.0%
Information Governance	-0.8%	79.4%	78.6%
Manual Handling	2.0%	67.2%	69.2%
Waste	-0.4%	84.0%	83.6%
Total	**-0.2%**	**82.32%**	**82.12%**

What Does the Data Tell Us - Essential Training

Throughout the pandemic, essential training compliance has shown a downward trend across the Trust and has been below the minimum threshold of 85% since March-21.

Face to face Manual Handling update sessions have been replaced by eLearning, this has increased accessibility to sessions and has led to a continued uptake in compliance

Actions – Essential Training

Head of Learning and Organisational Development

- Kallidus Learn which will replace NBT's MLE platform will give Managers greater oversight of team members compliance – **Jan-22**
- A new focus group to be established with representation from 9 essential training topics. A clear improvement strategy to be created and circulated to key stakeholders – **Dec-21**

Other Wider Actions

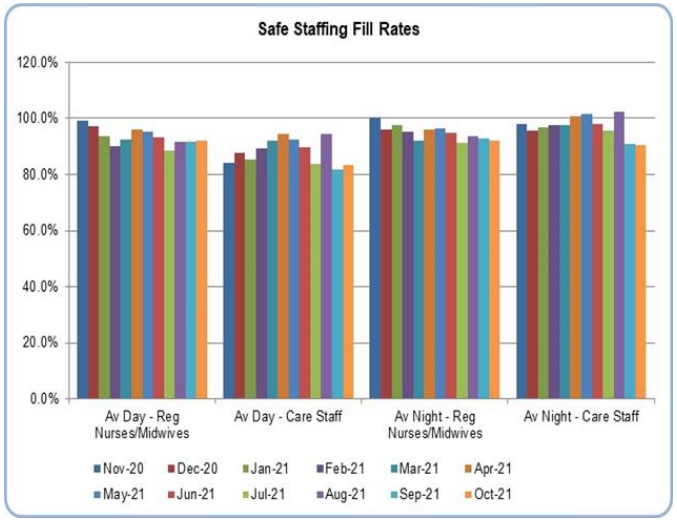
Head of Learning and Organisational Development

Leadership & Management Development

- With the increased number of Critical Incidents across the hospital, delegate attendance at workshops from clinical workforce has been disrupted – aim to reschedule programme activity after February 22 to avoid impact during winter
- Second cohort for the ILM Level 2 Leadership & Team Skills Award successfully launched October' 21 – 11 delegates

Apprenticeships

- HEE funding received to create 2 new B2 Healthcare Scientist Apprenticeships within Cardio Physiology. NBT is supporting Healthier Together in assessing the feasibility of converting these roles to be rotational across the ICS.
- NBT Apprenticeship Levy Utilisation for October -21 = 73%



Oct-21	Day shift		Night Shift	
	RN/RM	CA Fill	RN/RM	CA Fill
Southmead	92.1%	83.5%	91.9%	90.4%

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.

What Does the Data Tell Us

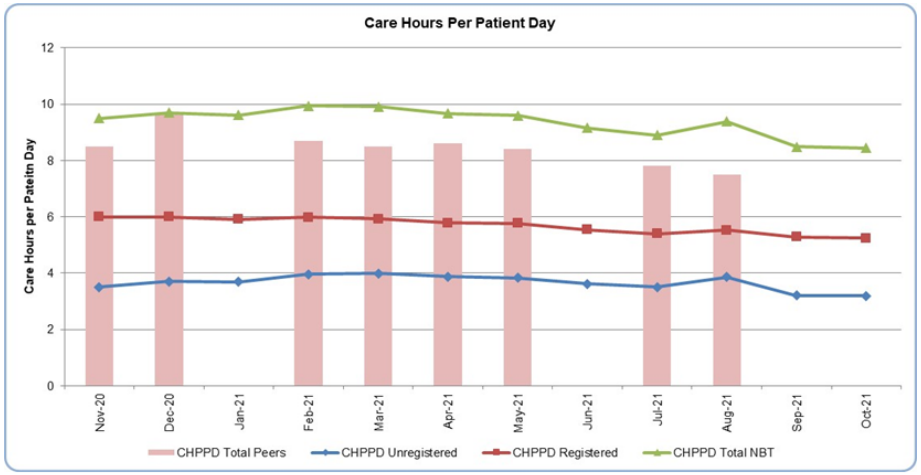
The safe staffing report now requires the wards to identify Nursing Associates including Trainees and AHP staff employed in an inpatient area. There are however ongoing issues with the reporting and this has been escalated to Allocate the roster provider. We will be back reporting as soon as it is possible.
Staff absence related to Covid self-isolation impact experienced during October as can be seen below. There is an organisational focus on recruiting to Care Staff (HCSW) vacancies.

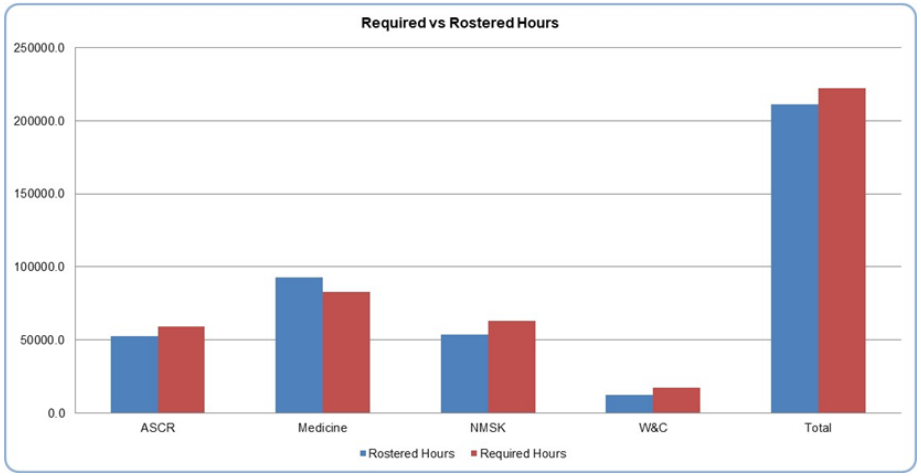
Wards below 80% fill rate for Registered Staff:
for all areas safe staffing maintained through daily staffing monitoring and supplementing with unregistered staff as required
7a (76.5% Day / 69.3% Night) staffing supplemented with redeployed RNs and HCSW.
CDS (74.5% day / 67.8% Night) vacancies, staffing deployed as required to meet patient needs across the service.
Percy Phillips (65.8% Day) vacancies, staffing deployed as required to meet patient needs across the service.
Mendip (77.2% Day / 76% Night) vacancies, staffing deployed as required to meet patient needs across the service.

Wards below 80% fill rate for Care Staff:
for all areas safe staffing maintained through daily staffing monitoring and supplementing with registered staff as required
9b (65.9% Day) Unregistered staff vacancies and absence.
AMU (65.2% Night) Unregistered staff vacancies and absence
28b (76.3% Day) staffing supplemented with redeployed RNs
34b (59.7% Day / 57.2% Night) Unregistered staff vacancies
Medirooms (59.7% Day / 57.2% Night) Unregistered staff vacancies
8b (56.7% Day) Unregistered staff vacancies
26b (76.6% Day) staffing supplemented with redeployed RNs
26a (79.6% Day) Unregistered staff vacancies and absence
NICU (29.2% Day / 43.5% Night) Unregistered staff vacancies, safe staffing maintained
through daily staffing monitoring and supplementing with registered staff as required.
Quantock (62.3% Day / 73.1% Night) vacancies, staffing deployed as required to meet patient needs across the service.
Mendip (74.9% Night) vacancies, staffing deployed as required to meet patient needs across the service.

Wards over 150% fill rate for Registered Staff:
Elgar (155.8% Day) patients requiring enhanced support with Registered Mental Health nursing

Wards over 150% fill rate for Care Staff:
33a (169.4% Night) patients requiring enhanced care support
Rosa Burden (163.2% Day / 171.2% Night) patients requiring enhanced care support





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

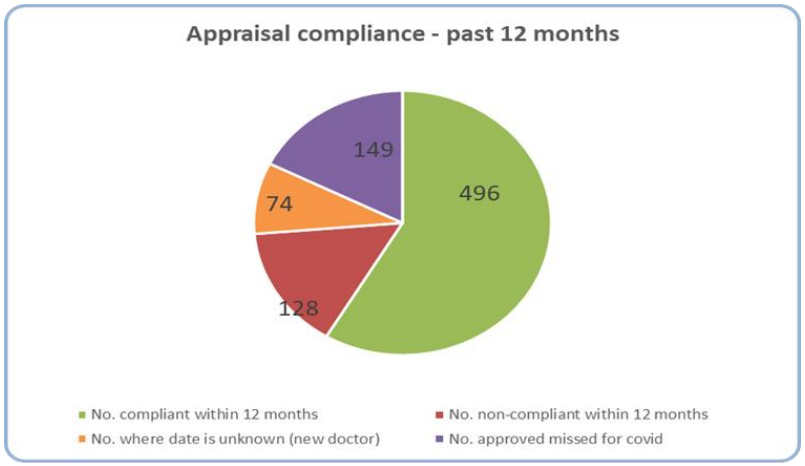
The chart shows care hours per patient day for NBT total and is split by registered and unregistered nursing. The chart shows CHPPD for the Model Hospital peers (all data from Model Hospital).

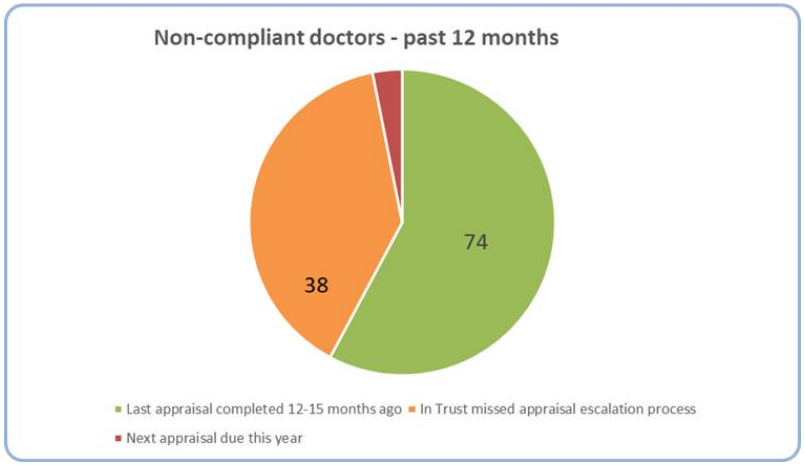
CHPPD are consistent with last month, rostered hours overall are above the required hours due to the decreased patient census and reduced lists.

Safe Care Live (Electronic Acuity Tool)

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

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





Medical Appraisal

What does the data tell us?

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

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

All revalidations prior to the 16th March 2021 were automatically deferred by the GMC for 12 months. The process restarted in full in March 2021. Due to these automatic deferrals, the number of revalidations due in 2021/22 has now risen.

What actions are being taken to improve?

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

Where possible, the revalidation team are making revalidation recommendations early for those doctors who were automatically deferred in order to reduce the number that will be due in 2021/22.

Finance

Board Sponsor: Chief Financial Officer
Glyn Howells

Statement of Comprehensive Income at 31st October 2021

	M7 Budget £m	M7 Actual £m	M7 Variance £m	YTD Budget £m	YTD Actuals £m	YTD Variance £m
Contract Income	55.7	55.9	0.2	385.6	393.4	7.8
Other Income	6.0	8.3	2.2	41.0	47.3	6.3
Pay	(37.3)	(37.4)	(0.1)	(260.0)	(261.1)	(1.1)
Non-Pay	(24.8)	(26.8)	(2.0)	(166.6)	(179.6)	(13.0)
Surplus/(Deficit)	**(0.4)**	**(0.0)**	**0.4**	**(0.0)**	**(0.0)**	**(0.0)**

Assurances

The year to date financial position to the end of October 2021 shows a breakeven position which is in line with Plan.

The Trust has made no changes to its forecast outturn of a breakeven position for the year and is formally reviewing the position during month 7 and also month 9.

Statement of Financial Position at 31st October 2021

	20/21 M12 £m	21/22 M06 £m	21/22 M07 £m	In-Month Change £m	YTD Change £m
Non Current Assets					
Property, Plant and Equipment	579.3	578.0	577.1	(0.9)	(2.2)
Intangible Assets	14.7	12.1	12.0	(0.2)	(2.8)
Non-current receivables	1.7	1.7	1.7	0.0	0.0
Total non-current assets	**595.8**	**591.8**	**590.8**	**(1.0)**	**(5.0)**
Current Assets					
Inventories	8.5	9.0	8.8	(0.3)	0.2
Trade and other receivables NHS	10.2	23.1	18.6	(4.5)	8.4
Trade and other receivables Non-NHS	26.3	26.6	28.7	2.1	2.4
Cash and Cash equivalents	121.5	94.4	104.3	9.9	(17.2)
Total current assets	**166.5**	**153.0**	**160.3**	**7.3**	**(6.2)**
Current Liabilities (< 1 Year)					
Trade and Other payables - NHS	26.9	4.9	6.9	2.0	(20.0)
Trade and Other payables - Non-NHS	98.7	103.7	100.3	(3.4)	1.6
Deferred income	8.5	9.7	18.3	8.6	9.9
PFI liability	12.3	15.2	15.2	0.0	3.0
Finance lease liabilities	2.8	2.5	2.4	(0.1)	(0.4)
Total current liabilities	**149.2**	**136.0**	**143.2**	**7.2**	**(5.9)**
Trade payables and deferred income	7.8	8.2	8.2	(0.0)	0.4
PFI liability	368.7	363.9	363.1	(0.8)	(5.5)
Finance lease liabilities	3.9	2.9	2.7	(0.1)	(1.2)
Total Net Assets	**232.6**	**233.8**	**233.7**	**(0.1)**	**1.1**
Capital and Reserves					
Public Dividend Capital	448.7	448.7	448.7	0.0	(0.0)
Income and expenditure reserve	(381.6)	(378.1)	(378.1)	0.0	3.5
Income and expenditure account - current year	3.5	(0.3)	(0.4)	(0.1)	(3.9)
Revaluation reserve	162.0	163.5	163.5	0.0	1.5
Total Capital and Reserves	**232.6**	**233.8**	**233.7**	**(0.1)**	**1.1**

Assurances and Key Risks

Receivables : Of the £8.4m year to date increase in NHS receivables, £2.6m relates to accrued Mass Vaccination Service income, £0.4m relates to higher NHS invoiced debt and £5.4m relates to higher accrued income across the Divisions.

Payables : Year to date NHS payables have reduced by £20.0m, of which £14.0m is a result of the monies paid in advance by NHS England relating to 2020/21, along with the settlement of a £7.9m credit note that was due to BNSSG CCG at 31 March 2021.

Cash : The cash balance has decreased by £17.2m in-year due to the settlement of a £7.9m credit note raised to BNSSG CCG in March 2021, the £14.0m return of cash paid in advance in August 2021, £3.8m payment of PDC dividend, plus increases of £5.7m cash received in advance from Health Education England.

Capital : Total capital spend to date is £10.5m, compared to a plan of £12.6m. Expenditure to date on the core plan is £5.5m below plan but this is offset by an additional £3.4m of capital expenditure on the Accelerator capital programme.

Forecast Outturn Position

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

	H1 Actual	H2 Financial Plan	21/22 Forecast	21/22 Budget
	£m	£m	£m	£m
Contract Income	337.5	338.1	675.7	662.3
Other Income	39.0	38.4	77.4	71.6
Pay	(223.7)	(233.1)	(456.8)	(442.2)
Non-Pay	(152.8)	(143.4)	(296.3)	(291.7)
Total	**0.0**	**0.0**	**0.0**	**0.0**

Risk and Mitigations

Each month an assessment of the Risks and Mitigations is completed and included in the monthly Finance Report. The Trust is developing schemes that will contribute to improving performance and / or investing in schemes that will deliver financial benefits in the 2022/23 financial year.

An increase in non-recurrent income in H2 to support recovery actions will be managed through Recovery Boards to support workstreams.

Regulatory

Board Sponsor: Chief Executive
Maria Kane

Monitor Provider Licence Compliance Statements at October 2021
Self-assessed, for submission to NHSI

Ref	Criteria	Comp (Y/N)	Comments where non compliant or at risk of non-compliance
G4	Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)	Yes	A Fit and Proper Person Policy is in place. All Executive and Non-Executive Directors have completed a self assessment and no issues have been identified. Further external assurance checks have been completed as appropriate and no issues have been identified.
G5	Having regard to monitor Guidance	Yes	The Trust Board has regard to NHS Improvement guidance where this is applicable.
G7	Registration with the Care Quality Commission	Yes	CQC registration in place. The Trust received a rating of Good from its inspection reported in September 2019. A number of mandatory actions were identified which are being addressed through an action plan. The Trust Board receives updates on these actions via its Quality 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, including an annual Internal Audit assessment.
P2	Provision of information	Yes	The trust submits information to NHS Improvement as required.
P3	Assurance report on submissions to Monitor	Yes	Scrutiny and oversight of assurance reports to regulators is provided by Trust's Audit Committee and other Committee structures as required.
P4	Compliance with the National Tariff	Yes	NBT complies with national tariff prices. Scrutiny by CCGs, NHS England and NHS Improvement provides external assurance that tariff is being applied correctly. It should be noted that NBT is currently receiving income via a block arrangement in line with national 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 guidance on service restoration.
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 2021 unless otherwise stated.

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

NBT Quality Priorities 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.

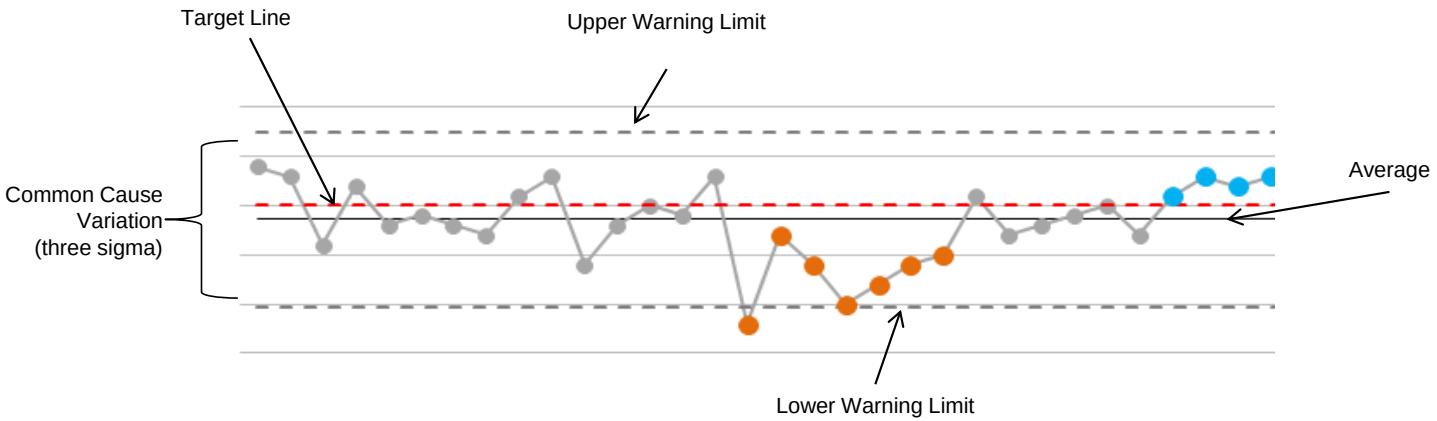
QP3 Ensuring excellence in our maternity services, delivering safer maternity care.

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
qFIT	Faecal Immunochemical Test
RAP	Remedial Action Plan
RAS	Referral Assessment Service
RCA	Root Cause Analysis
SI	Serious Incident
TWW	Two Week Wait
WCH	Women and Children's Health
WTE	Whole Time Equivalent

Appendix 2: Statistical Process Charts (SPC) Guidance



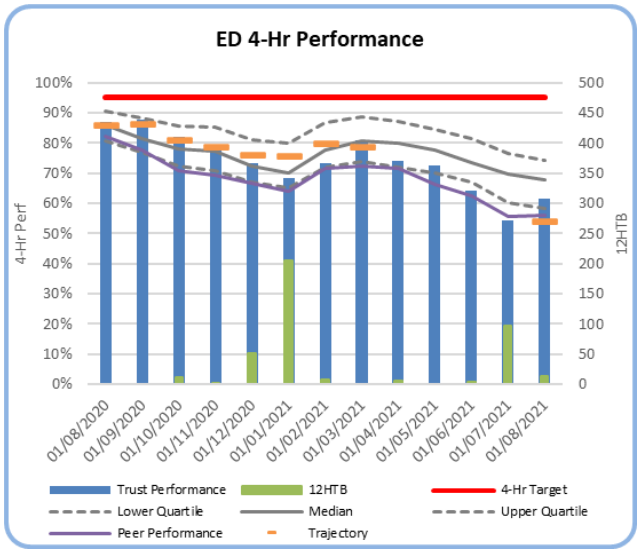
Orange dots signify a statistical cause for concern. A data point will highlight orange if it:
A) Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.
B) Runs for 7 consecutive points below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

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

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

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

Appendix 3: Benchmarking Chart Guidance



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

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

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

Quartiles are calculated using main NHS Trusts only.

Report To:	Trust Board - Public		
Date of Meeting:	25 November 2021		
Report Title:	Finance & Performance Committee Upward Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary		
Executive/Non-executive Sponsor (presenting)	Tim Gregory, Non-Executive Director		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper may need to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Committee recommends that Trust Board receive the report for assurance and note its content.		
Report History:	The report is a standing item to each Trust Board meeting following a Finance and Performance Committee. The last report was received at the October 2021 meeting.		
Next Steps:	The next report to Trust Board will be to the January 2022 meeting.		

Executive Summary	
The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the Finance & Performance Committee Meeting held on the 18 November 2021.	
Strategic Theme/Corporate Objective Links	**Provider of high-quality patient care** a. Experts in complex urgent & emergency care b. Work in partnership to deliver great local health services c. A Centre of Excellence for specialist healthcare d. A powerhouse for pathology & imaging **Developing Healthcare for the future** e. Training, educating and developing out workforce f. Increase our capability to deliver research g. Support development & adoption of innovations h. Invest in digital technology

Board Assurance Framework/Trust Risk Register Links	Reports received at the meeting support the mitigation of various BAF risks.
Other Standards Reference	Links to key lines of enquiry within the CQC regulatory framework.
Financial implications	Business cases approved by the Committee are within the delegated limits as set out in the Trust's Standing Financial Instructions and Scheme of Delegation.
Other Resource Implications	No other resource implications associated with this report.
Legal Implications	None identified.
Equality, Diversity and Inclusion Assessment (EIA)	N/A
Appendices:	Appendix 1: Finance monthly report

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1. Purpose

1.1 To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Finance and Performance Committee meeting held on the 18 November 2021.

2. Background

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

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

3.1. Operational Performance Summary

The Committee received an update on operational performance across the Trust during October 2021.

The Committee discussed a number of pressure areas, including the relatively static 2WW and 62-day cancer performance, and ongoing pressures for diagnostics activity. The drivers for this position are largely related to specialist workforce availability and the impact of Infection Prevention Control measures on efficiency.

On non-elective performance, the Committee were advised that nationally, performance is deteriorating. NBT's performance is still significantly pressured, but in some key areas it is improving, including a reduction in patients waiting 12-hours in the Emergency Department. The Trust is also benchmarking positively against other Adult Major Trauma Centres.

Trust Board will have access to the most up-to-date validated data which will be discussed under the Integrated Performance Report item.

3.2. Operational IM&T Update

The Committee received an update on the operational performance of the IM&T service across the Trust. This included updates on Clinical Coding, Data Quality, Information Governance, Business Intelligence and Medical Records.

The Director of IM&T provided a specific update on the actions being taken to appropriately validate and manage a number of open referrals which had been identified as part of the data transfer to the new Electronic Patient Record system. He confirmed that this was largely a data quality issue, and is being progressed with clinical input, working closely with the divisions.

The Committee also received an update on a recent unexpected failure of a back-up server over the preceding weekend. This was impacting the remedial work on data centre cooling

devices, which needed to be replaced. This had been delayed to mid-January 2022 pending a full Root Cause Analysis.

3.3. Finance Report (Month 7) incl. CIP update

The Director of Operational Finance provided an overview of the Trust's financial position. This identified that the actual result for Month 7 of 2021/22 is a breakeven position. The forecast outturn is that the Trust will achieve the breakeven plan at year end as well as delivering the capital plan. A copy of the report is annexed.

The Committee noted the risk of becoming long-term reliant on the significant amount of non-recurrent funding currently being used. The Chief Finance Officer confirmed that a robust process has been put in place to ensure that recurrent / non-recurrent business cases are required, and relevant budgets updated so that operationally people are very clear of their underlying recurrent budgets. However, he acknowledged the risk, particularly as non-recurrent funding is likely to be an ongoing national tool to tackle the elective backlog.

The Committee were also advised that senior resource had been identified at a system level (led by NBT) to undertake a review of the drivers of the system deficit (which is 8th worst in England), and understand organisational contributions to the overall position. A work programme was being agreed over the remainder of 2021/22 to focus on understanding the drivers and identifying actions and programmes to tackle this effectively.

3.4. Risk Reports

The Committee reviewed the Trust-level risk report and BAF report. It noted that the Committee agenda and discussion had been focused on the key risks reflected on both the Trust-Level Risk report and the Board Assurance Framework, particularly relating to operational performance, IM&T, and finance.

3.5. Committee Self-Assessment – Proposal

The Committee agreed to undertake a self-assessment questionnaire, which will be completed in 2021/22 and reported to Trust Board. It was noted that the timeliness and availability of validated performance data needed to be considered.

3.6. Business Case Update

There were no business cases for approval in November 2021. The Chief Finance Officer flagged that a December meeting of the Committee may need to be called to approve some emerging cases relating in part of the H2 recovery programme.

4. Summary and Recommendations

The Committee recommends that Trust Board receive the report for assurance and note its content.

North Bristol NHS Trust

Report To:	Finance and Performance Committee (FPC)		
Date of Meeting:	November 2021		
Report Title:	Finance Report for October 2021		
Report Author & Job Title	Simon Jones, Assistant Director of Finance – Financial Management		
Executive/Non-executive Sponsor (presenting)	Glyn Howells, Chief Financial Officer		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The FPC is asked to note: • the revised financial framework that the Trust is operating in, • Financial performance for the month and year to date • The associated assumptions, opportunities, risks, and mitigations. • the spend on Mass Vaccinations and Covid-19 expenditure areas • Delivery of Cost Improvement Plan savings and how they compare with divisional targets. • The Cash position and Capital spend levels		
Report History:	N/A		
Next Steps:	N/A		

Executive Summary
The financial framework for both H1 and H2 of 21/22 requires the Trust to deliver core operations within an agreed financial envelope and, in addition, to recover costs incurred in dealing with the Covid-19 pandemic in line with the required and prescribed national guidance. The financial performance for the year 21/22 remains to breakeven as set out in the Board approved budget paper. A phased plan was developed and submitted to NHSI in May 2021, with a further H2 update due for submission in November. The actual result for the Month 7 is a breakeven position. The forecast outturn is that the Trust will achieve the breakeven plan at year end as well as delivering the capital plan. The month 7 in month and year to date position is driven by and includes the following items: • The Trust has recognised Elective Recovery Fund (ERF) non-recurrent income of £8.9m for the year to date. The cost has accrued costs of delivery of the ERF activity to offset this income estimate. • Cash at 31st October amounts to £104.3m. The in-month increase of £9.9m is driven by £4.9m reimbursement of the pay award paid in H1 and £5.7m of cash received in advance from Health Education England.

• Total capital spend to date is £10.5m, compared to a plan of £12.6m for the first 7 months of the year. Expenditure to date on the core plan is £5.5m below plan but this is offset by an additional £3.4m of capital expenditure on the accelerator capital programme not planned at the start of the year. • The planning guidance for H2 was published on 30th September. A detailed summary of the guidance was provided in October and the financial impact on the Trust will be included and covered in the draft H2 Financial Plan which is covered in a separate paper for this meeting. • The income reported in M7 is based on notified allocations from BNSSG system.

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

1. Purpose

- This report is to inform and give an update to FPC on:
  - financial performance for October 2021 (Month 7) and the year-to-date position as at the end of October 2021.
  - This report is a standing item to the Trust Management Team and Finance and Performance Committee (FPC).
  - the revisions to the H2 financial framework that the Trust is operating in and under are summarised in the Financial Plan paper.

2. Summary

- NHSI/E has suspended the usual operational planning process for both H1 and H2 financial framework due to Covid-19 pandemic response.
- For this Financial Year the Trust is funded through a block contract arrangement and is expected to breakeven at 31st October.
- Non-recurrent income is provided to fund non-recurrent elective recovery actions including those covered by the Accelerator programme in the periods to the end of November.
- The position for the month of October shows a breakeven position for the month and year to date in line with expectations.
- No further income in respect of ERF activity were recognised in the M7 position due to the impact of COVID and the challenges with attaining the 89% RTT performance, the gateway to earning ERF.

- Cash at 31st October amounts to £104.3m. The in-month increase of £9.9m is driven by £4.9m reimbursement of the pay award paid in H1 and £5.7m of cash received in advance from Health Education England. (March 2021 balance £121.5m).
- The total value of CIP targeted for this financial year is £20.0m with £10m needed to achieve the planned outturn. The current identified CIP position is £6.0m, an increase of £0.2m compared to September with another £4.1m in the pipeline. The Trust has £1.7m (an increase of £0.5m from Month 6) completed and £1.4m (an increase of £0.7m from Month 6) implemented schemes at the end of Month 7. Further schemes will move to completed and implemented in coming months
- Total capital spend to date is £10.5m, compared to a plan of £12.6m for the first 7 months of the year. Expenditure to date on the core plan is £5.5m below plan but this is offset by an additional £3.4m of capital expenditure on the accelerator capital programme not planned at the start of the year. The Trust has a £5.9m capital plan for accelerator schemes with £3.4m spent YTD and £5.0m forecasted to be spend by the year end.
- The Trust received the guidance for the financial framework for the second half of the 21/22 financial year on 30 September and a separate paper on the H2 financial plan has been provided on the impact of this guidance including the financial elements and impacts of the guidance.
- The H2 financial plan has been developed and shows a plan to breakeven, details are included in a sperate paper. This plan includes non-recurrent income and expenditure. The System will submit its plan on 16 November and the Trust on 25 November.

3. Financial Performance

3.1. Total Trust

The table below summarises the Trust financial performance for month 7 (October) and year to date:

	M7 Budget £m	M7 Actual £m	M7 Variance £m	YTD Budget £m	YTD Actuals £m	YTD Variance £m
Contract Income	55.7	55.9	0.2	385.6	393.4	7.8
Other Income	6.0	8.3	2.2	41.0	47.3	6.3
Pay	(37.3)	(37.4)	(0.1)	(260.0)	(261.1)	(1.1)
Non-Pay	(24.8)	(26.8)	(2.0)	(166.6)	(179.6)	(13.0)
Surplus/(Deficit)	**(0.4)**	**(0.0)**	**0.4**	**(0.0)**	**(0.0)**	**(0.0)**

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

Against the requirement to break even, for the month of October the Trust delivered a breakeven position versus a budgeted deficit of £0.4m.

Contract Income year to date is £7.8m higher than planned. This is explained predominantly by non-recurrent income of £8.9m of Elective Recovery Fund ("ERF") in the year to date. The Trust has accrued costs of £8.9m in line with the income received in the year-to-date position. The ERF income is now validated and there is no material risk to the Trust.

Other Income year to date is £6.3m higher than plan, which is primarily driven by unbudgeted reimbursement income in respect of costs incurred in the Mass Vaccination programme, however this is offset by lower income from patient car parking and a reduction in the levels of private patient income. In month the Trust has also seen an additional £0.4m recovery of income in Pathology from UKHSA in relation to 20/21 costs.

Pay costs are £1.1m higher than plan year to date. The plan excluded the impact of the pay award, which we have recently received funding for. If the impact of July and August bank accelerator bank rates (£2.7m) is removed this leaves an underspend of £1.6m driven by vacancies in CCS around the Pharmacy and Therapies weekend working business cases.

Non pay costs to the end of October are £13.0m more than plan.

Non-Pay	£m	
Accelerator Programme costs	3.8	Fully Offset by Income, with further costs in H2
Service restoration costs	3.9	Non-recurrent costs
COVID System Contingency	1.9	Fully Offset by Income
Mass Vaccination Programme	1.7	Fully Offset by Income
Other	1.7	Non-delivery of CIPs offset by non-recurrent underspends clinical supplies
Total	**13.0**	

The Trust has made no changes to its forecast outturn of a breakeven position for the year having reviewed the figures during month 6. A further review will take place in month 9 and this will be reported to TMT and F&P in the January report.

The tables in sections 3.2 – 3.10 below provide the financial performance in month and YTD across North Bristol NHS Trust for the Core Trust, COVID 19, Mass Vaccination programme, Nightingale Hospital Bristol, and an analysis of the WTE position across the organisation.

3.2. Core Trust

The table below summarises the Core Trust including Accelerator Activity (excluding COVID, Mass Vaccination programme and Nightingale) financial performance for Month 7 (October) and year to date.

	M7 Budget £m	M7 Actual £m	M7 Variance £m	YTD Budget £m	YTD Actuals £m	YTD Variance £m
Contract Income	54.7	54.9	0.2	378.6	386.4	7.8
Other Income	6.0	7.4	1.3	41.0	41.6	0.6
Total Income	**60.7**	**62.3**	**1.6**	**419.6**	**428.1**	**8.4**
AHP's and STT's	(5.6)	(5.0)	0.6	(38.8)	(36.3)	2.5
Medical	(10.8)	(11.0)	(0.1)	(75.0)	(74.8)	0.2
Nursing	(12.5)	(12.5)	(0.0)	(89.1)	(90.3)	(1.1)
Other Non-Clinical Pay	(7.4)	(7.7)	(0.3)	(52.1)	(52.5)	(0.5)
Total Pay	**(36.3)**	**(36.3)**	**0.1**	**(255.0)**	**(253.8)**	**1.2**
Drugs	(4.0)	(4.2)	(0.2)	(26.9)	(28.7)	(1.8)
Clinical Supplies (Incl Blood)	(7.2)	(7.3)	(0.1)	(49.9)	(47.2)	2.7
Supplies & Services	(2.7)	(2.8)	(0.0)	(19.2)	(19.5)	(0.3)
Premises Costs	(2.9)	(2.9)	(0.0)	(19.9)	(21.1)	(1.2)
Other Non-Pay	(8.0)	(9.2)	(1.2)	(50.6)	(60.3)	(9.6)
Total Non-Pay Costs	**(24.8)**	**(26.4)**	**(1.6)**	**(166.6)**	**(176.7)**	**(10.1)**
Surplus/(Deficit)	**(0.4)**	**(0.4)**	**0.0**	**(2.0)**	**(2.5)**	**(0.5)**

As previously noted in 3.1 the key drivers of variance are the recognition of income and cost in respect of the ERF programme of £8.9m, removal of system mitigation income of £8.0m and underspends versus pay, investments and reserves.

The Core Trust position is offset by the COVID 19 allocation in section 3.3 below.

3.3. Covid 19 Total Trust.

The table below summarises the COVID-19 income and expenditure for the month and year to date.

	M7 Budget £m	M7 Actual £m	M7 Variance £m	YTD Budget £m	YTD Actuals £m	YTD Variance £m
Contract Income	1.0	1.0	0.0	7.0	7.0	0.0
Other Income	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**1.0**	**1.0**	**0.0**	**7.0**	**7.0**	**0.0**
AHP's and STT's	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.1)
Medical	(0.0)	0.0	0.0	(0.0)	(0.1)	(0.1)
Nursing	(0.0)	(0.3)	(0.3)	(0.0)	(2.3)	(2.3)
Other Non-Clinical Pay	(1.0)	(0.0)	1.0	(5.0)	(0.7)	4.3
Total Pay	**(1.0)**	**(0.3)**	**0.7**	**(5.0)**	**(3.3)**	**1.7**
Drugs	0.0	0.0	0.0	0.0	(0.0)	(0.0)
Clinical Supplies (Incl Blood)	0.0	0.0	0.0	0.0	(0.0)	(0.0)
Supplies & Services	0.0	(0.2)	(0.2)	0.0	(0.4)	(0.4)
Premises Costs	0.0	(0.1)	(0.1)	0.0	(0.8)	(0.8)
Other Non-Pay	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.1)
Total Non-Pay Costs	**0.0**	**(0.3)**	**(0.3)**	**0.0**	**(1.3)**	**(1.3)**
Surplus/(Deficit)	**(0.0)**	**0.4**	**0.4**	**2.0**	**2.5**	**0.5**

The Covid Financial Position as at the end of October 2021 and year to date include:

- £1.0m monthly income allocation
- In October £0.3m was spent to cover additional sickness and COVID related absences
- In October £0.3m was non-pay spend covering additional premises costs (cleaning and security costs).
- Ward 9B has now been fully converted to a blue COVID-19 ward to help manage the impact of the rising COVID numbers. The current assumption is that any surplus non-recurrent COVID funding will be retained by the trust and not refunded.

3.4 Mass Vaccination

The table below summarises the Mass Vaccination Programme income and expenditure for Month 7 (October) and year to date:

	M7 Budget £m	M7 Actual £m	M7 Variance £m	YTDB Budget £m	YTDA Actuals £m	YTDV Variance £m
Contract Income	0.0	0.0	0.0	0.0	0.0	0.0
Other Income	0.0	0.9	0.9	0.0	5.6	5.6
Total Income	**0.0**	**0.9**	**0.9**	**0.0**	**5.6**	**5.6**
AHP's and STT's	0.0	(0.1)	(0.1)	0.0	(0.4)	(0.4)
Medical	0.0	(0.0)	(0.0)	0.0	(0.2)	(0.2)
Nursing	0.0	(0.3)	(0.3)	0.0	(2.3)	(2.3)
Other Non-Clinical Pay	0.0	(0.3)	(0.3)	0.0	(1.0)	(1.0)
Total Pay	**0.0**	**(0.7)**	**(0.7)**	**0.0**	**(3.9)**	**(3.9)**
Drugs	0.0	0.1	0.1	0.0	0.0	0.0
Clinical Supplies (Incl. Blood)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)
Supplies & Services	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)
Premises Costs	0.0	(0.2)	(0.2)	0.0	(1.4)	(1.4)
Other Non-Pay	0.0	(0.0)	(0.0)	0.0	(0.3)	(0.3)
Total Non-Pay Costs	**0.0**	**(0.2)**	**(0.2)**	**0.0**	**(1.7)**	**(1.7)**
Surplus/(Deficit)	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**	**(0.0)**

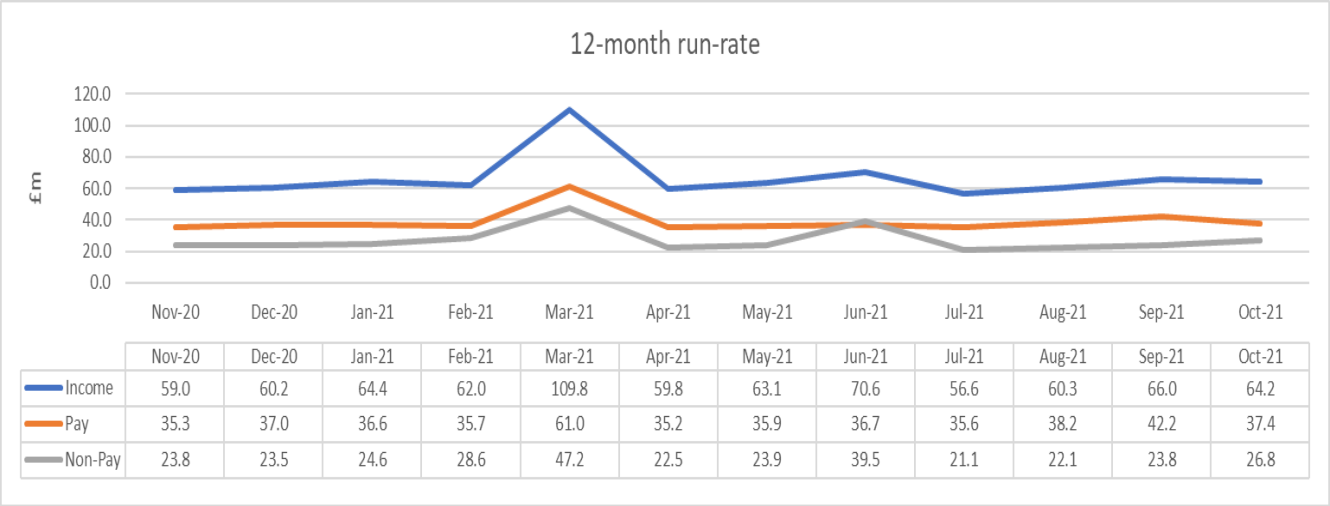
Durng October 2021 the Trust has continued delivery of Mass COVID-19 Vaccinations, which reulted in additional Pay Costs of £0.8m which is offset by the income the trust receives for this sevice. All the figures in the table above are in line with forecast. The majority of costs incurred are staff related as consumables as drugs costs are being met with nationally supplied stock. Income in line with expenditure was recorded and a breakeven position for year to date and Month 7 is reported.

3.5 Nightingale Hospital Bristol

These figures are no longer reported as the facility is now closed.

3.6 Trust Trends

The chart below sets out the income, pay and non-pay trends for the total Trust over the last 12 months. The March 2021 position shows the impact of one items including the annual leave accrual, the impact of the employers contribution to pensions, PPE costs and the income to offset these.



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Income	59.0	60.2	64.4	62.0	109.8	59.8	63.1	70.6	56.6	60.3	66.0	64.2
Pay	35.3	37.0	36.6	35.7	61.0	35.2	35.9	36.7	35.6	38.2	42.2	37.4
Non-Pay	23.8	23.5	24.6	28.6	47.2	22.5	23.9	39.5	21.1	22.1	23.8	26.8

The table below sets out the normalised income position:

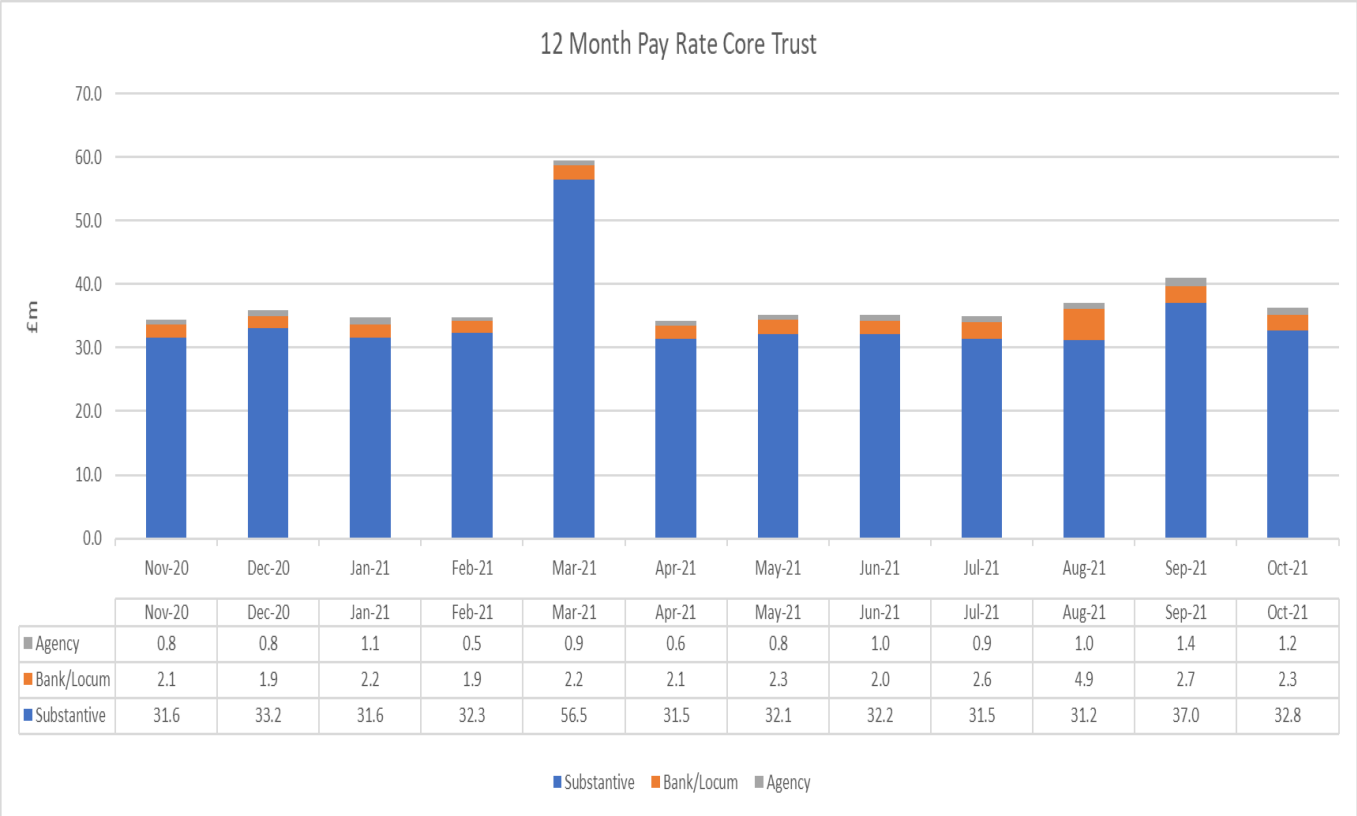
	M1	M2	M3	M4	M5	M6	M7	YTD
	£m	£m	£m	£m	£m	£m	£m	£m
Total income	**59.8**	**63.1**	**70.6**	**56.6**	**60.3**	**66.0**	**63.9**	**440.3**
Timing of year end income	2.0	(2.0)						0.0
ERF delivery	3.6	3.6	(6.9)	(0.3)				0.0
Mitigations deferral	(1.3)	(1.3)	(1.3)	4.0				0.0
High cost devices income	0.4	0.4	0.4	0.4	(1.6)			0.0
Pay Award Recognition	0.9	0.9	0.9	0.9	0.9	(4.3)		0.0
Total income	**65.3**	**64.6**	**63.6**	**61.6**	**59.6**	**61.8**	**63.9**	**440.3**

The Pay award recognition has been spread over 6 months at £0.9m a month including Month 6, when £5.1m was also received giving a total of £4.3m for the month.

The above table shows the impacts of one off non-recurrent transactions in a particular month, that relate to prior periods and how these impact the total income figure when extrapolated over the months they relate to.

Pay reduced slightly in October following the ceasing of the Accelerator programme, which resulted in spend of £2.4m in August and £0.7m in September, and the backdated element of the National Pay Award in September of £5.1m.

The chart below sets out the Core Trust pay costs for the last twelve months analysed between substantive, bank / locum, and agency. The March 2021 position shows the impact of one-off year end adjustments including the annual leave accrual and the employers pension contribution.



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Agency	0.8	0.8	1.1	0.5	0.9	0.6	0.8	1.0	0.9	1.0	1.4	1.2
Bank/Locum	2.1	1.9	2.2	1.9	2.2	2.1	2.3	2.0	2.6	4.9	2.7	2.3
Substantive	31.6	33.2	31.6	32.3	56.5	31.5	32.1	32.2	31.5	31.2	37.0	32.8

The bank cost between September and October has reduced by £0.4m explained by the reduction in the enhanced bank rates following the ending of the accelerator rate initiative.

The normalised pay position for the seven months ended 31st October 2021 is set out below:

Normalised pay	M1	M2	M3	M4	M5	M6	M7
	£m	£m	£m	£m	£m	£m	£m
Total pay	**34.2**	**35.2**	**35.2**	**35.0**	**37.1**	**41.1**	**36.3**
Accelerator enhanced bank rate impact					(2.4)	(0.7)	
National Pay Award	0.9	0.9	0.9	0.9	0.9	(4.2)	
Normalised pay	**35.1**	**36.1**	**36.1**	**35.9**	**35.6**	**36.2**	**36.3**
Total WTE's	**8893**	**8863**	**8841**	**8897**	**9111**	**8856**	**8816**
Substantive	**31.5**	**32.1**	**32.2**	**31.5**	**31.2**	**37.0**	**32.8**
Normalised pay	**0.9**	**0.9**	**0.9**	**0.9**	**0.9**	**(4.2)**	
Normalised substantive pay	**32.3**	**32.9**	**33.1**	**32.4**	**32.1**	**32.8**	**32.8**
Substantive WTE's	**8245**	**8190**	**8167**	**8123**	**8101**	**8130**	**8124**
Bank / Locum	**2.1**	**2.3**	**2.0**	**2.6**	**4.9**	**2.7**	**2.3**
Accelerator Costs					**(2.4)**	**(0.7)**	
Normalised bank / locum pay	**2.1**	**2.3**	**2.0**	**2.6**	**2.5**	**2.0**	**2.3**
Bank/Locum WTE's	**570**	**594**	**566**	**675**	**887**	**592**	**549**
Agency	**0.6**	**0.8**	**1.0**	**0.9**	**1.0**	**1.4**	**1.2**
Normalising adjustments							
Normalised pay	**0.6**	**0.8**	**1.0**	**0.9**	**1.0**	**1.4**	**1.2**
Agency WTE's	**79**	**79**	**108**	**99**	**124**	**135**	**143**

The Trust has seen a reduction in substantive WTE across 2021/22 which has been offset by higher agency spend as there has been a small reduction in bank uptake across this period.

Information on WTE's is included in section 3.7.

The Trust has not as yet released any of the provisions for holiday pay established in 20/21 or the Wellbeing Day, which will be reviewed in the second half of the year and adjustments made accordingly.

3.7 Workforce – WTE and Costs

3.7.1 Trust WTE Worked 12 months Position

The table below sets out the substantive, bank / locum and agency split between clinical and non-clinical:

14.1

Division	WORKED TYPE WTE	M8 WTE	M9 WTE	M10 WTE	M11 WTE	M12 WTE	M1 WTE	M2 WTE	M3 WTE	M4 WTE	M5 WTE	M6 WTE	M7 WTE
Clinical	Substantive	6,439	6,470	6,528	6,676	6,690	6,655	6,588	6,561	6,509	6,488	6,505	6,505
Non-Clinical	Substantive	1,561	1,585	1,573	1,599	1,602	1,589	1,601	1,606	1,614	1,613	1,625	1,620
Total	**Substantive**	**8,001**	**8,055**	**8,101**	**8,274**	**8,292**	**8,245**	**8,190**	**8,167**	**8,123**	**8,101**	**8,130**	**8,124**
Clinical	Bank/Locum	531	432	561	463	448	425	454	435	504	685	414	402
Non-Clinical	Bank/Locum	179	151	184	193	188	145	140	130	171	201	177	147
Total	**Bank/Locum**	**710**	**583**	**744**	**656**	**636**	**570**	**594**	**566**	**675**	**887**	**592**	**549**
Clinical	Agency	85	78	84	66	81	64	76	89	82	109	118	134
Non-Clinical	Agency	9	17	11	12	23	15	3	19	17	15	16	9
Total	**Agency**	**94**	**95**	**96**	**79**	**104**	**79**	**79**	**108**	**99**	**124**	**135**	**143**
	Trust Total	**8,805**	**8,732**	**8,941**	**9,009**	**9,032**	**8,893**	**8,863**	**8,841**	**8,897**	**9,111**	**8,856**	**8,816**

In month 7 we have seen a reduction in Bank / Locum usage and a small increase in agency usage.

Clinical

Across the last 12 months whilst the overall WTE has stayed static there has been a shift in clinical staffing mix with an increase in substantive and agency offset by a reduction in bank/locum.

Non-clinical

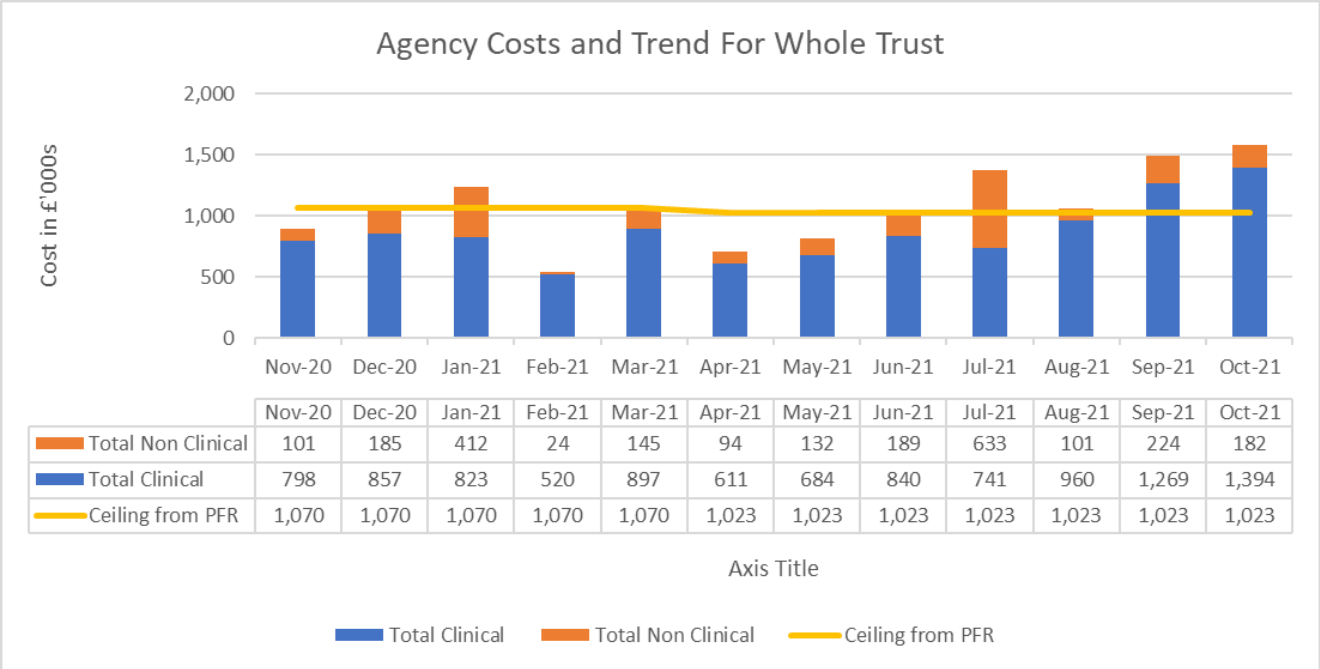
For non-clinical the last 12 months shows an increase in substantive posts with no corresponding decrease in agency or bank/locum.

On the clinical side the reduction is in Medicine and in Non-Clinical centrally charged WTE's have decreased.

3.7.2 Agency Usage and Cap Compliance

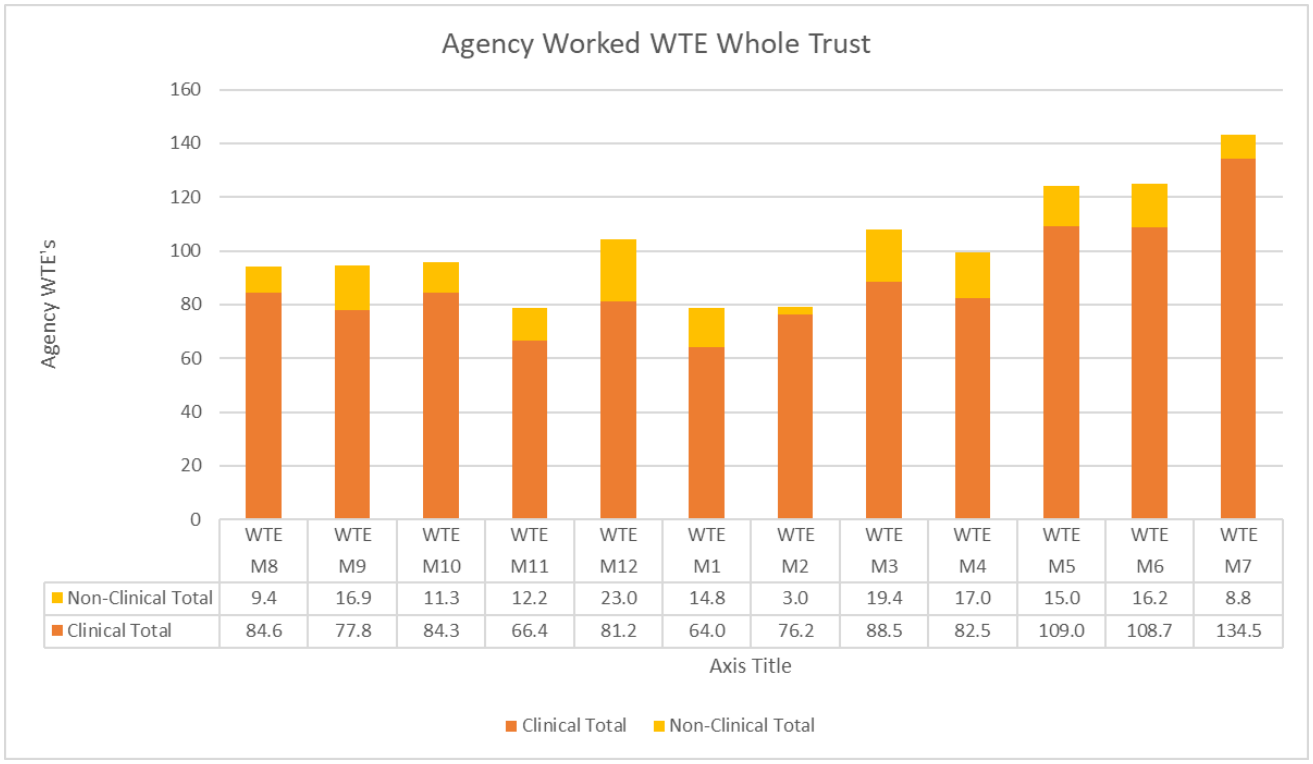
The agency ceiling value of £1.023m is taken from the Monthly PFR return provided to NHSE/I and it was breached in each month of quarter 2 of 2021. The ceiling is the maximum levels that NHSE/I are expecting for the organisation and is monitored as part of the PFR return each month.

The breaches of the Cap value in Month 6 and 7 were caused by increased use of Agency staff across the Clinical divisions, to cover vacancies and COVID absence.



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Total Non Clinical	101	185	412	24	145	94	132	189	633	101	224	182
Total Clinical	798	857	823	520	897	611	684	840	741	960	1,269	1,394
Ceiling from PFR	1,070	1,070	1,070	1,070	1,070	1,023	1,023	1,023	1,023	1,023	1,023	1,023

The numbers of agency staff being used by the Trust has increased slightly between month 6 and 7, with increases in the clinical staff in ASCR, CCS and Medicine.

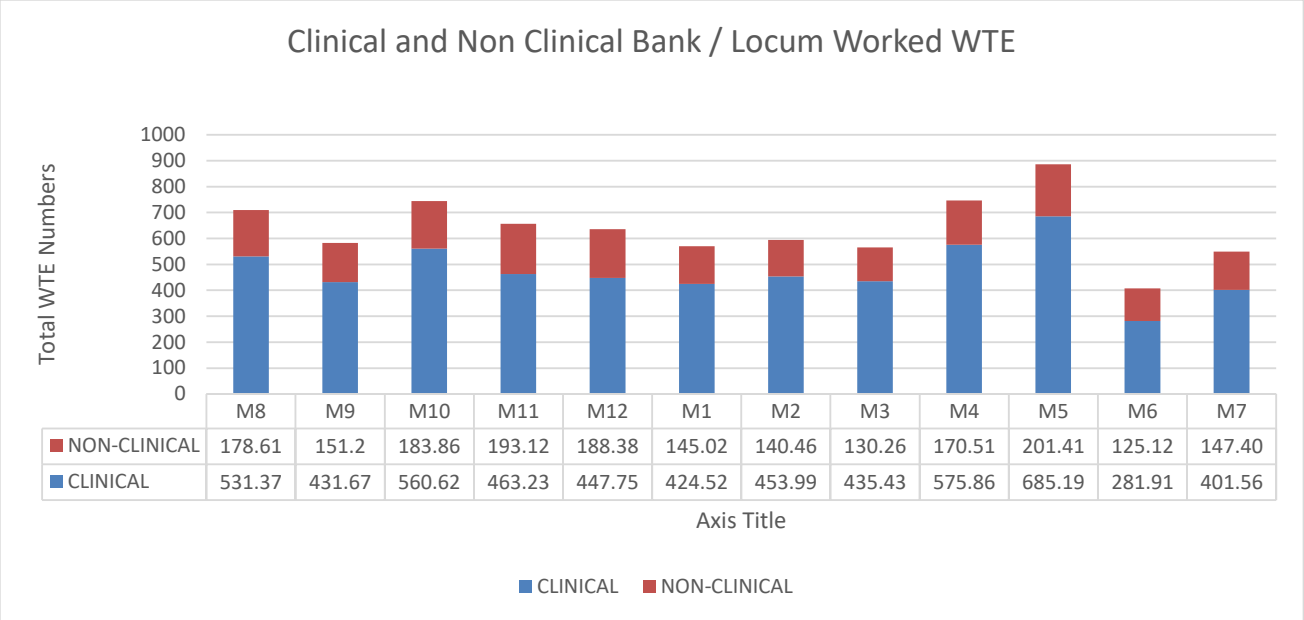


	WTE M8	WTE M9	WTE M10	WTE M11	WTE M12	WTE M1	WTE M2	WTE M3	WTE M4	WTE M5	WTE M6	WTE M7
Non-Clinical Total	9.4	16.9	11.3	12.2	23.0	14.8	3.0	19.4	17.0	15.0	16.2	8.8
Clinical Total	84.6	77.8	84.3	66.4	81.2	64.0	76.2	88.5	82.5	109.0	108.7	134.5

Across the trust we are currently using higher levels of agency to cover staffing gaps caused by COVID related issues and general vacancies particularly in Medicine including higher levels of Mental Health RNs.

3.7.3 Bank and Locum Staff Analysis

There has been a decrease in both Clinical and Centrally charged bank and Locum staff in Month 7, which in turn has seen a reduction is associated costs.



Medicine, NMSK and ASCR have reduced usage of Bank and Locums on the clinical side.

In M7 the rates that are paid to Bank Staff are being harmonised across NBT, UHBW and Sirona. Any back dated adjustments will be included in the payroll in November (Month 8) and December (Month 9).

3.8 Winter Costs

The Trust has allocated £2.9m in reserves for Winter. The table below shows the current profile by Division at Month 7 which totals £3.25m. Expenditure is expected to increase from month 8.

	M7	M8	M9	M10	M11	M12	Total
Medicine	0.2	0.3	0.3	0.5	0.2	0.2	1.7
ASCR	0.0	0.1	0.2	0.2	0.2	0.2	0.7
NMSK	0.0	0.0	0.0	0.0	0.0	0.0	0.2
CCS	0.0	0.0	0.1	0.1	0.1	0.1	0.2
W&C	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Central Ops	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Facilities	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	0.2	**0.5**	**0.6**	**0.8**	**0.6**	**0.6**	**3.3**

- A paper was presented to October F&PC and Trust Board highlighting the proposed winter costs. Whilst the paper was supported in principle the funding envelope was confirmed as £2.9m and an update was requested for Month 8 F&PC in November.
- Once the above process has been completed funding will be allocated to Divisions.
- Funding bids were prioritised based on (1) new bed mitigations, (2) safe staffing requirements and (3) previous years implementation models.
- Costs include £0.14m for ED Nursing (November to March) to be reconciled with new national ED Safe staffing tool and final amount subject to change.

3.9 Divisional Performance

Divisional income targets were set at 95% of the 19/20 activity levels, which represents the level of activity expected to be delivered within 19/20 outturn expenditure after adjustments for inflation.

Non-recurrent mitigation investment schemes were excluded from the divisional position in budget setting, however as business cases are approved the budget will be transferred from reserves to divisions. Non-recurrent Accelerator investment schemes were excluded from the divisional position in budget setting, however, as actual expenditure incurred Accelerator income will be transferred into the divisional position to offset costs. It should be noted that the Trust does not get incremental income under the COVID financial framework related to the levels of activity performed (other than through ERF) but rewarding divisions keeps the divisional focus on recovering activity levels and managing costs.

The table below summarises the Trust financial performance by Division, Corporate Services and non-clinical areas for September and year to date.

- In month 6 Divisional CIP targets were allocated into the Divisional Budget positions. The amount allocated is based on the estimated delivery of £10m for 21/22 less any CIPs delivered in the first five months of the year and will reduce the total value of the budget.
- At month 7 the clinical divisions reported a year-to-date surplus of £23.7m against a budget of £23.9m with the balancing figure to bring the position back to breakeven being held in non-clinical Divisions.
- For month 6, national guidance has required that Trusts recognise income to cover the cost of the National Pay Award. The income was paid to us in the Month 7 block payments. Further the Trust has allocated corporate reserves relating to other staff groups pay awards and incremental drift calculations to the divisions. A proportion of the related expenditure was already included in the run rate so this will represent an improvement against the M6 reported budget variances.

		M7 Budget £m	M7 Actual £m	M7 Variance £m	YTD Budget £m	YTD Actuals £m	YTD Variance £m
ASCR	Contract Income	12.1	11.0	(1.1)	71.1	70.0	(1.1)
	Other Income	0.1	0.4	0.2	2.1	2.2	0.2
	Pay	(10.5)	(10.2)	0.3	(53.4)	(54.5)	(1.1)
	Non-Pay	(1.1)	(2.2)	(1.1)	(12.2)	(13.5)	(1.2)
	Surplus/(Deficit)	**0.6**	**(1.1)**	**(1.6)**	**7.5**	**4.3**	**(3.2)**
CCS	Contract Income	4.6	4.7	0.1	27.2	28.4	1.2
	Other Income	1.3	1.3	0.1	7.6	7.6	0.0
	Pay	(8.0)	(7.0)	1.0	(40.4)	(37.3)	3.1
	Non-Pay	(2.6)	(3.6)	(1.0)	(19.1)	(20.4)	(1.3)
	Surplus/(Deficit)	**(4.7)**	**(4.6)**	**0.1**	**(24.7)**	**(21.7)**	**3.0**
MED	Contract Income	12.5	13.6	1.1	71.6	76.0	4.3
	Other Income	0.1	0.1	0.0	0.7	0.8	0.1
	Pay	(7.8)	(8.3)	(0.4)	(41.8)	(43.6)	(1.7)
	Non-Pay	(2.3)	(2.7)	(0.3)	(14.1)	(16.3)	(2.2)
	Surplus/(Deficit)	**2.5**	**2.8**	**0.3**	**16.4**	**16.9**	**0.5**
NMSK	Contract Income	10.8	9.1	(1.7)	67.3	65.4	(1.9)
	Other Income	0.4	0.3	(0.0)	1.9	1.7	(0.2)
	Pay	(5.6)	(5.5)	0.1	(30.2)	(29.8)	0.5
	Non-Pay	(3.3)	(2.8)	0.5	(21.8)	(20.0)	1.8
	Surplus/(Deficit)	**2.3**	**1.1**	**(1.1)**	**17.3**	**17.4**	**0.1**
W&CH	Contract Income	4.3	4.7	0.4	25.7	26.0	0.3
	Other Income	0.1	0.1	(0.0)	0.8	0.9	0.0
	Pay	(3.4)	(3.3)	0.1	(17.0)	(17.4)	(0.4)
	Non-Pay	(0.1)	(0.5)	(0.5)	(2.1)	(2.6)	(0.4)
	Surplus/(Deficit)	**1.0**	**0.9**	**(0.0)**	**7.4**	**6.9**	**(0.5)**
MASS VACCINATION	Contract Income	0.0	1.1	1.1	0.0	0.0	0.0
	Other Income	(0.0)	(0.8)	(0.8)	(0.0)	5.6	5.6
	Pay	0.0	(0.3)	(0.3)	0.0	(3.9)	(3.9)
	Non-Pay	0.0	(0.0)	(0.0)	0.0	(1.7)	(1.7)
	Surplus/(Deficit)	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**	**0.0**	**0.0**
TOTAL CLINICAL DIVISIONS		**1.6**	**(0.8)**	**(2.4)**	**23.9**	**23.8**	**(0.1)**
NON-CLINICAL AREAS	Contract Income	11.3	11.7	0.4	122.7	127.6	5.0
	Other Income	4.1	6.8	2.7	27.9	28.4	0.6
	Pay	(1.9)	(2.8)	(0.8)	(77.2)	(74.7)	2.4
	Non-Pay	(15.4)	(14.9)	0.4	(97.3)	(105.1)	(7.9)
	Surplus/(Deficit)	**(2.0)**	**0.8**	**2.8**	**(23.9)**	**(23.8)**	**0.1**
TRUST TOTAL		**(0.4)**	**(0.0)**	**0.4**	**(0.0)**	**(0.0)**	**(0.0)**

- In Month 7 CCS and Medicine posted a favourable variance to budget and NMSK and ASCR, were adverse to Budget, Women's and Children's and Mass Vaccinations broke even.
- CCS have a positive year to date position driven by the delay in implementation of pharmacy and therapies business case, higher direct access income allocations, lower pay run rates due to unfilled vacancies and unutilised pay award funding offset by the non-delivery of cost improvements.
- The Medicine division is £0.5m favourable to budget year to date, which is driven by a higher activity casemix and resulting income. Divisional pay costs are adverse due to the volume and cost of Bank and Agency Staff. The non-pay variance is driven by higher than anticipated drugs costs that are expected to be non-recurrent.

- Whilst NMSK is showing a £0.1m favourable variance year to date, the adverse position in month has been driven by lower income levels due to bed constraints and non-delivery of CIPs offset by lower pay and non-pay costs.
- ASCR is £3.2m adverse to budget year to date reflecting primarily lower elective income levels year to date circa £1.1m, non-delivery of CIPs £1.1m, higher consultant pay costs and Non-pay consumable costs.
- W&C is in £0.5m adverse to budget year to date reflecting higher consultant pay and non-pay costs driven by increased drugs costs, non-delivery of CIPs of £0.3m offset by £0.3m of additional income. In month 7 the W&C Division recognised income in relation to Ockenden in line with the agreed funding.

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

	20/21 M12 £m	21/22 M06 £m	21/22 M07 £m	In-Month Change £m	YTD Change £m
Non Current Assets					
Property, Plant and Equipment	579.3	578.0	577.1	(0.9)	(2.2)
Intangible Assets	14.7	12.1	12.0	(0.2)	(2.8)
Non-current receivables	1.7	1.7	1.7	0.0	0.0
Total non-current assets	**595.8**	**591.8**	**590.8**	**(1.0)**	**(5.0)**
Current Assets					
Inventories	8.5	9.0	8.8	(0.3)	0.2
Trade and other receivables NHS	10.2	23.1	18.6	(4.5)	8.4
Trade and other receivables Non-NHS	26.3	26.6	28.7	2.1	2.4
Cash and Cash equivalents	121.5	94.4	104.3	9.9	(17.2)
Total current assets	**166.5**	**153.0**	**160.3**	**7.3**	**(6.2)**
Current Liabilities (< 1 Year)					
Trade and Other payables - NHS	26.9	4.9	6.9	2.0	(20.0)
Trade and Other payables - Non-NHS	98.7	103.7	100.3	(3.4)	1.6
Deferred income	8.5	9.7	18.3	8.6	9.9
PFI liability	12.3	15.2	15.2	0.0	3.0
Finance lease liabilities	2.8	2.5	2.4	(0.1)	(0.4)
Total current liabilities	**149.2**	**136.0**	**143.2**	**7.2**	**(5.9)**
Trade payables and deferred income	7.8	8.2	8.2	(0.0)	0.4
PFI liability	368.7	363.9	363.1	(0.8)	(5.5)
Finance lease liabilities	3.9	2.9	2.7	(0.1)	(1.2)
Total Net Assets	**232.6**	**233.8**	**233.7**	**(0.1)**	**1.1**
Capital and Reserves					
Public Dividend Capital	448.7	448.7	448.7	0.0	(0.0)
Income and expenditure reserve	(381.6)	(378.1)	(378.1)	0.0	3.5
Income and expenditure account - current year	3.5	(0.3)	(0.4)	(0.1)	(3.9)
Revaluation reserve	162.0	163.5	163.5	0.0	1.5
Total Capital and Reserves	**232.6**	**233.8**	**233.7**	**(0.1)**	**1.1**

Receivables

- Of the £8.4m year to date increase in NHS receivables, £2.6m relates to accrued Mass Vaccination Service income, £0.4m relates to higher NHS invoiced debt and £5.4m relates to higher accrued income across the Divisions.
- The £4.5m in-month reduction in NHS receivables was largely driven by the retrospective reimbursement of the pay award paid to employees in September 2021, there was £5.1m of accrued income in respect of this as at 30 September 2021, for which the cash was paid to NBT during October.

- The value of invoiced debt is £22.3m, of this £6.9m relates to Non-NHS individuals and organisations and is over 365 days old. £3.7m of the non-NHS debt older than 365 days relates to private and overseas patients and has been fully provided for. The Financial Services team are working on new credit pathways to reduce the level of aged non-NHS debt. They are reviewing all debt over 365 days with a view to significantly reducing the balance at year end through a combination of further debt collection and identifying uncollectable debt for write off.

Outstanding invoiced debtors, £m	Total	Up to 30 days	30-60 days	60-90 days	90-180 days	180-365 days	365 + days
NHS	7.7	2.5	1.1	0.8	1.4	0.9	1.0
Non-NHS	14.6	3.8	1.3	0.2	0.8	1.5	6.9
Total	**22.3**	**6.4**	**2.3**	**1.0**	**2.3**	**2.4**	**7.9**

Payables

- Year to date NHS payables have reduced by £20.0m, of which £14.0m is a result of the monies paid in advance by NHS England relating to 2020/21, along with the settlement of a £7.9m credit note that was due to BNSSG CCG at 31 March 2021 plus £1.9m of net other increases. Of the £3.4m in-month decrease in non-NHS payables, £2.1m relates to a reduction in accrued capital expenditure due to invoices being received. £1.3m social security costs received in month.

Deferred Income

- Deferred income has increased by £8.6m in-month, of which £5.2m relates to monies received in advance from Health Education England due to quarterly invoicing arrangements, £1.9m relates to deferral of a rates rebate, £0.8m relates to research income,.

Cash

- The cash balance has decreased by £17.2m in-year due to the settlement of a £7.9m credit note raised to BNSSG CCG in March 2021, the £14.0m return of cash paid in advance in August 2021 by NHS England of monies paid to NBT during 2020/21 for reimbursement of Covid revenue costs and lost income, £3.8m payment of PDC dividend, plus increases of £5.7m cash received in advance from Health Education England, £2.1m in-year slippage on the capital programme and £0.7m of other net increases.
- The cash balance increased by £9.9m in-month due to £4.9m of retrospective reimbursement from commissioners in relation to the pay award, £5.7m cash received in advance from Health Education England, along with £0.7m of other net decreases.
- A high-level cash flow forecast has been developed which shows that the Trust is able to manage its affairs without any external support for the 2021/22 financial year.

	Nov-21 (Forecast) £m	Dec-21 (Forecast) £m	Jan-22 (Forecast) £m	Feb-22 (Forecast) £m	Mar-22 (Forecast) £m
Cash brought forward	**104.3**	**106.1**	**106.0**	**106.9**	**103.8**
Total in-month cash movement	**1.8**	**(0.1)**	**0.9**	**(3.1)**	**(5.9)**
Cumulative cash balance	**106.1**	**106.0**	**106.9**	**103.8**	**98.0**

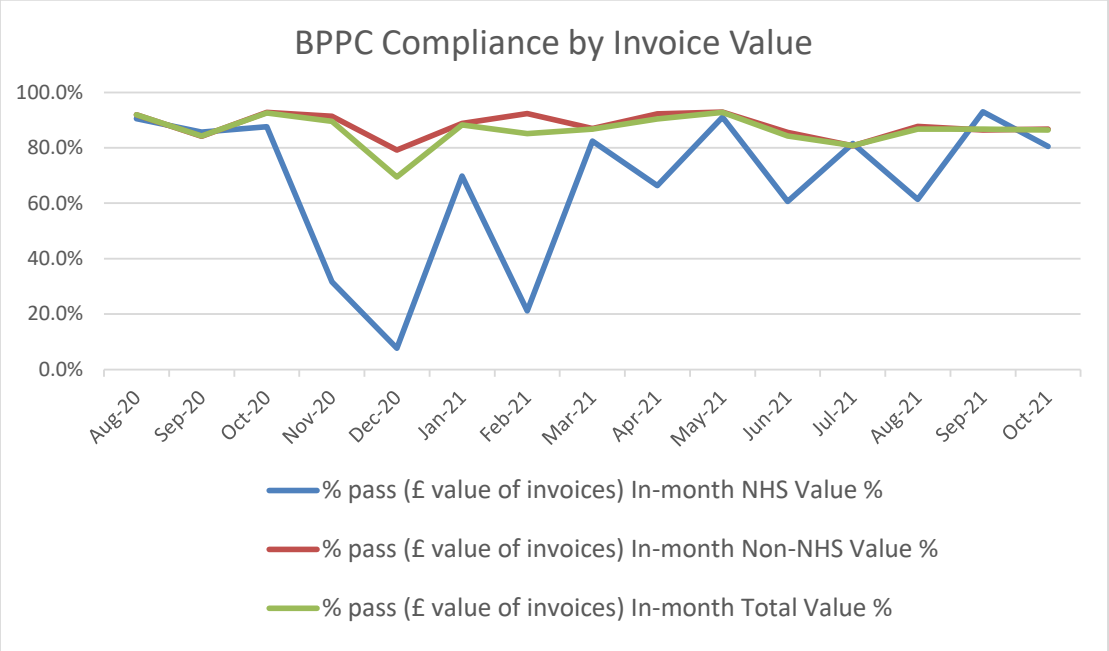
- The cash balance of £104.3m continues to remain high, there is no significant reduction in cash resulting from the known 2021/22 financial framework and the cash forecast assumes a breakeven I&E position at year end.
- The year-to-date cash balance is after £3.8m payment of PDC dividend, of which £1.4m is a prepayment relating to the remaining 5 months of the 2021/22 financial year.

Capital

- Total capital spend to date is £10.5m, compared to a plan of £12.6m for the first 7 months of the year. Expenditure to date on the core plan is £5.5m below plan but this is offset by an additional £3.4m of capital expenditure on the accelerator capital programme not planned at the start of the year.
- The Capital Planning Group reviewed the forecast outturn position at month 6 to assess whether further activity is required to ensure delivery and identified a number of additional schemes to mitigate the underspend. The capital plan is forecast to be delivered in full by year end and will be monitored closely by Capital Planning Group.

2021/22 Capital Expenditure	2021/22 plan £m	Year to date Plan £m	Year to date Actual £m	Year to date Variance from plan £m
Divisional Schemes	3.5	1.8	0.3	(1.5)
CRISP	6.0	4.3	0.8	(3.5)
Medical equipment	5.5	2.6	0.5	(2.1)
IM&T	5.5	3.2	5.1	1.9
Charity and grant funded	0.6	0.4	0.0	(0.4)
PFI lifecycle	0.6	0.3	0.4	0.1
Total Core Plan	21.7	12.6	7.1	(5.5)
Accelerator programme	0.0	0.0	3.4	3.4
Total	21.7	12.6	10.5	(2.1)

- The Better Payment Practice Code The Better Payment Practice Code (BPPC) achievement of invoices paid within 30 days, by value, is 86.7% for the year to date in 2021/22, compared to 86.6% for 2020/21. BPPC achievement by volume of invoices has fallen from 86.4% in 2020/21 to 83.6% for the year to date. The Financial Services team have arranged for changes to supplier terms to ensure coherence with NHS standard 30-day terms. They have also identified certain suppliers and users where the BPPC can be improved and will focus on this to bring the achievement level to the 95% target by year end.

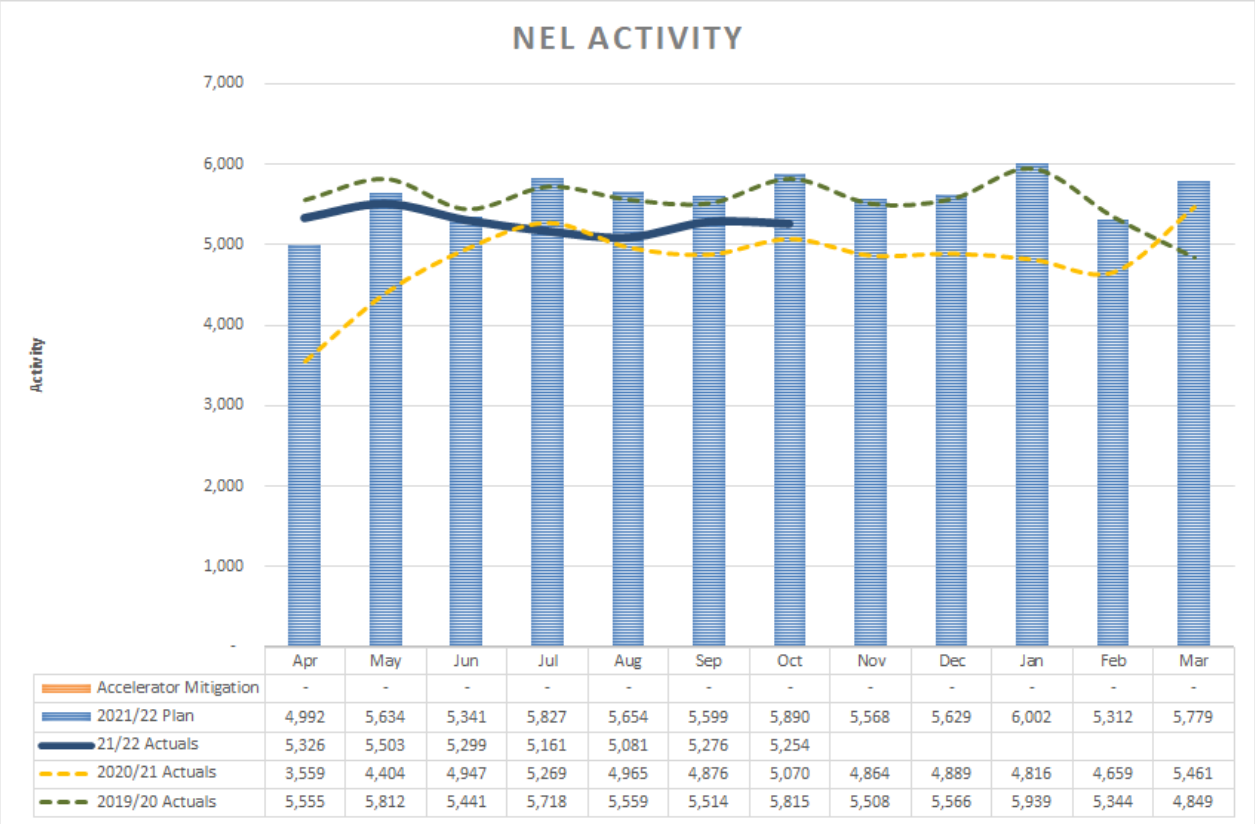


5. Activity Summary Year to Date Trends

The charts below summarise activity for 21/22 non-elective, elective (day case and inpatients) along with A&E attendances and compare activity to previous years as well as showing achievement against original plan and Accelerator stretch targets.

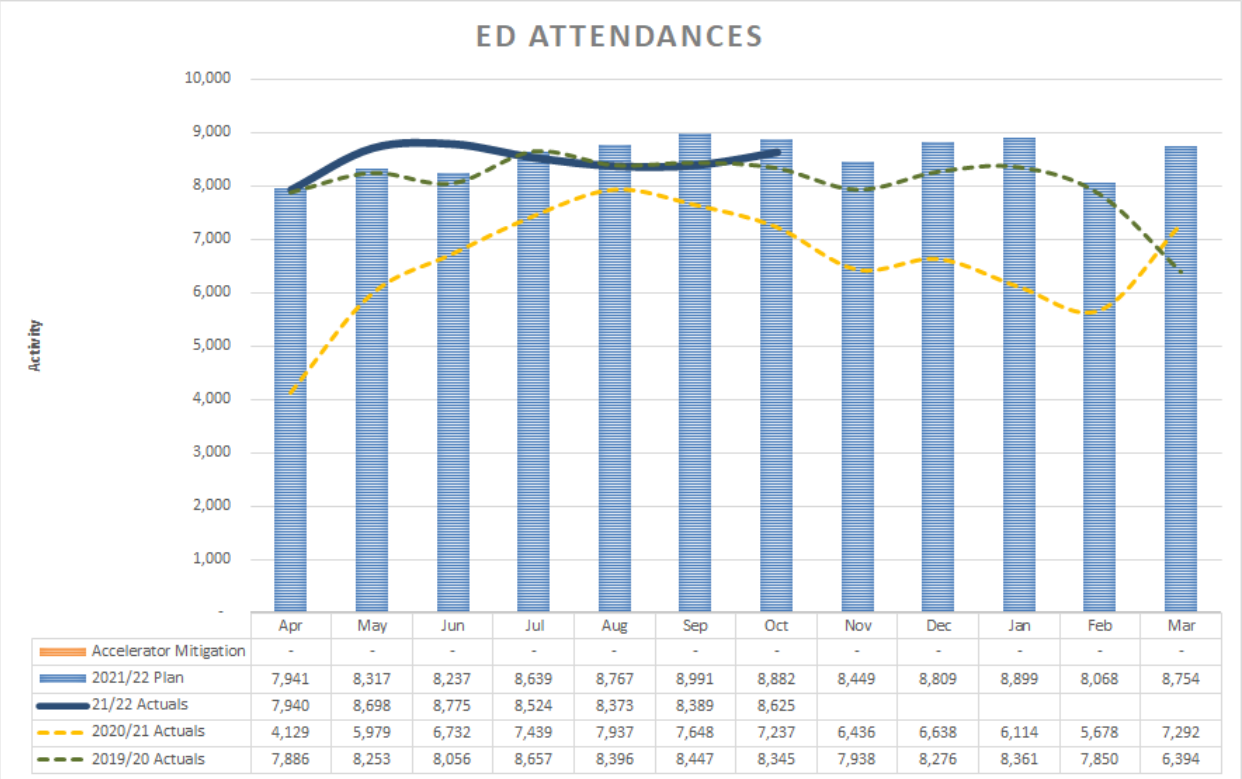
Levels of non-elective activity have decreased slightly throughout October (0.4% below September) and are 4% above this time last year, however they continue to remain lower than 19/20 (10% below).

Non-elective excess bed days have remained steady since June and continue at higher rates than this time last year but at lower levels than 19/20.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Accelerator Mitigation	-	-	-	-	-	-	-	-	-	-	-	-
2021/22 Plan	4,992	5,634	5,341	5,827	5,654	5,599	5,890	5,568	5,629	6,002	5,312	5,779
21/22 Actuals	5,326	5,503	5,299	5,161	5,081	5,276	5,254					
2020/21 Actuals	3,559	4,404	4,947	5,269	4,965	4,876	5,070	4,864	4,889	4,816	4,659	5,461
2019/20 Actuals	5,555	5,812	5,441	5,718	5,559	5,514	5,815	5,508	5,566	5,939	5,344	4,849

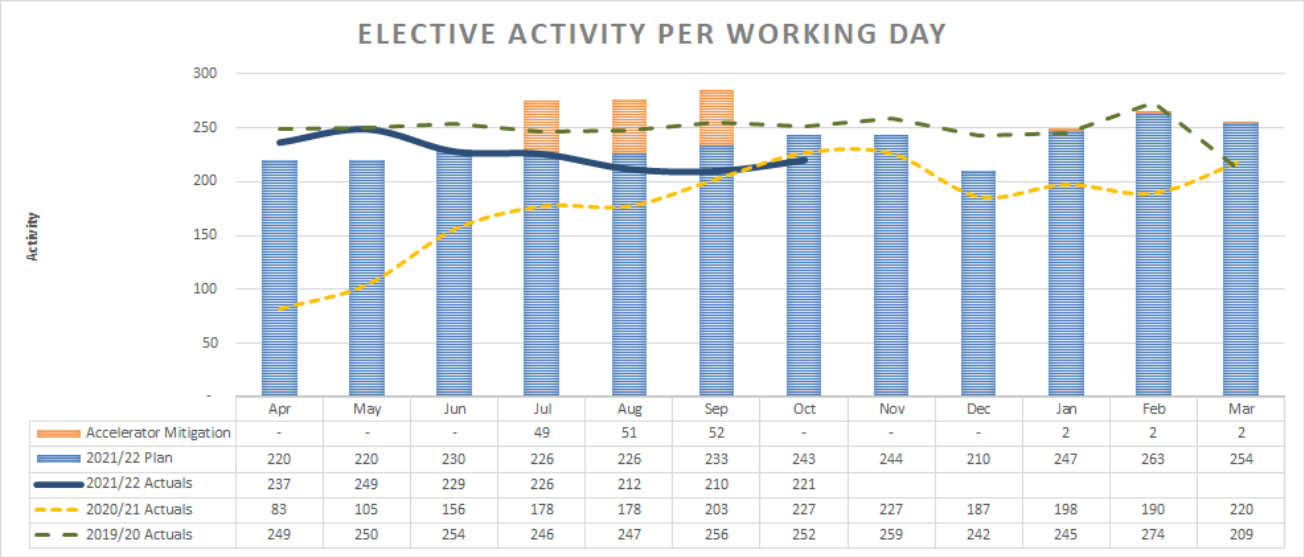
ED attendance levels remain higher than last year and although levels had reduced during Q2, they are now almost back at June peak and are circa 19% higher than this time last year and circa 3% below plan levels.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Accelerator Mitigation	-	-	-	-	-	-	-	-	-	-	-	-
2021/22 Plan	7,941	8,317	8,237	8,639	8,767	8,991	8,882	8,449	8,809	8,899	8,068	8,754
21/22 Actuals	7,940	8,698	8,775	8,524	8,373	8,389	8,625					
2020/21 Actuals	4,129	5,979	6,732	7,439	7,937	7,648	7,237	6,436	6,638	6,114	5,678	7,292
2019/20 Actuals	7,886	8,253	8,056	8,657	8,396	8,447	8,345	7,938	8,276	8,361	7,850	6,394

14.1

To allow for comparability between years elective activity is shown by day below. There has been a steady decline in activity since May and October levels were 12% below 2019/20, 3% below this time last year and 9% below plan (before Accelerator stretch is considered).



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Accelerator Mitigation	-	-	-	49	51	52	-	-	-	2	2	2
2021/22 Plan	220	220	230	226	226	233	243	244	210	247	263	254
2021/22 Actuals	237	249	229	226	212	210	221					
2020/21 Actuals	83	105	156	178	178	203	227	227	187	198	190	220
2019/20 Actuals	249	250	254	246	247	256	252	259	242	245	274	209

6. National Capital and Board Reviewed Revenue Funding Bids

6.1 National Capital Bids

The BNSSG System submitted a bid to NHSEI in September 21 in relation to Community Diagnostic Centre (CDC) in the region. This bid was for £40m capital and £20m revenue. The capital funding for this item was included in the recent HM Treasury budget announcement and the Trust & System are awaiting confirmation of whether this bid was successful.

6.2 Revenue Funding Business Cases update

Scheme Name	Year	Amount £m	Status	Purpose	Board Approval	Revenue/Capital £m
SW Centre (Removal of Vaginal Mesh)	21/22 onwards	£0.6 per year	Finalising arrangements with NHSE, expected to be concluded in Q3 2021-22.	South West Centre for the Removal of Vaginal Mesh	✓	£0.6m of recurrent income to provide the service, costed at £0.6m pa. M6 2021-22 the Trust received £0.2m non-recurrent mobilisation funds.
Pathology MES	21/22 onwards	£1.8 per year	Board approved. DHSC have requested additional information on lifecycle costs and accounting treatment.	Managed equipment contract for Pathology	✓	£1.8m of spend is recurrent revenue. Small capital spends on enabling works.

6.3 Targeted Investment Fund (TIF)

TIF is a revenue and capital fund from NHSE for H2 2021/22 that supports systems to go further on elective recovery. Nationally there is a £700m fund available of which at least £500m must be spent on capital with £250m of that ringfenced for technology. The TIF funding is non-recurrent. Further details will be provided on confirmation of successful system revenue and capital bids.

7. Cost Improvement Program as at 31st October.

The budget reduction targets set for each division and the amounts delivered to date are as below.

Cash Releasing or Productivity	Division	FYE Target	Completed Schemes	Schemes in Implementation	Schemes in Planning	Total FYE	FYE Gap
Cash Releasing	ASCR	2.2	0.1	0.3	1.1	1.5	0.8
	CCS	2.0	0.6	0.0	0.4	1.0	1.0
	CORP	0.8	0.5	0.1	0.2	0.8	0.0
	FAC	1.0	0.1	0.9	0.0	1.0	0.0
	MED	1.6	0.1	0.0	0.7	0.8	0.8
	NMSK	1.7	0.1	0.1	1.0	1.2	0.5
	WCH	0.7	0.0	0.0	0.0	0.0	0.7
Cash Releasing	Total	10.0	1.5	1.4	3.4	6.3	3.7
Productivity	ASCR	0.0	0.2	0.0	0.0	0.2	(0.2)
	CCS	0.0	0.0	0.0	0.0	0.0	0.0
	MED	0.0	0.0	0.0	0.0	0.0	0.0
Productivity	Total	0.0	0.2	0.0	0.0	0.2	(0.2)
Trust Totals		10.0	1.7	1.4	3.4	6.5	3.5

- The Trust CIP target for 2021/22 is £10.0m of full year effect savings
- From month 6 onwards £10m of the CIP figures are included and recorded in Departmental Budgets and the Divisional Performance Table in 3.9 reflects this reallocation.
- The Trust CIP target for 2021/22 is £10.0m of full year effect savings
- The current identified CIP position is £6.4m, of which £6.2m is cash releasing and £0.2m productivity schemes
- Completed schemes amount to £1.7m, an increase of £0.5m from last month.
- £1.4m schemes are in the Implementation phase, an increase of £0.7m from last month, and £3.4m of schemes are in Planning stage
- A further £1.8m of schemes are in development (pipeline) and this includes £0.7m of income (local tariff reviews and coding) and £0.3m of productivity schemes.
- In October the Facilities Division received confirmation of £5.1m of rates rebates for the six years until 2022/23. Of this, £0.9m relates to 21/22 and in Month 8 this will be recognised as a completed scheme.
- Overall, 35% of the target currently needs to be identified.
- Departments are working towards an outline plan for 22/23 and onwards.

9. Finance Risk Rating (Single Oversight Framework)

- The current rating for trust is Segment 3: Mandated & targeted support: support needs identified in Quality of care, Finance & use of resources and Operational performance.
- Perforamnce against the Framework will be updated once the H2 plan has been submitted for reporting for the remainder of the year.

10. Assumptions, opportunities, and risks

- The Trust has assumed that any surplus covid cost funding from the system can be retained.
- There is a risk that non-recurrent funding is currently being used to cover recurrent costs as block contracts are being rolled over based on 2019/20 costs whilst inflation and other cost pressures are increasing the recurrent cost base of the Trust.
- Further recurrent investments in quality and safety have been approved in advance of confirmation of potential commissioner funding. Mechanisms for allocating recurrent funding across the system are not yet fully developed.
- Potential risks to the delivery of the Trust cost improvement programme may arise.
- H2 guidance is now published, and this confirms a lower level of efficiency than previously assumed. The risks and mitigations table below had previously assumed an efficiency requirement in the second half of 2021/22 of £10m. The guidance indicates that the efficiency asked of the system is at the low end of initial expectations and system calculations identify potential efficiency requirement of circa £5.8m reduction in income and £1.1m reduction in expenditure.
- The Trust is still targeting delivery against its internal CIP target of £10m in 21/22.Originally this was £20m however £10m was reallocated to the Divisional Budgets in Month 6.

11. Forecast

- The Forecast Outturn Position for the end of the financial year is still expected to be breakeven.

	H1 Actual	H2 Financial Plan	21/22 Forecast	21/22 Budget
	£m	£m	£m	£m
Contract Income	337.5	338.1	675.7	662.3
Other Income	39.0	38.4	77.4	71.6
Pay	(223.7)	(233.1)	(456.8)	(442.2)
Non-Pay	(152.8)	(143.4)	(296.3)	(291.7)
Total	**0.0**	**0.0**	**0.0**	**0.0**

- Risk and Mitigations as of 31 October 2021 are set out below. The table shows breakeven position as the most likely year end forecast. The Trust is developing schemes that will contribute to improving performance and / or investing in schemes that will deliver financial benefits in the 2022/23 financial year:

	£m	Commentary
Risks		
Other Risks		
Non delivery of efficiency benefits	(0.3)	
Increase in agency and locum costs, including Registered Mental Health Nurses	(3.0)	Increasing costs in line with September and October levels
Non-recurrent investment in elective and urgent care activity beyond current plans	(0.7)	
Total	**(4.0)**	
Opportunities		
Mitigating Actions		
Balance sheet review	1.5	Release of accruals
Delays in recruitment	0.5	
Rates rebates	1.0	Recognition of rebates
Depreciation / PDC benefit from delays in investment	1.0	Lower capital charges due to delays in capital expenditure programmes
Total	**4.0**	
Most likely outturn	**0.0**	

- Where non-recurrent income has been received in year, there is a risk that we will not be able deliver recovery actions fully, which could lead to an underspend, this will be managed through Recovery Boards to support the workstreams, system-wide discussions and review of actions to mitigate through Balance Sheet flexibility.

12. Recommendation

F&PC are asked to note:

- Financial performance for the month , year to date and forecast end of year position.
- The associated assumptions, opportunities, risks, and mitigations included in this report.
- The spend on Mass Vaccinations and Covid-19 expenditure areas.
- Delivery of Cost Improvement Plan savings and how they compare with divisional targets.
- The impact of the Accelerator Programme.
- The Cash position and Capital spend levels.
- BPPC performance

Report To:	Trust Board - Public		
Date of Meeting:	25 November 2021		
Report Title:	Quality Committee Upward Report		
Report Author & Job Title	Xavier Bell, Director of Corporate Governance & Trust Secretary Isobel Clements, Senior Corporate Governance Officer & Policy Manager		
Executive/Non-executive Sponsor (presenting)	John Iredale, Non-Executive Director and Chair of QC		
Does the paper contain:	**Patient identifiable information?**	**Staff identifiable information?**	**Commercially sensitive information?**
*If any boxes above ticked, paper to be received at *private* meeting			
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board should receive the report for assurance and note the activities Quality Committee (QC) has undertaken on behalf of the Board.		
Report History:	The report is a standing item to the Trust Board following each Committee meeting.		
Next Steps:	The next report will be received at Trust Board in January 2022.		

Executive Summary	
The report provides a summary of the assurances received and items discussed and debated at the Quality Committee (QC) meeting held on 11 November 2021.	
Strategic Theme/Corporate Objective Links	**Provider of high-quality patient care** **Employer of choice**
Board Assurance Framework/Trust Risk Register Links	Link to BAF risk SIR14 relating to clinical complexity, risk COV 2 relating to overwhelming effects of Covid-19 locally and risk SIR1 relating to lack of capacity affecting performance and patient safety.
Other Standards Reference	CQC Standards.

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

1. Purpose

1.1 To provide a highlight of the key assurances received, items discussed, and items for the attention/ approval of Trust Board from the Quality Committee (QC) meeting held on 11 November 2021.

2. Background

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

2.2 Trust Board should note that November's meeting was the first meeting of the Committee in its capacity as 'Quality Committee' as opposed to 'Quality & Risk Management Committee'.

3. Meeting on 11 November 2021

3.1 <u>NHS Patient Safety Strategy – Patient Safety incident Response Framework (PSIRF)</u>
The Committee received an overview and update of NBT's progress in preparing for and implementing the NHS Patient Safety Incident Response Framework, which has previously been approved by Trust Board. It was noted that NBT is at the forefront of the implementation of PSIRF nationally, and its Framework is a public facing document.

The PSIRF replaces the Serious Incident Framework. Rather than using a purely investigative model, PSIRF takes a continues improvement approach. This does not mean that reactive investigations do not take place, but the focus is on proactive investigations via the Trust's patient safety themes.

The Committee welcomed the progress and noted the strong engagement with external stakeholders and experts, and the adoption of systems-based investigations focusing on findings and safety recommendations, with patient and family involvement, rather than previous "Root Cause Analysis" approach.

The Committee noted that the successful implementation and embedding of the new approach will rely on a cultural shift, and that this element of the implementation needed ongoing attention. It was reassured that this is taking place, as well as engagement and sharing with Integrated Care System partners.

3.2 Internal Professional Standards

The Committee received and reviewed the draft Internal Professional Standards policy. This was received for discussion and to provide assurance on the systems in place to ensure a safe and effective service to patients in the Urgent Care pathway.

The Committee noted that the document brings together a set of agreed expectations and standards into one place. It was recognised that the engagement from clinical staff had been extensive. It was also noted that the document would be renamed to "Internal Clinical Standards" to ensure that they are differentiated from professional standards required by various regulators and professional bodies.

The Committee welcomed the document with its full support and encouraged ongoing discussions with system partners to ensure alignment of clinical standards where appropriate.

3.3 Clinical Policies prioritisation/ risk stratification

The Committee received an update on the status of Trust-wide clinical policies and guidelines, particularly those policies which are currently overdue for review and may therefore present a risk to the organisation.

The Committee was advised that a number of governance forums have been created to ensure that clinical policies and guidelines are reviewed/approved in an appropriate manner with appropriate input from clinical staff and IM&T support. Work has been undertaken to ensure that authors and responsible officers for each policy are appropriately identified, and the challenging work of ensuring that policies are updated is ongoing. It was noted that this relies heavily on clinical staff who are also under sustained operational pressure at this time.

The Committee noted that the scale of the programme was significant, and that there needed to be ongoing focus on prioritising the most important and high-risk policies/guidelines for immediate review and update. It was agreed that regular updates should come back to the Committee, including an update on how the prioritisation process is progressing.

3.4 Safeguarding team – Highlights (from annual report received in September)

The Committee received a short presentation from the Head of Safeguarding, outlining key highlights from the past year and plans for both Adults and Children's' safeguarding

arrangements in the coming year. The Committee recognised the ongoing significant work of the safeguarding service at NBT.

3.5 Organ & Transplant annual report

The Committee received this annual report covering NBT's organ donation activities for 2020/21. It was confirmed that NBT performed in line with national best practice guidance and despite the challenges of the past year, saw an increase in the number of proceeding donors, bucking the national trend of 25% reduction.

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

The Trust's IPC clinical leads attended to present the annual report. This report recognised the unprecedented nature of the year, with the Covid-19 pandemic management becoming the team's main priority and focus in supporting the organisation's emergency response.

The Committee also received an update on *C. Difficile* infections, following up from a previous presentation to the Committee earlier in 2021. This highlighted an increase in *C. Difficile* infections in the South West vastly higher than the national increase. This update focused on actions being taken within NBT and across the SW regional IPC collaborative to decrease numbers.

3.7 Quality (previously Ward) Accreditation

The Committee received an update on the introduction of a quality accreditation scheme to NBT. The approach aims to go beyond performance management to continuous quality improvement.

The Committee welcomed the programme and recognised that it will be empowering for staff and create opportunities for learning and sharing good practice. The access to timely data was identified as being key to success.

3.8 Quality Plan update Q2

The Committee recognised the positive progress made against the quality plan despite ongoing operational pressures throughout 2021/22 to-date.

Two workstreams were rated red, relating to the improvement areas of Safe Discharge and Quality measures within the Emergency Zone. The Committee recognised that this did not mean that the operational delivery and clinical oversight in these areas was "red" but was linked to the status of the improvement projects.

3.9 Quality Risk Report & Board Assurance Framework

The Committee reviewed the patient safety and quality trust-level risks and agreed to consider future deep-dive topics informed by the trust-level risks.

3.10 Other items:

The Committee also received the following items:

- CQC Assurance Report (monitoring visits and Quality Business Intelligence)
- Sub-committee upward report(s):
  - Clinical Effectiveness & Audit Committee
  - Patient Safety & Clinical Risk Committee
  - Drugs & Therapeutics Committee
- QC forward work-plan 2021/22

4. Identification of new risk & items for escalation

None identified.

5. Recommendations

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

Report To:	Trust Board Meeting			
Date of Meeting:	25 November2021			
Report Title:	Audit & Risk Committee Report			
Report Author & Job Title	Xavier Bell, Director of Corporate Governance			
Executive/Non-executive Sponsor (presenting)	Richard Gaunt, Non-Executive Director (Committee Chair)			
Purpose:	**Approval/Decision**	**Review**	**To Receive for Assurance**	**To Receive for Information**
	X		**X**	
Recommendation:	The Trust Board is recommended to receive the report for assurance, note the revised Board Assurance Framework and approve: • the revised Audit Committee Terms of Reference, • the updated Standing Orders & Standing Financial Instructions			
Report History:	The report is a standing item to each Trust Board meeting following an Audit & Risk Committee meeting.			
Next Steps:	The next report to Trust Board will be to its meeting in February2022.			

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 4 November2021.	
Strategic Theme/Corporate Objective Links	**1. Provider of high quality patient care** **2. Developing Healthcare for the future** **3. Employer of choice** **4. An anchor in our community**
Board Assurance Framework/Trust Risk Register Links	The Committee is now the Audit & Risk Committee, with oversight of the Trust's overall risk management systems and processes.
Other Standard Reference	Links to the CQC Well Led domain and key lines of enquiry.
Financial implications	None within this report.
Other Resource Implications	No other resource implications associated with this report.

Legal Implications including Equality, Diversity and Inclusion Assessment	None identified.
Appendices:	Appendix 1: Revised Terms of Reference Appendix 2: Revised Standing Orders & Standing Financial Instructions Appendix 3: Board Assurance Framework

1. Purpose

To provide a highlight of the key assurances, escalations to the Board and identification of any new risks from the Audit& Risk Committee meeting held on 4 November2021.

2. Background

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

3. Meeting of 4 November2021

3.1. External Audit Progress Report:
The Committee received a short report from External Auditors, noting that the Trust is in the intervening period between closing the 2020/21 accounts and starting the 2021/22 audit.

The Committee endorsed the suggestion that the audit of Trust accounts and the audit of Charity accounts be de-coupled, with the specific timing of the charitable accounts audit in 2022 to be agreed between the Finance team and External Auditors.

3.2. Internal Audit Update:
The Committee received a progress report from Internal Auditors. This set out an update on progress against the internal audit forward plan, where a number of audits have slipped to later in the year. Internal Audit are working with the Executive Team to identify work which can be brought forward (with two already identified).

The Committee were advised that the management actions arising from the 2021 Health & Safety audit were being reviewed with the new Head of Health & Safety to consider whether there was a more effective or appropriate approach. The outcome of these discussions will be reported to the February Committee meeting.

The report from Internal Audit outlined several internal audit actions where due dates were being extended, and actions where management considered the action to now be closed. The Committee discussed and endorsed the extended deadlines and closed actions.

3.3. Internal Audit Report – Patient Property:
The Committee received an internal audit report on the management of patient property within the hospital. The report raised 6 findings and actions and an overall rating of "Partial Assurance with Improvements Required".

The Committee observed that the findings related to relatively basic requirements such as clear policies and ownership of the process, which was concerning. The Committee were advised that the process will now sit within the Nursing/Patient Experience portfolio, with an update on this audit and associated actions going to the next meeting of the Patient & Carer Experience Committee.

Trust Board is asked to note Audit Committee's request that the Patient & Carer Experience Committee oversee the delivery of the actions within this Audit.

The Committee also recommends that an updated internal audit should be carried out sometime after June 2022 when actions and policy updates arising from these recommendations should all be fully completed and embedded.

3.4. Counter Fraud Report:

The Committee received an update from the Local Counter Fraud Specialist. This provided an overview of proactive engagement planned for November (Fraud Awareness Month), including virtual seminars, additional on-site presence, and engagement with divisional staff.

The Committee also received Counter Fraud audit reports on:

- Conflicts of Interest – this raised two medium risk recommendations and two low risk recommendations, and the associated actions agreed with management. The Committee was reassured that the Trust had a good system in place.

  It was noted that the number of gifts being declared was very low compared to the size of the organisation, and that significant awareness raising activity needed to take place.

- Patient Expenses – this highlighted that the Trust has strong processes in place, with only one medium recommendation raised.

3.5. Standing Orders & Standing Financial Instructions:

The Committee reviewed a revised set of SO/SFI which proposed three key changes:

(1) That delegated authority for business cases be increased as follows:

CFO – increase from <£100k to **<£1m**

CEO - increases from >£100k - £500k to **>£1m – £2.5m**

FPC – increases from >£500k - £1m to **>£2.5m**

Trust Board – increases from >£1m to **>£2.5m (on recommendation from FPC)**

The Committee supported these changes, on the basis that the Trust's turnover had significantly increased proportionately, and it was felt that there were sufficient checks and balances in place to ensure Board/Committee oversight and awareness of decisions being taken.

(2) It also supported an increase in contract signature approval limits as follows:

- **Up to EU threshold – Divisional Operations Director or relevant Corporate Director**
- **EU threshold to £500,000 – Director of Finance**
- **Over £500,000 - Chief Executive**

To:

- **Up to EU threshold – Divisional Operations Director or relevant Corporate Director**
- **EU threshold to £2m – Chief Finance Officer**
- **Over £2m - Chief Executive**

(3) The Committee also supported updates to the Standing Orders allowing NHS Supply Chain framework arrangements to be treated in the same manner as Department of Health framework arrangements, reducing procurement bureaucracy.

The Committee recommends the revised Standing Orders and Standing Financial Instructions to Trust Board for approval (see *Appendix 2*).

3.6. Risk Report & Board Assurance Framework (BAF)

The Committee received the Trust Level Risk Report and Board Assurance Framework in its new guise as Audit & Risk Committee.

An update on the recent Executive Assurance Forum meeting was also provided, with several risks to be added to the register and along with updates to actions and ownership/delivery dates. The Committee acknowledged that the risk report was in the process of being updated, and that it would expect to see better definition of gaps and associated actions in the next iteration.

Additionally, the Committee:

- Observed the need for a review of Trust level risk appetite and scoring process. This is currently scheduled for a February 2022 Board seminar,
- Noted that the ASCR Division had no Trust Level Risks, which warranted some review, and
- Observed that there needed to be a clear triangulation between the BAF, Trust Level Risks and the KPIs in the Integrated Performance Report.

The Board and the Executive Team are asked to note these comments and take them into account when reviewing and updating the risk register.

The BAF is included at *Appendix 3.* [Post-meeting note]: this is the most recent version of the BAF, which post-dates the version reviewed by Audit Committee, and has been updated by the Executive Team. This includes a recommendation that one BAF risk be closed:

Current wording:	Reason for closing:
SIR 1: The Trust has limited capital funding and many competing priorities for investment (as well as other non-capital cost pressures). The gradual move towards system involvement in capital prioritisation an approval adds an additional layer of complexity in capital planning.	Having reviewed the risk, the Executive Team felt that it is not currently a significant strategic risk: • The organisation has clear capital limits and allocations set by regulators, • The availability of capital is rarely the limiting factor in progressing NBT's plans/strategy

Lack of investment in appropriate technologies and infrastructure in a timely manner impacts the ability of the Trust to deliver: - operational targets - financial performance and - quality improvement.	• In the current climate, there is a great deal of capital funding available for national priorities • Capital allocations and plans will increasingly be determined via system routes, and this is covered under a separate BAF risk

The Board is asked to discuss and endorse this amendment.

3.7. Single Tender Actions:
The Committee received a report on Single Tender Actions (STA). It was noted that some of the high-value STAs in the report related to technical monopolies on NHS Supply Chain framework agreements and were therefore not a significant concern.

It was agreed that a report of "spend on Purchase Order" vs "spend off Purchase Order" needed to be presented to the next Committee meeting so that the scale of improvement required was clear, ahead of the implementation of a new procurement system in 2022.

3.8. Revised Terms of Reference:
The Committee endorsed the revised terms of reference which outlined the new Committee responsibility for oversight of risk management systems and processes. Trust Board is asked to approve the terms of reference (*Appendix 1*)

3.9. Declarations of Interest

The Committee received an update on Declarations of Interest, including a list of declarations received since the last report in May 2021.

4. New risks or items for escalation

4.1. Trust Board is asked to note Audit Committee's request that the Patient & Carer Experience Committee oversee the delivery of the actions within the Patient Property Audit.

4.2. The Board and the Executive Team are asked to note the Committee's comments on the risk report and BAF and take them into account when reviewing and updating these documents.

5. Recommendations

The Trust Board is recommended to receive the report for assurance, note the revised Board Assurance Framework and approve:

- the revised Audit Committee Terms of Reference, and
- the updated Standing Orders & Standing Financial Instructions

Audit & Risk Committee Terms of Reference

Date Approved	~~27 May 2021~~Trust Board: 25 November 2021
Frequency Review	Annual
Next Review	November~~May~~ 2022
Terms of Reference Drafting	Trust Secretary
Review	Audit Committee ~~06/05/2021~~: 4 November 2021
Approval	Trust Board
Version Number	1.3~~2~~

1. Constitution

1.1. The Trust Board hereby resolves to establish a committee of the Board to be known as the Audit & Risk Committee ("the Committee").

1.2. The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

1.3. The terms of reference can only be amended with the ratification of the Trust Board.

2. Authority

2.1. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee is authorised by the Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.3 The Committee has ultimate responsibility for receiving assurance on the Trust's system of internal control by means of independent and objective review of financial and corporate governance, risk management across the whole of the Trust's activities (clinical and non-clinical), and compliance with law, guidance and regulations governing the NHS.

3. Membership

3.1 The Committee will be appointed by the Trust Board from amongst the non-executive directors of the Trust and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Trust Board.

3.2 At least one of the members of the Committee will have recent and relevant financial experience.

3.3 The Chair of the Trust will not be a member of the Committee.

4. Attendance at Meetings

4.1 On invitation from the Chair of the Committee, meetings will normally be attended by the:

- Chief Financial Officer
- Assistant Director of Finance (Financial Services)
- Director of Corporate Governance/Trust Secretary
- Deputy Trust Secretary
- Head of Internal Audit
- Senior management representatives from the appointed external auditors
- Counter Fraud Specialist

4.2 The Accountable Officer should be invited to attend meetings and should discuss at least annually with the Committee the process for assurance that supports the annual governance statement. The Accountable Officer should also attend when the Committee considers the draft annual governance statement and the annual report and accounts.

4.3 Other executive directors/managers should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director/manager.

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

4.5 Representatives from other organisations and other individuals may be invited to attend on occasion.

4.6 The Trust Chair may be invited to attend meetings of the Committee in order that they can understand how the Committee works, but will have no voting rights.

4.7 The Head of Internal Audit, the representative of External Audit and the Counter Fraud Specialist have a right of direct access to the Chair of the Committee.

4.8 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

5. Quorum

5.1 The quorum necessary for the transaction of business shall be two Non-executive members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised by the Committee.

6. Frequency of Meetings and Conduct

6.1 The Committee will meet at least five times a year, timed in accordance with the discharge of its key responsibilities. The Chair may call additional meetings where these are deemed necessary.

6.2 The Trust Board, Accountable Officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary.

6.3 At least once a year the Committee will meet privately with the external and internal auditors.

6.4 Agenda items should be submitted to the Corporate Governance Team at least eight working days before the meeting.

6.5 An agenda of items to be discussed and supporting papers will be sent to each committee member and person required to attend~~,~~ by the Corporate Governance Team at least five working days before the meeting.

6.6 Terms of Reference can only be changed by the Committee and approved by the Trust Board.

7. Responsibilities

Integrated Governance, Risk Management and Internal Control

7.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

7.2 In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements, in particular the Annual Governance Statement attached to the Annual Report and Accounts, together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to submission to the Trust Board.
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- The policies and procedures for all work related to counter fraud, bribery and corruption as set out in the NHS Standard Contract and as required by the NHS Counter Fraud Authority

7.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

~~7.3~~7.4 This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

7.5 The Committee shall also ensure that the Trust has robust risk management systems and processes in place and shall receive a regular report setting out all Trust Level Risks and the Board Assurance Framework. The Committee will actively seek assurance that:

- an up-to-date risk register is maintained, and that relevant staff are able to access the risk register to raise concerns and know that concerns will be reviewed and addressed.
- act as the forum for risk to be discussed, and ensure that where serious concerns are raised, action is taken, and that action plans are carried through to completion, and the reporting loops closed. This may be progressed directly by the Committee or via delegation to other key committees (see below). In doing so, the Committee will ensure that there are robust links with clinical and non-clinical directorates to ensure a culture of effective risk management is present throughout the organisation.

~~7.4~~

other key committees - for example the four other assurance committees of the Trust Board - (Finance and Performance, People, Charity, Quality, ~~and Risk Management~~ and Patient and Carer Experience Committee) so that it understands processes and linkages. These other Committees must not usurp the Committee's role.

Internal Audit

7.7 The Committee will ensure that there is an effective internal audit function that meets the requirements of the *Public Sector Internal Audit Standards 2017* and provides appropriate independent assurance to the Committee, Accountable Officer and the Trust Board. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved.
- Review and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework and with reference to the risk register.
- Considering the major findings of internal audit work; and management's response to recommendations made.
- Ensuring co-ordination between the internal and external auditors to optimise the use of audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation.
- Carrying out an annual review of the effectiveness of internal audit.
- Regular monitoring of key performance metrics aligned to the delivery of the service.

External Audit

7.8 The Committee will review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved through:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee.

- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Trust Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring there is in place a clear policy for the engagement of external auditors to supply non-audit services.
- Regular monitoring of key performance metrics aligned to the delivery of the service.

Counter Fraud

7.9 The Committee will satisfy itself that the Trust has adequate arrangements in place for counter fraud, bribery and corruption that meet NHS Counter Fraud Authority's standards and will review the outcomes of work in these areas.

7.10 Specifically it will:

- Approve the Trust's Counter Fraud strategy and Local Counter Fraud Specialist annual work plan, including the resources allocated for the delivery of the strategy and work plan.
- Receive and review progress reports of the Local Counter Fraud Specialist against the four principles of the overall NHS Counter Fraud Strategy.
- Monitor the implementation of management actions arising from counter fraud reports.
- Receive and discuss reports arising from quality inspections by the counter fraud service.
- Make recommendations to the Trust Board as appropriate in respect of counter fraud at the Trust.
- Receive, review and approve the annual report of the Local Counter Fraud Specialist.

Other Assurance Functions

7.11 The Committee will review the findings of other significant assurance functions, both internal and external to the Trust; and consider the implications to the governance of the Trust.

7.12 These will include, but will not be limited to:

- Any reviews by Department of Health and Social Care arm's length bodies, or regulators and inspectors, - for example the Care Quality Commission, NHS Resolution etc.
- Professional bodies with responsibility for the performance of staff or functions – for example, Royal Colleges and accreditation bodies.

7.13 The Committee will review the work of other committees within the Trust, where their work can provide relevant assurance to the Audit Committee's own scope of work. In particular, this will include the four other assurance committees of the Trust Board (Finance and Performance, People, Charity, Quality, ~~and Risk Management~~ and Patient and Carer Experience Committee).

7.14 In reviewing the work of the Quality ~~and Risk Management~~ Committee, and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

7.15 The Committee will review and make recommendations to the Trust Board for any changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

7.16 The Committee will examine the circumstances associated with each occasion when Standing Orders are waived.

Management

7.17 The Committee will request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7.18 The Committee may also request specific reports from individual functions within the Trust, for example, clinical audit, as may be appropriate to the understanding of the overall arrangements.

Financial Reporting

7.19 The Committee will monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.20 The Committee will ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review for completeness and accuracy of the information provided.

7.21 The Committee will review the Trust Annual Report and financial statements before submission to the Trust Board. It will focus on:

7.22 The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.

7.23 Changes in, and compliance with, accounting policies, practices and estimation techniques.

7.24 Unadjusted misstatements in the financial statements.

7.25 Significant judgements in preparation of the financial statements.

7.26 Significant adjustments resulting from the audit.

7.27 Letters of Representation.

7.28 Explanations for significant variances.

8. Reporting

8.1 Minutes of the Committee's meetings will be formally recorded; and will be circulated to members of the Committee and others as necessary. The minutes will be circulated to the Chair for confirmation within 10 working days of the meeting and communicated to members as soon as the Chair has confirmed that he/she is content with them.

8.2 The Chair of the Committee will present a report to the next meeting of the Trust Board, summarising the key issues and will ensure that it draws to the attention of the Trust Board any issues that require disclosure to the Trust Board or require executive action.

8.3 The Committee will provide the Trust Board with an Annual Report, timed to support finalisation of the accounts and the Annual Governance Statement, summarising its conclusions from the work it has done during the year and including the following:

- The fitness for purpose of the Trust's assurance framework.
- The completeness and 'embeddedness' of risk management in the Trust.
- The integration of the governance arrangements.
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existences as a functioning business.
- The robustness of the processes behind the quality accounts.
- A description of how the Committee has fulfilled its terms of reference.
- Give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

9. Monitoring and Effectiveness

9.1 In order to support the continual improvement of governance standards, the Committee will complete a self-assessment of effectiveness at least annually and will identify any matters where it considers that action on improvement is needed and will make recommendations as to the steps to be taken.

9.2 The Committee will review these terms of reference annually.

10. Administrative Support

10.1 The Committee will be supported administratively by the Corporate Governance Team whose duties in this respect will include:

- Provide timely notice of meetings.
- Agreement of agendas with the Chair and attendees.
- Preparation, collation and circulation of papers in good time.
- Ensuring that those invited to the meeting attend.
- Taking the minutes and helping the Chair to prepare reports to the Trust Board.
- Keeping a record of matters arising and issues to be carried forward.
- Advising the Committee on pertinent issues/areas of interest/policy developments.

- Ensuring that action points are taken forward between meetings.
- Ensuring that Committee members receive the development and training they need.

Auditor Panel Terms of Reference

Date Approved	27 May 2021
Frequency Review	Annual
Next Review	May 2022
Terms of Reference Drafting	Trust Secretary
Review	Audit Committee
Approval	Trust Board
Version Number	0.2

1. Constitution

7.1. The Trust Board hereby resolves to nominate its Audit Committee to act as its auditor panel in line with schedule 4, paragraph 1 of the *Local Audit and Accountability Act 2014.*

7.2. The auditor panel is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

8. Authority

2.1 The auditor panel is authorised by the Trust Board to carry out the functions specified below and can seek any information it requires from any employees/relevant third parties. All employees are directed to co-operate with any request made by the auditor panel.

2.2 The auditor panel is authorised by the Trust Board to obtain outside legal or other independent professional advice – for example, procurement specialists, and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any 'outsider advice' must be obtained in line with the organisation's existing rules.

9. Membership

3.1 The auditor panel will comprise the entire membership of the audit committee with no additional appointees. This means that all members of the auditor panel are independent non-executive directors.

3.2 The Chair of the audit committee will be appointed Chair of the auditor panel by the Trust Board.

3.3 The Chair of the Trust will not be a member of the auditor panel.

3.4 The auditor panel Chair and/or members of the panel can be removed in line with rules agreed by the Trust Board.

10. Attendance at Meetings

4.1 The auditor panel's Chair may invite executive directors and others to attend depending on the requirement of each meeting's agenda. These invitees are not members of the auditor panel.

5. Quorum

5.1 To be quorate, independent members of the auditor panel must be in the majority AND there must be at least two independent members present or 50% of the auditor panel's total membership, whichever is the highest.

6. Frequency of Meetings and Conduct

6.1 The auditor panel will consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the audit committee.

6.2 Auditor panel business will be identified clearly and separately on the agenda and audit committee members will deal with these matters as auditor panel members NOT as audit committee members.

6.3 The panel's Chair shall formally state at the start of each meeting that the auditor panel is meeting in that capacity and NOT as the audit committee.

7. Conflicts of Interest

7.1 Conflicts of interest must be declared and recorded at the start of each meeting of the auditor panel.

7.2 A register of panel members' interests must be maintained by the panel's Chair and submitted to the Trust Board in accordance with the Trust's existing conflicts of interest policy.

7.3 If a conflict of interest arises, the Chair may require the affected panel member to withdraw at the relevant discussion or voting point.

8. Functions

The auditor panel's functions are to:

8.1 Advise the Trust Board on the selection and appointment of the external auditor. This includes:

- Agreeing and overseeing a robust process for electing the external auditors in line with the organisation's normal procurement rules.
- Making a recommendation to the Trust Board as to who should be appointed.
- Ensuring that any conflicts of interest are dealt with effectively.

8.2 Advise the Trust Board on the maintenance of an independent relationship with the appointed auditor.

8.3 Advise (if asked) the Trust Board on whether or not any proposal form the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.

8.4 Advise on (and approve) the contents of the Trust's policy on the purchase of non-audit services from the appointed external auditor.

8.5 Advise the Trust Board on any decision about the removal or resignation of the external auditor.

9. Reporting

9.1 The Chair of the auditor panel must report to the Trust Board on how the auditor panel discharges its responsibilities.

9.2 The minutes of the panel's meetings must be formally recorded and submitted to the Trust Board by the panel's Chair. The Chair of the auditor panel must draw to the attention of the Trust Board any issues that require disclosure to the full Trust Board or which require executive action.

10. Administrative Support

10.1 The Committee will be supported administratively by the Corporate Governance Team whose duties in this respect will include:

- Provide timely notice of meetings.
- Agreement of agendas with the Chair.
- Preparation, collation and circulation of papers in good time.
- Ensuring that those invited to the meeting attend.
- Taking the minutes and helping the Chair to prepare reports to the Trust Board.
- Keeping a record of matters arising and issues to be carried forward.
- Advising the Committee on pertinent issues/areas of interest/policy developments.
- Arranging meetings for the Chair.
- Ensuring that panel members receive the development and training they need.
- Providing appropriate support to the Chair and panel members.

12. Monitoring Effectiveness

12.1 The terms of reference will be reviewed on an annual basis.

Board Assurance Framework (BAF)

Introduction

The following document is the Trust's Board Assurance Framework (BAF) for 2021/22. The Board Assurance Framework defines and assesses the principle strategic risks to the Trust's objectives. It provides the Trust Board with assurance that those risks are being proactively managed and mitigated.

The BAF is designed to provide the Trust Board with a simple but comprehensive method for the effective and focussed management of principal risks to its strategic and business objectives. The Board defines the principal risks and ensures that each is assigned to a lead director as well as to a lead committee:

- The lead director is responsible for assessing any principal risks assigned to them by the Board and for providing assurance as to the effectiveness of primary risk controls to the lead committee;
- The role of the lead committee is to review the lead director's assessment of their principal risks, consider the range of assurances received as to the effectiveness of primary risk controls, and to recommend to the lead director any changes to the BAF to ensure that it continues to reflect the extent of risk exposure at that time;
- The Audit Committee is responsible for providing assurance to the Trust Board that the BAF continues to be an effective component of the Trust's control and assurance environment;
- The Trust Board reviews the whole BAF on a quarterly basis to ensure that the principal risks are appropriately rated and are being effectively managed; and to consider the inclusion within the BAF of additional risks that are of strategic significance.

A guide to the criteria used to grade all risks within the Trust is provided in Appendix A.

Trust Strategic & Business Plan Objectives:

Strategic Theme:	Aligned BAF Risk:
1. Provider of high quality patient care	SIR1 COV2 SIR8 SIR14 SIR15
2. Developing Healthcare for the future	COV2 SIR10 SER4

RESPONSIBLE COMMITTEES/BOARDS:

Finance & Performance Committee
- SIR1 (with QRMC)
- SIR8
- SIR10 (with P&DC)
- SIR16
- SIR15
- SER4

People Committee
- SIR2

Quality Committee
- SIR1 (with F&PC)
- COV1
- SIR14

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

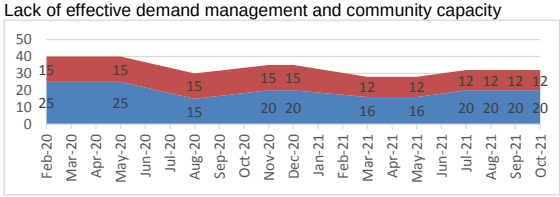
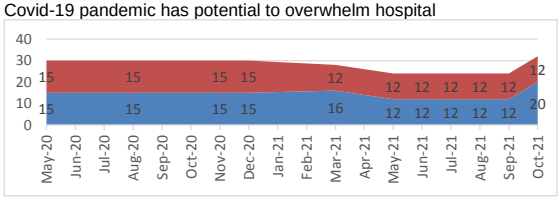
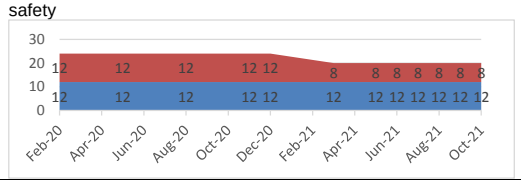
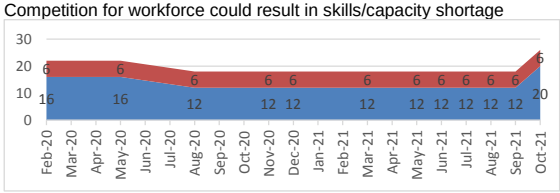
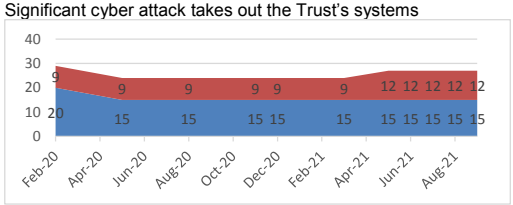
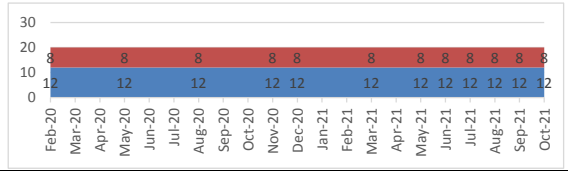
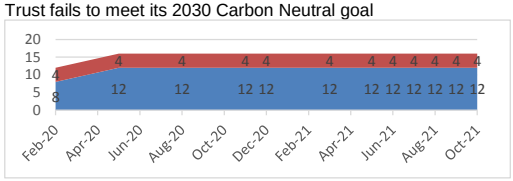
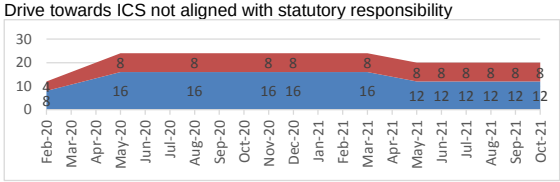
3. Employer of choice	**COV2 SIR2 SIR8 SIR14 SER4**
4. An anchor in our community	**COV2 SIR8 SIR10 SIR16**

Version Control:

Version:	Summary of changes:	Reported to:
V1	Approved by Trust Board 26/02/2020	Trust Board 26/02/2020
V2	All risks updated in May 2020, two new Covid-19 risks proposed, plus climate change risk added	Trust Board 28/05/2020
V3	Covid-19 risk scores reduced	QRMC 16/06/2020
V4	Covid-19 risk score (Cov-1) increased following discussion at QRMC	To Trust Board August 2020
V5	BAF – alignment to strategy/business plan updated Actions across all risks updated. Risk ratings on SIR 1, SIR 2, COV1 and COV2 updated.	Extracts to F&P Committee (18/08/2020) and P&D Committee (19/08/2020) Full BAF to Trust Board 27/08/2020.
V6	Updates to SIR8 and SIR10	Extract to F&P Committee (20/10/2020)
V7	BAF redrafted, risks consolidated, and overall number reduced. Actions updated in January 2021	Relevant risks to QRMC (19/11/2020), People & Digital (9/12/2020), Finance & Performance (10/12/2020)
V8	BAF risks updated and actions updated Feb/March 2021	To Trust Board 25/03/2021 Extracts to F&PC 22/04/2021
V9	BAF risks updated and actions updated May 2021 Version 9.1 contains further updates from May 2021 Version 9.2 contains updates from internal Audit report 2021	To QRMC 11/05/2021 To Trust Board 27/05/2021 To Trust Board 29/07/2021
V10	Updates to risks SIR1, COV2, SIR14 for QRMC (Sept 2021) Update to risk SIR2 for People Committee (October 2021) Updates to SIR1 and COV2 for QRMC (October 2021)	To QRMC 14/09/2021 To People Committee 15/10/2021 To QRMC 15/10/2021
V11	Updates to FPC Risks	To FPC 21/09/2021
V12	Updates to various risks by Chief Operating Officer	To Executive Assurance Forum 27/10/2021
V13 V13.1	Updates from 27 October 2021 Executive Assurance Forum Updates from JS and HB on COV2, SIR1,	To Quality Committee November 2021 Trust Board November 2021

Board Assurance Framework (BAF)

Summary of Risks

Risk	Current Residual Risk	Risk Summary and Trend	Forecast Trajectory (next 12 months)	Risk	Current Residual Risk	Risk Summary and Trend	Forecast Trajectory (next 12 months)
SIR1	16	Lack of effective demand management and community capacity 	⇔				
COV2	12	Covid-19 pandemic has potential to overwhelm hospital 	⇔	SIR14	12	Sustained demand and increased acuity will impact on patient safety 	⇔
SIR2	12	Competition for workforce could result in skills/capacity shortage 	↑	SIR15	15	Significant cyber attack takes out the Trust's systems 	⇔
SIR8	12	Lack of investment in retained estate results in inappropriate spaces to deliver care 	⇔	SIR16	12	Due to lack of resource and complexity of required planning, Trust fails to meet its 2030 Carbon Neutral goal 	⇔
SER4	12	Drive towards ICS not aligned with statutory responsibility 	⇔				

Assurances set out for each risk in the Board Assurance Framework are categorised in line with the 'three lines of defence' model of risk management:

Key:

(1) **First line - Functions that own and manage risks**
(2) **Second line - Functions that oversee risks**
(3) **Third line - Functions that provide independent assurance**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 1	**Jon Scott, Chief Operating Officer** Last reviewed: 19/11/2021 **Finance & Performance Committee** **Quality Committee** Last reviewed: QRMC 15/10/2021	**Patient flow across the hospital is constrained by:** - **Low numbers of early ward discharges** - **inconsistent "internal professional standards"** - **strained community capacity,** **This affects the performance of the hospital against key operational performance and quality targets. In turn this:** - **affects patient experience** - **leads to potential patient harm, and** - **affects the reputation of the Trust and of the NHS.** Note: Elements of this risk are outside of the Trust's direct control (demand management & community capacity) – actions are focused on those areas that are within the organisation's influence. EXTERNALLY AND INTERNALLY DRIVEN RISK	Inherent likelihood: **5 (Almost certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	Internal: FLOW boards (real-time bed state) Right to Reside data Integrated Discharge Service Repatriation Policy Urgent Care Improvement Board (internal) H2 Recovery and Winter plan OPEL/ICI Escalation & COVID-19 surge policies/procedures COVID-19 Command & Control (Internal) Accountability Framework Divisional Review assessment of and support to Divisions. External: COVID-19 Command & Control (External) Whole System Operational Group (WSOG – external) - over 21-day LoS Patients reviewed in detail OPEL escalation process in system forums (Whole System Operational Group, OOH Delivery Group) Discharge Programme Investment Re-launched internal Urgent Care Board action plan Initiation of NHSEI UEC Recovery Model Engagement with National UEC Improvement Team	**Internal Assurance** Board rounds and site management processes (1) Integrated Performance Report (2) Patient flow metrics – daily control centre information (1) Executive Team weekly review of dashboards and ED quality metrics (2) Performance report to Finance & Performance Committee (2) Finance & Performance Committee deep-dives into operational performance (2) QRMC Deep dives into patient harm (2) Divisional Performance Reviews (2) Urgent Care Board(2) **External Assurance** Urgent & Emergency Care Steering Group (external) (2) System Delivery & Operational Group (external) (2) CQC 2019 inspection – Urgent and Emergency Services rated Good (3)	Residual likelihood: **5 (Likely)** Residual impact: **4 (severe)** Residual risk rating: **20** **(Severe)** Previous residual risk rating: **3x5=15** **4x5=20** **5x4=20** Residual risk rating last changed: **22/10/2020** **09/03/2021** **08/07/2021** Forecast trajectory (next 12 months): ⇔		Implementation of agreed Winter Plan and H2 Recovery Programme. (19/11/21). **Owner: COO** Ongoing scrutiny and actions: - implementation of internal professional standards (19/11/21) - implementation of 15 point Medicine Division action plan (24/11/21) - Exploring UTC capacity provision including additional physical space for ambulances and SDEC programme and additional temporary staff resource to Medicine Division (19/11/21) - Minors streaming programme (Winter 21/22) **Owner: COO** Implementation of discharge to Assess included within the 2021-22 Winter Plan agreed 19/11/21 (Winter 21/22) Review of additional funding mechanism to patient families underway. (Winter 21/22) Patient families are being contacted to increase support to patients and improve discharges. (Winter 21/22) **Owner: Whole System Operational Group (Chair - Lisa Manson, Member COO).**	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**
							External: Staffing crisis within social and community care is restricting discharge of patients to bedded and domiciliary care and increasing the number of beds occupied by patients whose care package is delayed.		

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Developing healthcare for the future Employer of choice Anchor in the community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
COV 2	**Jon Scott, Chief Operating Officer** **Helen Blanchard, Director of Nursing & Quality (Director of Infection Prevention Control)** Last reviewed: 22/11/2021 **Quality Committee** Last reviewed: 15/10/2021	**Due to the impact of social distancing, lockdowns, and other IPC controls during the past 12-18 months, it is probable that 2021/22 winter period will see an increase in infectious diseases within the hospitals (such as flu, norovirus and ongoing Covid-19 infections). This would likely impact across several areas including:** - **Capacity to provide effective and safe care to patients** - **Impact on bed numbers due to IPC controls and closed beds, impacting patient flow in the hospital** - **Reduction in staff numbers due to staff sickness, self-isolation, and shielding, and** - **Increase in patients waiting packages of care due to staffing shortages in the domiciliary and care market** - **Public confidence in the hospital and the NHS.** Note: drivers of this risk are outside of the organisation's direct control actions are focused on those areas that are within the organisation's influence. EXTERNALLY DRIVEN RISK	Inherent likelihood: **5** **(Almost certain)** Inherent impact: **5** **(Catastrophic)** Inherent risk rating: **25** **(Extreme)**	**Internal** COVID-19 Command and Control structures in NBT, including groups overseeing: - Data analytics - IPC - Workforce - PPE - Staff testing Covid-19 Surge and super-surge plans / policies for ICU and general acute capacity, testing and mortuary Increased capacity for remote working Daily Operational Bed Meetings Winter plan Escalation & COVID-19 surge policies/procedures COVID-19 Command & Control (Internal)**External** Significant engagement in system and regional forums Engagement and leadership role in Severn Critical Care Network System COVID-19 Command and Control structures National Vaccination Programme, including Covid-19 booster programme and Flu vaccination programme	**Internal Assurance** COVID-19 sit-rep [1] NBT specific pandemic modelling [1] COVID-19 reports to Trust Board and TMT (monthly) [2] Integrated Performance Report [2] **External Assurance** Regional and local specific pandemic modelling [3] Reports and updates via local and regional forums [3]	Residual likelihood: **4** **(Likely)** Residual impact: **5** **(Severe)** Residual risk rating: **20** **(High)** Previous residual risk rating: **3x4=12** **4x4=16** **5x5=25** **4x3=-12** **4x4=16** **4x5=20** Residual risk rating last changed: **15/01/2021** **09/03/2021** **17/05/2021** **16/07/2021** **06/10/2021** **25/10/2021** Forecast trajectory (next 12 months): ⇔		New Infection Prevention Control guidance due for release in November, to determine if it allows opportunities to change practice and increase clinical activity. **Date:** 23/11/2021 **Owner:** Director of Nursing & Quality Further concerted efforts to promote the uptake of booster and flu vaccinations in progress. **Date:** Throughout winter – campaign ends Feb/March 2022 **Owner:** Executive Team (Medical Director lead)	Target likelihood: **3** **(Possible)** Target impact: **4** **(Severe)** Target risk rating: **12** **(High)**

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	Employer of choice		

Ref	Lead Director / Lead Committee	**Principal risk:**	**Inherent risk score**	**Primary controls**	**Assurances**	**Residual risk score**	**Gaps in control or assurance**	**Planned actions *(including owner and delivery date)***	**Target risk score**
SIR 2	**Jacqui Marshall, Director of People & Transformation** Last reviewed: 18/11/2021 **People Committee** Last reviewed: 08/06/2021	**National/system competition for workforce in key specialties/ professions (e.g. sonographers & histopathologists), together with increasing demands on remaining staff plus post-Covid-19 fatigue could result in skills/capacity shortages within the Trust and increased instability in the workforce.** **Consequences would include** - **Increased reliance on expensive agency staff** - **Higher turnover, which could result in dramatic increase in recruitment activity and associated costs** - **Poor patient safety & experience due to staff shortages.** Elements of this risk are outside of the Trust's direct control (training of professionally registered medics and other specialists) – actions are focused on those areas that are within the organisation's influence. INTERNALLY & EXTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	BNSSG Workforce Strategy Nursing Workforce Group overseeing mitigating work Medical Workforce Group overseeing mitigation work Retention steering group & Pathfinder Programme Retention interventions (overseen by Retention steering group) Covid-19 Recovery & Restoration Programme Award-winning, nationally recognised Staff Health & Wellbeing offering Buying & selling annual leave policy Itchy feet campaign Flexible working offer expanded Strong development and leadership offer Increased opportunities through SLM Programme BNSSG workforce recovers cell in place from Feb 2021 BNSSG development of EVP offer BNSSG integrated staff bank Increased use of traineeship and apprenticeships. Shared recruitment material and Employee Value Proposition for system recruitment.	**Internal Assurance** Integrated Performance Report – HR/Well-Led section [2] People Committee deep-dives and performance review [2] People Balanced Scorecard [1] Staff survey results & action plans [2] Voice Programme [1] Happy App [1] Exit interview data [1] Pulse Surveys [1] Freedom to Speak Up Report [2] Recruitment & retention deep-dive – March 2021 People Committee meeting [2] System-level workforce cell monitors and shares terms and conditions data and any operational WLI proposals to ensure transparency and parity. [2] **External Assurance** Gender pay-gap report (2018) [3] National Retention Data [3]	Residual likelihood: **5 (Almost certain)** Residual impact: **4 (Severe)** Residual risk rating: **20** **(Extreme)** Previous residual risk rating: **4x4=16 3x4=12 5x4=20** Residual risk rating last changed: **12/08/2020 05/10/2021** Forecast trajectory (next 12 months): ↑	There is potential competition between providers within the BNSSG ICS for the same staff, and there are identified differentials in grading between similar roles. There are insufficient trained staff in certain professions (including nursing, sonographers, histopathologists etc.) to meet ongoing and increasing needs.	System-level Workforce Plan (1, 3,5 year) is under development via the system workforce cell **Due date: 1 April 2022** **Owner: Director of People & Transformation** (DoPT) Focus on retention initiatives, including agile working, health & wellbeing, revised sickness policies (focusing on supportive wellbeing), system people plan. **Due date: many of these initiatives are ongoing. The system people plan and initiatives are** **Owner: DoPT** International recruitment pipeline – additional 11 staff joined via this pipeline in August 2021. Pipeline ongoing for 2021/22. **Due date: 31/03/2022** **Owner: DoPT**	Target likelihood: **2 (Unlikely)** Target impact: **3 (Moderate)** Target risk rating: **6** **(Moderate)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care Employer of choice An anchor in our local community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 8	**Simon Wood, Director of Facilities** Last reviewed: 22/07/2021 **Finance & Performance Committee** Last reviewed: 22/04/2020	**A lack of investment in retained estate results in inappropriate spaces to deliver care, and estate which does not comply with relevant legislation. This may result in issues with staff retention, patient experience and complaints, compliance concerns and an impact on financial and operational sustainability** Note: The Trust has control over its internal capital spend. This risk is considered a controllable risk. INTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	Capital Planning Group & sub-structure Capital Plan and Estates Strategy/Masterplan approved 2020 Health & Safety Committee & policies Preventative Maintenance Programme 2019/20 and emerging 2020/21 capital programme Facilities help-desk (to advise on any deterioration of estate) Facilities Management walk-arounds/inspections Executive walk-arounds Expected capital programme slippage used as a contingency for unexpected works in the retained estate.	**Internal Assurance** Capital Planning reports to Finance & Performance Committee (twice-yearly) (2) Health & Safety reports to People & Digital Committee (quarterly + annual report) (2) ERIC Benchmarking confirms relative position to other Trusts (annual process) (2) WACH – condition and H&S survey (2018) (1) South Bristol Dialysis and Westgate House condition survey (2018) (1) Fire risk audits undertaken regularly across the site (1) Six Facet Survey completed 2020 (3) Estates Master Plan (August 2020) (1) **External Assurance** Fire Safety Assurance Survey (Brunel - 2019) (3)	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(High)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): ⇔	There is ongoing uncertainty around the financial framework and funding mechanism for the NHS long-term (post Covid-19). The Trust continues to ensure that there is regular capital investment in Critical Infrastructure towards compliant and appropriate clinical accommodation. However, this is limited by all other Trust-wide requirements therefore some programmes will be delivered over extended periods. It is assumed that major estates improvements will be specifically externally funded.	NBT is remaining engaged in system discussions to ensure that it is able to respond to changing national requirements. **Owner: Chief Executive** **Due Date: October 2021 (MOU finalisation)** The Trust Estates/Capital Team are progressing various significant schemes to "shovel ready" state, in anticipation of national funding calls becoming available. Elective Care Centre, W&C Estates and Accommodation Projects are specifically being progressed in this manner. Update to F&PC Planned for Q2 2021/22. **Owner: Director of Estates, Facilities & Capital Planning** **Due Date: Sept 2021**	Target likelihood: **2 (Unlikely)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

NHS North Bristol NHS Trust

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality clinical care Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 14	**Tim Whittlestone, Medical Director Helen Blanchard, Director of Nursing & Quality** Last reviewed: 22/11/2021 **Quality Committee** Last reviewed: 15/10/2021	**Sustained demand and increased acuity of patients in hospital will impact on patient safety and outcomes, leading to harm in patients and poorer patient experience.** Note: while this risk is externally driven, there are element of the risk that the trust can control through efficient and effective working. INTERNALLY & EXTERNALLY DRIVEN RISK	Inherent likelihood: **5 (Almost certain)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **25** **(Extreme)**	Safety and quality work across the Trust Clinical Risk Operational Group oversees all SI and adverse events Patient Safety & Clinical Risk Committee Divisional quality governance structures reporting to Divisional Boards Divisional quality reviewed in Divisional performance review meetings Patient experience work across the Trust Learning from Deaths process and new Medical Examiner function Freedom to Speak Up structure and function Patient harm reviews for delayed cancer patients - overseen by Cancer Board Patient Safety Incident Response Framework (NBT Early Adopter)	**Internal Assurance** Quality and patient outcomes monitored by QRMC and its governance sub-structure (2) Safer staffing reviews every 6 months with daily monitoring (1) Patient experience and outcomes monitored by Patient & Carer Experience Committee and its governance sub-structure (2) Integrated Performance Report - Quality Data (2) QRMC oversight and deep dive reviews e.g. long-wait patient harm, falls etc.(2) Clinical audit outcomes and action plans - reported to QRMC (2) Quality Accounts (1) Internal Audit processes - Divisional Governance Audit (repeat in 2019/20) & audit of GE governance review (2019/20) (3) Freedom to speak up reports to board (biannual) (2) CQC Reports (3) CQC service level visits (3) Medical Examiner Model (jointly with UHBW) (2) **External Assurance** Annual national patient survey results & FFT (3)	Residual likelihood: **4 (Likely)** Residual impact: **3 (Moderate)** Residual risk rating: **12** **(High)** Previous residual risk rating: **3x3=9 3x4=12 4x4=16 4x3=12 3x4=12** Residual risk rating last changed: **21/10/2020 15/01/2021 17/03/2021** Forecast trajectory (next 12 months): ⇔	Current performance pressures in the Emergency Department, and lack of patient flow, are creating sustained demand on the hospital, with increasing number of Covid-19-positive patients.	Ongoing scrutiny and actions: - Trust wide engagement and commitment to the H2 Recovery programme, including; - implementation of internal professional standards - redesign of ambulance handover pathway and zone - Queue streaming and displacement - Appraisal and re-design of emergency zone and direct admit zones - Exploring UTC provision - Minors streaming programme **Due Date: Update to Trust Board November 2021** **Owner: COO**	Target likelihood: **2 (Possible)** Target impact: **3 (Moderate)** Target risk rating: **6** **(High)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Provider of high quality patient care		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Primary controls	Assurances	Residual risk score	Gaps in control or assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 15	**Neil Darvill, Director of IM&T** Last reviewed: 17/05/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**A significant cyber-attack takes out the Trust's IT systems leading to an inability to treat patients and the potential loss of critical data.** Note: while this risk is externally driven, there are element of the risk that the trust can control through mitigations and additional back-up/protection. EXTERNALLT DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **5 (Catastrophic)** Inherent risk rating: **20** **(Extreme)**	IT security measures Daily immutable system back-ups Business continuity and recovery plans Timely server and software updates NHS Digital cyber security programme Care Cert Server and Network vulnerability scanners STP Cyber Security Group aligning organisational standards and ensuring best practice. Extensive migration to Windows 10 and Office 365 during 2020/21 Updated Enterprise Network completed in Q4 2019/20 NHS Digital South West Regional Cyber Security Group for direction and access to national solutions.	**Internal Assurance** Data security protection return (draft presented to October 2020 People & Digital Committee) (2) Cyber security report (monthly to IM&T Divisional Board and F&P Committee) (2) **External Assurance** Information Commissioner Audit December 2019 (3) Penetration Tests and assessments, October 2020(2) KPMG Data Security Protection Toolkit audit May 2021 (3)	Residual likelihood: **3 (Possible)** Residual impact: **5 (Catastrophic)** Residual risk rating: **15** **(Extreme)** Previous residual risk rating: **4x5=20** Residual risk rating last changed: **22/05/2020** Forecast trajectory (next 12 months): ⇔	Significant work has been completed in 2019/20 and early 2020/21 to reduce the likelihood of a cyber-security incident, through updating networks and migration to up-to-date operating systems. Work is now planned in 2020/21 to reduce the impact of any successful cyber-security attack.	Additional work is underway to implement software tools to proactively monitor network activity and quickly identify and respond to any changes to normal activity. **Owner: Phil Wade** **Due Date: Q3 2020/21** Update May 2021: Active Directory Log Data is now uploaded for analysis as part of the South West Regional Security Information and Event Management (SIEM) solution. Update July 2021: Firewall log data is now uploaded for analysis as part of the South West Regional Security Information and Event Management (SIEM) solution.	Target likelihood: **3 (Possible)** Target impact: **4 (Severe)** Target risk rating: **12** **(High)**
								The Trust's online back-up solution is being updated, which will allow more effective restoration of activity lost in the event of a cyber-security attack. **Owner: Phil Wade** **Due Date: Q3 2020/21** Update May 2021: The solution has been implemented and migrations to the platform are now underway. Final completion expected Q3 2021/22	
							The Trust does not yet have cyber security insurance in place. This is consistent with other NHS organisations due to the immaturity of this particular insurance market	A key entry criterion for insurance is to obtain Cyber Essentials Plus certification. The Trust is pursuing this certification and hopes to complete this in Q2 2020/21 and then investigate appropriate insurance cover. **Owner: Director of IM&T** **Due date: end of Q2 2021/22**	

Board Assurance Framework (BAF)

Trust Strategic Theme:	An anchor in our Community		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Areas of influence/controls	Monitoring/assurance	Residual risk score	Gaps in influence or monitoring/assurance	Planned actions *(including owner and delivery date)*	Target risk score
SIR 16	**Simon Wood, Director of Estates, Facilities & Capital Planning** Last reviewed: 14/09/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**There is a risk that due to lack of resource and the complexity of the required planning, the Trust fails to meet its 2030 Carbon Neutral goal (i.e. key objective in Business Plan not met)** **This would constitute a failure to support Bristol's One City Plan and Climate Strategy and would represent a reputational risk** Note: The Trust has control over setting its internal priorities. This risk is considered a controllable risk. INTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **4 (Severe)** Inherent risk rating: **16** **(Extreme)**	NBT's has a Sustainable Development (SD) structure in place and formally approved to lead and steer An annual, Board approved, Green Plan There is an SD Steering Group with multi-disciplinary and NED membership. An understanding of NBT's current basic carbon footprint already exists. Monitoring of annual carbon emissions occurs Business Planning process includes a Carbon Assessment Tool to support Divisions/Directorates in identifying carbon reduction opportunities. Procurement and spending choices will be available to the Trust Representation with Civic and local Partners is in place at many levels and multiple streams which can assist influencing around Carbon 2030 progress	NBT carbon footprint is calculated and reported using the national NHS tool (1) Sustainable Development Steering Group and TMT / Trust Board approve annual Green Plan (ex-SDMP) which details carbon reduction efforts (2) National Sustainable Development Unit takes an overview of Trust SD activities (3) ERIC/Model Hospital comparative data (1) Possible Occasional Internal Audit assessments (2) Carbon and Energy Manager, Senior Sustainability Partner and Sustainability Partner (FM) posts (1)	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(Severe)** Previous residual risk rating: **N/A** Residual risk rating last changed: **N/A** Forecast trajectory (next 12 months): ⇔	Insufficient in-house expertise to identify and prioritise the full range of measures/actions required to achieve carbon neutrality by 2030, (including measures outside of our control.) Carbon Assessment Tool is not being completed by all Divisions/Directorates	Appointed a consultant to develop a Carbon 2030 Route-map (prioritised plan) to inform 2022/23 business planning. 11 month programme agreed, running from March 2021. Headlines in Nov 2021. **Owner: Sustainable Development Unit** **Due Date: February 2022** Recruit Carbon 2030 champions from each Div/Dir to support identification of measures, implementation of projects and progress monitoring. Sustainability Advocate role description shared, tested effectively with Medicine, roll-out in Sept 2021 **Owner: Sustainable Development Unit** **Due Date: Sept 2021** Additional funding (£2.3M) has been awarded from the Public Sector Decarbonisation Scheme (with £700K NBT contribution) to support investment in energy efficiency/renewables. Update: 14 October 2021 - This is now progressing, action to be closed. **Owner: Director of Estates, Facilities & Capital Planning** **Due Date: outcome of expected July/Aug 2021**	Target likelihood: **2 (Unlikely)** Target impact: **2 (Minor)** Target risk rating: **4** **(Moderate)**

Board Assurance Framework (BAF)

Trust Strategic Theme:	Developing healthcare of the future Employer of choice		

Ref	Lead Director / Lead Committee	Principal risk:	Inherent risk score	Areas of influence	Monitoring/assurance	Residual risk score	Gaps in influence or monitoring/assurance	Planned actions *(including owner and delivery date)*	Target risk score
SER 4	**Maria Kane, Chief Executive** **Xavier Bell, Director of Corporate Governance** Last reviewed: 110/11/2021 **Finance & Performance Committee** Last reviewed: 22/04/2021	**The practical implications of the new statutory Integrated Care Systems are not yet fully understood, with guidance still at a formative stage, and significant elements may be left for local determination.** **As an example, the mechanism for allocating income from Commissioner to Provider to cover additional costs or underlying deficits is not defined in the draft legislation.** **This risks uncertainty in lines of accountability and responsibility, and consequences could include an impact on the organisation's ability to plan effectively.** Note: while the Trust can influence ICS development, the drivers behind this risk are largely outside the Trust's control. EXTERNALLY DRIVEN RISK	Inherent likelihood: **4 (Likely)** Inherent impact: **4 (Extreme)** Inherent risk rating: **16** **(Extreme)**	Chair and Chief Executive relationships with senior regulators Lobbying at regional/national level (Chair & Executives), and lobbying via NHS Providers NBT Executive and Chair attendance at formal Healthier Together governance meetings such as Partnership Board and Healthier Together Executive Meeting NBT represented in system by CEO, COO and DOF via key meetings such as: - System DOFs meeting - System Delivery Oversight Group - System CEO meetings Director of Corporate Governance involved in Healthier Together governance working group Trust Board fed into BNSSG Healthier Together response to NHSE/I ICS consultation 2020/21 Trust Board Chair submitted NBT response to NHSEI ICS consultation 2020/21	CCG Board Reports (local) [(1)] NHSE/I Board Reports (national and specialised commissioning) [(1)] System Operational Planning and Long-Term Plan processes [(1)] Healthier Together Reports [(1)] Healthier Together Development Programme Participation [(1)] Government White Paper February 2021[(1)] Engagement in ICS Development Programme – run by Healthier Together [(1)] NBT/UHBW Provider Collaborative Board Meetings/Agenda [(2)] UHBW & NBT Acute Provider Collaborative Board meetings [(2)] System MOU agreed by Healthier Together Partnership Board (October 2021) [(2)]	Residual likelihood: **3 (Possible)** Residual impact: **4 (Severe)** Residual risk rating: **12** **(Extreme)** Previous residual risk rating: **4x4=16** Residual risk rating last changed: **17/05/2021** Forecast trajectory (next 12 months): ⇔	ICS development and formal governance structures are still under development	Participation in ongoing ICS governance framework development work throughout 2020/21. ICS Board structure, membership, and decision-making development sessions are scheduled for November Partnership Board meetings. **Due date: December 2021** **Lead: Director of Corporate Governance**	Target likelihood: **2 (Rare)** Target impact: **4 (Severe)** Target risk rating: **8** **(High)**

Board Assurance Framework (BAF)

Board Assurance Framework (BAF)

APPENDIX A: RISK SCORING MATRIX

Every risk recorded within the Trust's risk registers is assigned a rating, which is derived from an assessment of its Impact Score (severity of potential hard) and its Likelihood Score (the probability that the risk event will occur). The risk grading criteria summarised below provide the basis for all risk assessments recorded within the Trust's risk registers, at strategic, operational and project level.

Impact Score (severity of potential harm)

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
Patient Experience	Unsatisfactory patient experience not directly related to patient care Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Unsatisfactory patient experience – readily resolvable Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Minor implications for patient safety if unresolved	Mismanagement of patient care Repeated failure to meet internal standards Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Major patient safety implications if findings are not acted on	Serious mismanagement of patient care Multiple complaints/ independent review Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service Inquest/ombudsman inquiry Gross failure of patient safety if findings not acted on
Patient Safety	Minimal injury requiring no/minimal intervention or treatment.	Low harm injury or illness, requiring minor/short-term intervention. Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Increase in length of hospital stay by 4-15 days	Severe injury leading to long-term incapacity/disability Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects
Health & Safety	No time off work	Requiring time off work for <3 days	Requiring time off work for 4-14 days RIDDOR / MHRA / agency reportable incident	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects
Workforce	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality.	Late delivery of key objective / service due to lack of staff. Minor error due to insufficient training. Ongoing unsafe staffing level.	Uncertain delivery of key objective / service due to lack of staff. Serious error due to insufficient training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. Very high turnover. Critical error due to insufficient training.
Performance, Business Objectives	Interim and recoverable position Negligible reduction in scope or quality Insignificant cost increase	Partial failure to meet subsidiary Trust objectives Minor reduction in quality / scope Reduced performance rating if unresolved	Irrecoverable schedule slippage but will not affect key objectives Definite reduction in scope or quality Definite escalating risk of non-recovery of situation Reduced performance rating	Key objectives not met Irrecoverable schedule slippage Low performance rating	Trust Objectives not met Irrecoverable schedule slippage that will have a critical impact on project success Zero performance rating
Service Delivery & Business Continuity	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Financial	No or minimal impact on cash flow	Readily resolvable impact on cash flow Loss of 0.1–0.25 per cent of Trust's annual budget	Individual supplier put Trust "on hold" Loss of 0.26–0.5 per cent of Trust's annual budget	Major impact on cash flow Purchasers failing to pay on time Uncertain delivery of key objective Loss of 0.6–1.0 per cent of Trust's annual budget	Critical impact on cash flow Failure to meet specification/ slippage Non-delivery of key objective/ Loss of >1 per cent of Trust's annual budget
IM&T	Information system issue affecting one service user	Information system issue affecting one department Poor functionality of trust wide system, readily resolvable and not impacting service delivery	Information system issue affecting one division Poor functionality of trust wide system impacting service delivery, but readily resolvable.	Information system issue affecting more than one division. Poor functionality of trust wide system impacting service delivery, not readily resolvable	Complete failure of trust wide information system that directly impacts service delivery.
Reputational	Rumours	Local Media – short term	Local Media – long term	National Media < 3 days	National Media ≥ 3 days. MP Concern (Questions in House)
Statutory Duty & Inspections	No or minimal impact or breach of guidance/ statutory duty Minor recommendations	Non-compliance with standards reduced rating. Recommendations given.	Single breach in statutory duty Challenging external	Enforcement Action Multiple challenging recommendations	Prosecution Multiple breaches in statutory duty

Board Assurance Framework (BAF)

	1	2	3	4	5
Risk Type	**Negligible**	**Minor**	**Moderate**	**Severe**	**Catastrophic**
			recommendation Improvement notice	Improvement notices Critical report	Complete systems change required Severely critical report

Likelihood Score

The Likelihood Score is calculated by determining how likely the risk is to happen according to the following guide. Scores range from 1 for rare to 5 for almost certain.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Broad descriptor	This will probably never happen/recur	Do not expect it to happen/recur	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability Will it happen or not?	<0.1 per cent	0.1–1 per cent	1.1–10 per cent	11–50 per cent	>50 per cent

The **Risk Score** is determined by the Impact x Likelihood.

Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Severe	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Low	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Grade:

1-3	Low Risk
4-6	Moderate Risk
8-12	High Risk
15 - 25	Extreme Risk

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

Internal Policy Number: CO12

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

Main Author(s):	Chief Executive (for SOs and SRP) ~~Director of Finance~~Chief Finance Officer (for SFIs and SoDA) Director of Corporate Governance/Trust Secretary
Consultation:	Executive Team Audit Committee Trust Board
Ratifying Committee:	Trust Board
Executive Lead:	Xavier Bell, Director of Corporate Governance/Trust Secretary
Date of Approval:	26 November 2020
Next Review Due:	~~26~~ November 202~~1~~2 – or earlier if required by legislation or regulatory change
Version:	8.2~~1~~

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

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.

	V8.2 November 2021 – Annual Review

Trust Standing Orders

North Bristol NHS Trust

Contents

This version of the Standing Orders can only be guaranteed to be the current adopted version, if it is opened directly from the Trust's intranet library of policies and procedures.

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.

Introduction

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

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

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

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

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

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

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

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

Interpretation

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

X. The following definitions apply for this document.

Legislation definitions:

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

- **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.
- ~~**Director of Finance**~~**Chief Finance Officer** ~~is the Director of Finance;~~ and is the chief finance officer of the Trust.
- **Committee** is committee appointed by the Trust Board.
- **Committee Members** are formally appointed by the Trust Board to sit on, or to chair specific committees.
- **Clinical Directors** are specialty leads reporting to and accountable to the Chief Operating Officer, with professional oversight from the Medical Director. They are ***excluded*** from the term "Director" for the purposes of this document, unless specifically stated otherwise.
- **Directors** are the Non-Executive Directors and the Executive Directors
- **Director of Facilities** is the Director of Estates Facilities and Capital Planning
- **Establishment Order** is the North Bristol National Health Service Trust (Establishment) Order 1999, Statutory Instrument number 625.
- **Executive Director** is an officer of the Trust. Up to five will be voting members of the Trust Board, appointed in accordance with the Membership and Procedure Regulations, 1990. The remainder will not be eligible to vote on the Trust Board.
- **Funds Held on Trust** are those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Part 11 (eleven) of the NHS Act 2006. Such funds may or may not be charitable.
- **Motion** is a formal proposition to be discussed and voted on during the course of a Trust Board or Committee meeting.
- **NHS Improvement (NHSI)** is responsible for the oversight of NHS trusts and has delegated authority from the Secretary of State for Health for the

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

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

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

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.

2.3. The Executive Directors shall include:

2.3.1. Chief Executive

2.3.2. ~~Director of Finance~~Chief Finance Officer, or equivalent

2.3.3. Medical Director

2.3.4. Director of Nursing, or equivalent

2.3.5. Chief Operating Officer

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

3. Appointment of the Chair and directors

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

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

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

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

4. Vice-Chair

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

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

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

5. Tenure of office

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

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

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

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

7. Functions and roles of Chair and directors

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

Part II – Meetings

8. Ordinary meetings of the Trust Board

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

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

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

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

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

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

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

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

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

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

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

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

9. Extraordinary meetings of the Trust Board

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

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

10. Notice of meetings

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

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

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

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

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

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

11. The agenda and Supporting Papers

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

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

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

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

12. Chair of meetings

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

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

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

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~~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~~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~~directors' present and eligible to vote so request.

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

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

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

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

13.8.1. either or both of those persons may attend and take part in the meetings of the Trust Board.

13.8.2. if both are present at a ~~meeting~~meeting, they will cast one vote if they agree.

13.8.3. in the case of ~~disagreement~~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.

14. Quorum

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

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

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

15. Record of attendance

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

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

16. Minutes

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

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

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

17. Notice of motion

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

18. Motions

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

18.1.1. an amendment to the motion.

18.1.2. the adjournment of the discussion or the meeting.

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

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

18.1.5. that the motion be now put

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

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

19. Right of reply

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

20. Motion to rescind a decision of the Trust Board

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

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

21. Declaration of Interests and Register of Interests

Declaration of Interests

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

21.2. Interests are:

21.2.1. Financial interests, where an individual may get direct financial benefit from the consequences of a decision they are involved in making.

21.2.2. Non-financial professional interests, where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.

21.2.3. Non-financial personal interests, where an individual may benefit personally in ways which are not linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.

21.2.4. Indirect interests, where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

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

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

21.5. Declarations of interests should be considered by the Trust Board and retained as part of the record of each Trust Board meeting. Any changes in interests should be declared at the next Trust board meeting following the change occurring.

21.6. If a conflict of interest is established during the course of a Trust Board meeting, whether arising from a declared interest or otherwise, the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The declared conflict of interest should be recorded in the minutes of the meeting. When a Director has declared an interest arising solely from a position with a charity or voluntary body under this Standing Order, the Trust Board may resolve that the director may remain in the meeting and take part in the discussion, but not vote on the relevant item. A record of this decision shall be made in the minutes.

21.7. Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

Register of Interests

21.8. The Trust Secretary will ensure that a Register of Interests is established and maintained to record formally declarations of interests of directors and other decision-making staff. The Register of Interests will include details of all directorships and other relevant and material interests which have been declared by both executive and Non-Executive Directors.

21.9. These details will be kept up to date by means of an annual review of the Register of Interests in which any changes to interests declared during the preceding twelve months will be incorporated.

21.10. The Register of Interests will be available to the public and open to inspection at the Trust's usual place of business at any time during normal business hours (between 09:00am and 17:00pm on any working day).

21.11. With the exception of the requirement to report interests in the Annual Report (Standing Order 21.7), this Standing Order also applies in full to any committee or sub-committee or group of the Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a director).

22. Disability of directors in proceedings on account of pecuniary interest

22.1. Subject to Standing Order 21 and the provisions of this Standing Order, if a director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

22.2. The Secretary of State may, subject to such conditions as they may think fit to impose, remove any disability imposed by this Standing Order, in any case where it appears to them to be in the interests of the NHS that the disability should be removed.

22.3. The Trust Board, or any committee or sub-committee may, if it thinks fit, provide for the exclusion of a director from a meeting while any contract, proposed contract or other matter in which that person has a pecuniary interest, direct or indirect, is under consideration.

22.4. Any remuneration, compensation or allowances payable to a director by virtue of paragraph 233, Part 11 of the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this Standing Order.

22.5. For the purpose of this Standing Order a director shall be treated, subject to Standing Order 2 as having an indirect pecuniary interest in a contract, proposed contract or other matter, if:

22.5.1. they, or a nominee of theirs, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or,

22.5.2. they are a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

22.5.3. and in the case of persons living together as a couple, whether married or not, the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

22.6. A director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

22.6.1. of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body;

22.6.2. of an interest in any company, body or person with which they are connected as mentioned in Standing Order 22.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

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

22.7.1. They have an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, **and**

22.7.2. the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, **and**

22.7.3. the share capital is of more than one class, the total nominal value of shares of any one class in which he has a beneficial interest does not exceed one-hundredth of the total issued share capital of the class.

This does not affect their duty to disclose the interest

22.8. This Standing Order also applies in full to any committee or sub-committee or group of the Trust Board; and to any member of such committee or sub-committee or group (whether or not they are a director).

23. Standards of Business Conduct

23.1. The Trust considers it to be a priority to maintain the confidence and continuing goodwill of its patients, public and fellow service providers. The Trust will ensure that all staff are aware of the standards expected of them and will provide guidance on their personal and professional behaviour.

23.2. The NHS Constitution 2016 identifies a number of key rights that all staff have and makes a number of further pledges to support staff in delivering NHS services. It goes on to set out the legal duties and expectations of all NHS staff, including:

- to accept professional accountability and maintain the standards of professional practice as set out by the relevant regulatory bodies;
- to act in accordance with the terms of contract of employment;
- not to act in a discriminatory manner;
- to protect confidentiality;
- to be honest and truthful in their work;
- to aim to maintain the highest standards of care and service;
- to maintain training and personal development to contribute to improving services;
- to raise any genuine concerns about risks, malpractice or wrongdoing at work at the earliest opportunity;
- to involve patients in decisions about their care and to be open and honest with them and;
- to contribute to a climate where the truth can be heard and learning from errors is encouraged.

23.3. The Trust adheres to and expects all staff to abide by the seven principles of public life set out by the Parliamentary Committee on Standards of Public Life. These are:

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

23.4. All staff are expected to conduct themselves in a manner that reflects positively on the Trust and not to act in a way that could reasonably be regarded as bringing their job or the Trust into disrepute. All staff must:

- act in the best interests of the Trust and adhere to its values and this code of conduct;
- respect others and treat them with dignity and fairness;
- seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- be honest and act with integrity and probity;
- contribute to the workings of the Trust and its management and directors in order to help them to fulfil their role and functions;
- recognise that all staff are individually and collectively responsible for their contribution to the performance and reputation of the Trust;
- raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate and;
- accept responsibility for their performance, learning and development.

23.5. All Directors must act in accordance with the Professional Standards Authority's 'Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England' 2012.

23.6. All staff shall declare any relevant and material interest, such as those described in Standing Order 21 and in the Trust's Declarations of Interest Policy. The declaration should be made on appointment to the Executive Director, clinical director, or senior manager to whom they are accountable. If the interest is acquired or recognised subsequently, a declaration should be made via the Trust's online declarations of interest system in line with the Declarations of Interest Policy. The system will then add the interest to the Trust's Register of Interests.

23.7. Officers who are involved in, have responsibility for, or are able by virtue of their role or

functions to influence the expenditure of taxpayer monies, may be required by the Trust to give statements from time to time, or in connection with particular contracts, confirming that they have no relevant or material interest to declare.

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

23.9. Gifts and hospitality shall only be accepted in accordance with the Trust's Declarations of Interest Policy. Officers of the Trust shall not ask for any rewards or gifts; nor shall they accept any rewards or gifts of significant value.

23.10. All gifts and hospitality, other than those that are of clearly minimal value (as determined in the Trust's Declarations of Interest Policy), should be declared via the Trust's online declarations of interest system. Acceptance of gifts by way of inducements or rewards is a criminal offence under the Fraud Act, 2006 and the Bribery Act 2010.

23.11. In addition to Standing Orders 21 and 22 and this Standing Order, an officer must also declare to the Chief Executive or Trust Secretary any other employment, business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with interests of the Trust, unless specifically allowed under that officer's contract of employment.

Part III – Arrangements for the exercise of functions by delegation and committees

24. Exercise of functions

24.1. Subject to Standing Order 3 and any such directions as may be given by the Secretary of State for Health, the Trust Board may delegate any of its functions to a committee or sub-committee appointed by virtue of Standing Order 25, or to a director or an officer of the Trust. In each case, these arrangements shall be subject to such restrictions and conditions as the board thinks fit.

Emergency powers

24.2. The powers which the Trust Board has retained to itself within these Standing Orders may in emergency be exercised by the Chief Executive and the Chair acting jointly and, if possible, after having consulted with at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Trust Board for ratification.

Delegation to committees

24.3. The Trust Board shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The Trust Board shall approve the constitution and terms of reference of these committees and their specific powers.

Delegation to officers

24.4. Those functions of the Trust, which have not been retained as reserved by the Trust Board or delegated to a committee of the Trust Board, shall be exercised on behalf of the Trust Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Trust Board.

Schedule of Decisions Reserved for the Trust Board

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

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

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

Scheme of Delegated Authorities

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

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

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

25. Appointment of committees

25.1. Subject to Standing Order 3 and such directions as may be given by, or on behalf of, the Secretary of State for Health, the Trust may, and if directed by them, shall appoint committees of the Trust, consisting wholly or partly of directors of the Trust or wholly of persons who are not directors of the Trust. Committees will be subject to review by the Trust Board from time to time.

25.2. A committee appointed under Standing Order 25 may, subject to such directions as may be given by, or on behalf of, the Secretary of State for Health or the Trust Board, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the committee (whether or not they include directors of the Trust).

25.3. The Standing Orders of the Trust, as far as they are applicable, shall apply with

appropriate alteration, to meetings of any committee or sub-committee.

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

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

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

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

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

Statutory and Mandatory Committees

Role of Audit Committee

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

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

Role of Auditor Panel

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

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

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

Board.

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~~November 2021):

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

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

26. Proceedings in committee to be confidential

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

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

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

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

27. Election of Chair of committee

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

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

28. Special meetings of committee

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

Part IV – Custody of seal and sealing of documents

29. Custody of seal

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

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.

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~~canvassed, they shall notify the Chief Executive in writing. The purpose of this Standing Order shall be included in any form of application or otherwise brought to the attention of candidates.

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

34. Relatives of directors or officers of the Trust

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

34.2. Every director and senior officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that director or senior officer is aware. It shall be the duty of the Chief Executive to report to the committee with responsibility for oversight of remuneration and terms of service any such disclosure made.

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

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

Part VI – Tendering and contracting procedures

35. General

35.1. The Trust use Bristol and Weston Purchasing Consortium (BWPC) otherwise known as ~~will develop a longer-term procurement strategy in conjunction with the~~ its Trust's procurement service supplier~~, Bristol and Weston Purchasing Consortium (BWPC). Click here for the BWPC website : BWPC - Home ()~~

~~35.1.~~

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

35.2.1. these Standing Orders

35.2.2. the Trust's Standing Financial Instructions

35.2.3. any direction by the Trust Board

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

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

35.5. Contract procedures shall take account of the Trust's Declarations of Interest Policy and the necessity to avoid any possibility of collusion or allegations of collusion between contractors and suppliers; or between contractors and suppliers and staff of the Trust.

35.6. The application of the provisions of this part of the Standing Orders to contracts and purchases may be varied by resolution of the Trust Board from time to time.

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36. Delegated authority to enter into contracts

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

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

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

37. Competition in purchasing or disposals – procedures

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

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

38. Disposals of land and buildings

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

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~~Chief Finance Officer will advise the Audit Committee, and internal and external audit.

41. Availability of Standing Orders

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

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

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

North Bristol NHS Trust Board

Appendix 1 – Schedule of decisions reserved to the Trust Board

Introduction

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

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

1.1. Approve, including variations to:

1.1.1. Standing Orders for the regulation of its proceedings and business (SO40).

1.1.2. this Schedule of matters reserved to the Trust Board (SO 24).

1.1.3. Standing Financial Instructions (SO 44, SFI 2)

1.1.4. Scheme of Delegated Authorities, including financial limits in delegations, from the Trust Board to officers of the Trust (SO 24, SO 40).

1.1.5. suspension of Standing Orders (SO 39)

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

1.2.1. administration of public and private agendas of Board meetings (SO 8)

1.2.2. calling extra-ordinary meetings of the Board (SO 9)

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

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

1.4.1. delegate functions from the Board to the committees (SO 24)

1.4.2. delegate functions from the Board to a director or officer of the Trust (SO 24)

1.4.3. approve the appointment of members of any committee of the Trust Board or the appointment of representatives on outside bodies (SO 25)

1.4.4. receive reports from Board committees and take appropriate action in response to those reports (SO 25)

1.4.5. confirm the recommendations of the committees which do not have executive decision making powers (SO 25)

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

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

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

1.5.1. Appoint the Chief Executive (SO 3)

1.5.2. Appoint the Executive Directors (SO 3)

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

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

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

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

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

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

2. Determination of strategy and policy

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

2.2. Approve the Trust's strategic direction:

2.2.1. annual budget, strategy and business plans

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

2.2.3. clinical and service development strategy

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

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

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~~1 million (SoDA 13f)

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

3.1.4. capital investment over £~~1~~ 2.5 million in value, supported by a business case and in line with the approval guidance issued by ~~the NTDA~~NHS England & Improvement. (SoDA 13c, 13d)

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

Commented [XB1]: Values aligned to those now proposed in tables in SFI/SoDA

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

3.3. Approve individual contracts and commitments to pay, other than Commissioning Contracts, of a revenue nature amounting to, or likely to amount to over £2.5~~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~~ NHS England & Improvement (SoDA 8f)

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

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

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

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

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

4. *Quality, financial and performance reporting*

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

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

4.2.1. The Care Quality Commission

4.2.2. NHS Improvement

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

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

4.5. Approve the Quality Account

5. *Audit arrangements*

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

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

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

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

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

ENDS

North Bristol NHS Trust Standing Financial Instructions

Appendix 2 – Standing Financial Instructions

1. Interpretation

1.1. The Chair of the Trust is the final authority in the interpretation of Standing Orders on which the Chief Executive and Trust Secretary shall advise them. In the case of the Standing Financial Instructions they will be advised by the ~~Director of Finance~~Chief Finance Officer.

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

Legislation definitions:

No additional legislation

Other definitions:

1.2.1. **Budget manager** is the director or employee with delegated authority to manage the finances (Income and Expenditure) and resources for a specific area of the Trust.

1.2.2. **Commissioning** is the process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources.

1.2.3. **Contracting and procuring** is the process of obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

1.2.4. **Divisional Operations Directors (Corporate Manager)** are the senior operational managers; and their formally nominated deputies, for the division or specialty, as designated by the Executive Director.

1.2.5. **Procurement Service provider** is the group that manages the Trust's procurement strategy and processes. The current service provider: Bristol and Weston NHS Purchasing Consortium (BWPC) is hosted by the Trust

1.2.6. **Shared Business Service (SBS)** is the NHS Shared Business Services, which is contracted by the Trust for general ledger provision and maintenance, core accounting for accounts payable and receivable and VAT processes.

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

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

North Bristol NHS Trust Standing Financial Instructions

2. Introduction

2.1. These Standing Financial Instructions (SFIs) are issued for the regulation of the conduct of the Trust, its directors and officers in relation to all financial matters with which they are concerned.

2.2. The SFIs explain the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

2.3. They identify the financial responsibilities which apply to everyone working for the Trust; and shall be used in conjunction with the Schedule of Decisions Reserved to the Board (appendix 1) and the Scheme of Delegated Authorities (appendix 3) which both also form part of the Trust's Standing Orders.

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

2.5. These SFIs do not refer to all legislation or regulations and advice issued by the Department of Health applicable to the Trust. Any uncertainty regarding the application of these SFIs should be discussed with the ~~Director of Finance~~Chief Finance Officer, prior to action.

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

Compliance with these SFIs

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

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

Responsibilities and delegations

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

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

2.10.1. approving the financial strategy

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

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

2.10.4. approving the method of providing financial services.

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

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

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

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

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

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

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

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

2.14. **The ~~Director of Finance~~Chief Finance Officer** is responsible for:

2.14.1. maintaining and implementing the Trust's financial policies

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

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

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

2.15.1. the security of the property of the Trust

2.15.2. avoiding loss

2.15.3. achieving economy and efficiency in the use of resources

3. Financial framework

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

4. Business and budget plans

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

4.2. The plans will include:

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

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

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

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

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

4.3.3. reflect resource plans, including workload and workforce plans

4.3.4. be prepared within the limits of available funds

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

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

4.3.7. include summary financial projections for the longer term

4.3.8. identify and assess significant financial risks.

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

5. Management of the financial resource

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

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

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

Setting the annual financial plan

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

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

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

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

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

Managing and reporting the financial position during the year

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

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

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

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

5.9.4. monitoring and reporting financial performance against plans and forecasts

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

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

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

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

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

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

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

5.13.3. trends and projections

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

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

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

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

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

5.16.2. financial consequences of changes in Trust policy

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

5.17. The ~~Director of Finance~~Chief Finance Officer shall:

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

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

6. Annual accounts, reports and returns

6.1. The ~~Director of Finance~~Chief Finance Officer shall:

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

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

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

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

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

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

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

7.1. The ~~Director of Finance~~Chief Finance Officer is responsible for:

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

7.1.2. the prompt banking of all monies received.

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

Fees and charges for the provision of healthcare

7.3. The ~~Director of Finance~~Chief Finance Officer shall:

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

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

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

7.4. The ~~Director of Finance~~Chief Finance Officer 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~~Chief Finance Officer promptly of money due to the Trust arising from transactions which they initiate, or deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

NHS service agreements for the provision of services

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

7.7. The ~~Director of Finance~~Chief Finance Officer shall provide up to date advice on:

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

7.7.2. costing and pricing of services

7.7.3. payment terms and conditions

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

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

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

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

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

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

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

Research and development

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

Sponsorship and concession agreements

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

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

7.15. The **Director of Facilities** 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~~Chief Finance Officer shall authorise all concession agreements entered into by the Trust.

8. Procurement, tendering and contracting procedure

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

8.2. All contracts made shall ensure best value for money using the Trust's

procurement service provider (BWPC) and processes established by the ~~Director of Finance~~Chief Finance Officer. For each contract a Trust Officer shall be nominated and hence responsible for overseeing and managing the contract on behalf of the Trust.

European Union and Government directives regarding public procurement

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

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

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

Competitive tendering and quotations

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

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

- 8.7.1. the supply of goods, materials and manufactured articles
- 8.7.2. services, including management consultancy services from non-NHS organisations
- 8.7.3. design, construction and maintenance of building and engineering works, including construction and maintenance of grounds and gardens

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

- 8.8.1. the estimated contract value is not reasonably expected to exceed £25,000 over the anticipated term of the contract and will be determined through formal quotations
- 8.8.2. the supply is proposed under special arrangements negotiated by the DH, in which event the special arrangements must be complied with
- 8.8.3. It is a government directive that tenders over the value of £25,000 must be

advertised in 'Contracts Finder'

8.8.4. the supply requirement is a compliant call off ~~measured term contract~~ against a Framework, Contract, or other appropriate legal mechanism which has been ~~put in place~~established following a formal tendering process carried out by its procurement services provider.

~~8.8.4.~~8.8.5. the supply is from a compliant call off against a Framework, Contract, or other appropriate legal mechanism which has been established by NHS or Government organisation, that has been evaluated and approved for use by its procurement services provider and authorised by the trust.

Commented [D2]: Inserted here – rather than in 8.9 in recognition that these agreements will have been through an approval route and therefore been validated as representing value for money and compliant.

Commented [D3]: The intention here is to introduced the use of NHS SC and Crown Commercial in line with Government / DH approach.

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~~
- 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**~~**Chief Finance Officer** shall ensure that:

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

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

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

Audit Committee and be recorded in an appropriate Trust record

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

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

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

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

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

- Their Carbon reduction plan
- Their Social Value contribution
- ~~8.15.2.~~ Their management of Modern Slavery within their supply chain

~~8.15.3.~~8.15.4. the tender process and rules are in accordance with up-to-date and relevant specialist guidance, which is recognised, or recommended by the DH

Tendering procedure

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

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

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

8.17.1. record of issue of invitations to tender

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

8.17.3. process and record of opening tenders

8.17.4. evaluation of tenders (inc. completeness, accuracy, compliance with prescribed format etc)

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

8.17.6. reasons behind decision to award the contract

Quotations: competitive and non-competitive

8.18. The **Trust Board** shall approve the value range whereby formal tendering procedures are not adopted, but quotations will be required. This range is currently for intended expenditure that is reasonably expected to exceed £25,000.

8.19. The ~~**Director of Finance**~~**Chief Finance Officer** 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

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**~~**Chief Finance Officer** shall identify specific procedures to be followed in the instance of a recognised event of exceptional circumstance.

9. Contracts and purchasing

9.1. The **Trust Board** shall only enter into contracts on behalf of the Trust that are within the statutory powers delegated to it by the Secretary of State and shall comply with:

9.1.1. the Trust's Standing Orders and Standing Financial Instructions

9.1.2. EU Procurement Directives and other statutory provisions

9.1.3. any relevant directions issued, or recognised by the DH

9.1.4. such of the NHS standard contract conditions as are applicable

9.2. In all contracts made by the Trust, the Trust Board shall:

9.2.1. seek to obtain best value for money

9.2.2. for contracts subjected to tendering, or quotation, ensure that the contracts contain the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

9.3. The **Chief Executive** and **Executive Directors** shall nominate managers to oversee and manage each contract on behalf of the Trust

9.4. The Procurement Service shall maintain a record of the details of all requisitions and orders placed. No requisition or order shall be placed for items for which there is no provision in an authorised budget.

Longer term commitments

9.5. All contracts, leases, tenancy agreements and other commitments, which might result in a long-term liability, must be notified to; and authorised, in accordance with the limits set out in the Scheme of Delegated Authorities, in advance of any commitment being made.

Healthcare Service Agreements

9.6. The ~~**Director of Finance**~~**Chief Finance Officer** shall ensure that SLAs and extra-contractual arrangements agreed with other NHS trusts, for provision of services to the Trust, are agreed in accordance with the current guidance set out by the DH.

In-house services

9.7. The **Trust Board** shall determine which in-house services should be market tested by competitive tendering; and the frequency with which this should be done. In instances where competitive tendering is required, the Board shall nominate suitably qualified staff to administer the process and ensure that EU procurement and competition laws, legislation and DHSC guidance are applied correctly, including:

9.7.1. setting clearly defined specifications for the service

9.7.2. clear separation between the in-house service provider tender team and the Trust's commissioning team

9.7.3. independent evaluation process

9.8. The **Chief Executive** shall ensure that best value for money can be demonstrated for all services provided on an in-house basis and shall nominate officers to oversee and manage the contract on behalf of the Trust, separate from those that are providing the service.

10. Non-pay expenditure

10.1. Requisitions and orders are subject to the delegations and limits set out in SFI 8 and SFI 9.

10.2. The ~~Director of Finance~~Chief Finance Officer shall:

10.2.1. maintain the list of managers who are authorised to place requisitions and orders for the supply of goods and services

10.2.2. set the maximum value of each requisition or order and the system for authorisation above that level

10.2.3. set out procedures for seeking of professional advice regarding the supply of goods and services

10.3. These delegation limits are maintained in the Scheme of Delegated Authorities.

Requisitioning and ordering goods and services

10.4. The ~~Director of Finance~~Chief Finance Officer shall maintain adequate systems and procedures for the ordering (including requisitions) of goods and services. These shall include:

10.4.1. procedural instructions and guidance on the obtaining of goods, works and services incorporating the thresholds identified in the Scheme of Delegated Authorities

10.4.2. recognition of the Trust's approved supply arrangements, including, but not limited to the following:

- recognised Trust wide procurement systems, (EROS and NHS Supply Chain) which incorporate automatic system controls to ensure adherence to approval and authorisation requirements
- other recognised controlled ordering systems for specific service areas (Pharmacy, Estates, Catering, Disablement Services) providing that they can evidence a secure audit trail
- framework agreements made by the Trust, or by the Procurement Service, including approved suppliers of temporary, locum and interim staff placements; and contractual arrangements for on-going ad-hoc support from chosen service suppliers (eg emergency maintenance and repair services for medical equipment)

Commented [D5]: This section already envisages the use of Frameworks – but they are not enabled.

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~~Chief Finance Officer for any contractual arrangement that may involve taking on an

ongoing obligation, or legal responsibility.

10.5.2. sufficient budget exists to pay for the item ordered, or if insufficient budget is available, the ~~Director of Finance~~Chief Finance Officer has authorised the purchase

10.5.3. a Purchase Order is raised on an approved electronic ordering system prior to the goods or services being received.

10.5.4. orders are not split, or otherwise manipulated to circumvent authorisation and delegation limits

10.5.5. goods and equipment are not accepted on trial, or on loan, where there is an associated risk or commitment to current or future expenditure, unless specifically approved by the ~~Director of Finance~~Chief Finance Officer 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.

~~Ordering and purchasing using non-approved supply arrangements~~

Receipt of goods and services and system of payment and payment verification

~~10.9.~~10.8. The ~~Director of Finance~~Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or with national guidance (such as the Better Payments Practice Code).

~~10.10.~~10.9. Such requirements will be specified in any SLA with the Shared Business Service provider.

~~10.11.~~10.10. The ~~Director of Finance~~Chief Finance Officer shall:

10.12.1. ensure the prompt payment of all properly authorised accounts and claims

10.12.2. maintain an adequate system of verification, recording and payment of all amounts payable, including relevant thresholds. The system will include:

- a record of Trust employees, including specimens of their signatures and/or facilities for secure electronic certification, authorised to raise requisitions and certify invoices
- certification that:
  - goods have been duly received, examined and are in accordance with specification and the prices are correct
  - work done or services rendered have been satisfactorily completed in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct
  - contractual measurement units, such as time, materials or expenses are accurate, meet contractual requirements; are supported by appropriate confirmation; and are charged at the agreed rates
  - where appropriate, the expenditure is in accordance with regulations

and all necessary authorisations have been obtained

- the account is arithmetically correct
- the account is in order for payment

10.12.3. identify procedures to follow for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.12.4. maintain instructions to employees regarding the handling and payment of accounts within the Finance Department.

Prepayments and payments on account

~~10.12.~~10.11. The ~~**Director of Finance**~~**Chief Finance Officer** shall specify the circumstances under which goods and services can be paid in advance of receipt, through the use of prepayments. These circumstances will include instances where one or more of the following apply:

10.13.1. the ~~**Director of Finance**~~**Chief Finance Officer** 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)

~~10.13.~~10.12. The **budget holder** shall confirm that the goods and services due under a prepayment arrangement are received satisfactorily and in accordance with the contractual arrangements.

Payments to contractors by instalments

~~10.14.~~10.13. The ~~**Director of Finance**~~**Chief Finance Officer** shall identify adequate procedures to address interim payments made on-account in contracts for building and engineering works. These will include arrangements for receipt of independent and appropriate certificates and confirmations of work completed, to the required standards.

~~10.15.~~10.14. Final payments certificates shall only be issued after the Trust's nominated contract manager has certified the accuracy and completeness of the value of the final account submitted by the contractor; and has confirmed that the procedure set out in the contract terms has been followed properly.

~~10.16.~~10.15. Overruns to contracts shall be reported in accordance with the Scheme of Delegated Authorities.

~~10.17.~~10.16. With reference to Appendix 3 (SoDA 8x), all planned (including Capital funded) procurements with a projected value of over £100k* must have a signed off Options Appraisal and/or Business Case report for the Procurement which is produced in conjunction with BWPC. This should be noted only applies to planned procurements with exceptions only via the Single Tender Action process.

~~10.18.~~10.17. All Options Appraisals, and ultimately procurement Business Case's must include Whole Life Costs estimates as well as identification of projected savings.

~~10.19.~~10.18. The above process also applies to Extensions and Variations with a projected value which exceeds £100k

*A genuine pre-estimate of contract value must be ascertained and should not automatically be based on previous years expenditure, but also based on an estimate of future demand, and any additional value gained by the supplier.

Variations and extensions to contracts

~~10.20.~~10.19. Contracts may be designed to allow for variations to the sum agreed, or the goods and services to be delivered. These variations shall be clearly identified and subject to specific limits; and shall be approved as part of the contract process. Further, or new variations shall be subject to the authorisation process in place for new contracts. Variations shall be authorised in advance of commencement.

~~10.21.~~10.20. Where variations are needed in emergency, approval should be sought from a relevant authorising officer; and shall be confirmed and authorised, using the relevant contract procedure, on the next working day.

~~10.22.~~10.21. Extensions to contracts shall be confirmed in writing and authorised in accordance with the Scheme of Delegated Authorities. Contract Extensions should not exceed the maximum term permitted under the terms of the contract defined when the contract was let.

Joint finance arrangements with local authorities and voluntary bodies

~~10.23.~~10.22. Payments to local authorities and voluntary organisations shall comply with procedures laid down by the ~~Director of Finance~~Chief Finance Officer which shall be in accordance with current legislation.

11. Terms of service and payment of members of the Trust Board and employees

Board members, directors and specified senior managers

11.1. The **Trust Board** shall be accountable for taking decisions on the remuneration and terms of service of directors and senior managers not on Agenda for Change terms and conditions. The Board shall establish a Remuneration and Nominations Committee responsible for determining the remuneration of; and appointment of directors and senior staff in accordance with Standing Orders.

11.2. The **Remuneration and Nominations Committee** shall:

11.2.1. advise the Board about appropriate remuneration and terms of service for the Chief Executive, other directors and any staff remunerated outside of the Agenda For Change arrangements, (as described in the terms of reference of the Committee), employed by the Trust:

- all aspects of salary (including any performance-related elements and

bonuses)

- provisions for other benefits, including pensions and cars
- arrangements for termination of employment and other contractual terms

11.2.2. advise the Board on the remuneration and terms of service of directors and any staff remunerated outside of the Agenda for Change arrangements to ensure they are fairly rewarded for their contribution to the Trust, whilst having proper regard to the Trust's circumstances and performance; and to the provisions of any national arrangements for such members and staff where appropriate

11.2.3. monitor and evaluate the performance of individual directors and senior employees

11.2.4. advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate

11.3. The Trust shall pay allowances to the Chair and Non-Executive Directors of the Board in accordance with instructions issued by the DH.

Other employees

11.4. The Trust Board shall consider and approve proposals presented by the **Director of People & Transformation** for the setting of remuneration and conditions of service for those employees not covered by the Remuneration and Nominations Committee.

Funded establishment and staff appointments

11.5. The staff establishment plans incorporated within the annual plans approved by the Trust Board shall be regarded as the funded establishment. The funded establishment of any department should reflect the Trust's approved workforce plans, which form part of the Trust's budget plans submitted to the NHS TDA.

11.6. The **Director of People and Transformation** shall ensure adherence to the Agenda for Change rules and approved policies and procedures and terms and conditions for employees paid on alternative contractual arrangements, including the consultant contract. These procedures shall address:

11.6.1. setting starting pay rates and conditions of service, for employees

11.6.2. approving plans to engage, re-engage employees, either on a permanent or temporary nature, or hire agency staff

11.6.3. agreeing to changes in any aspect of remuneration, including re-grading, within the Agenda for Change allowed rules.

11.6.4. ensuring that all employees are issued with a contract of employment in a form which complies with employment legislation

11.7. The **Budget Holder** shall ensure that the cost of the appointment, or change in conditions can be met within the limit of their approved budget and funded establishment.

Processing payroll

11.8. The ~~Director of Finance~~**Chief Finance Officer** shall maintain procedural instructions for delivery of the Trust's payroll function. These procedures shall be compliant with employment legislation, the Data Protection Act and HM Revenues and Customs regulations.

11.9. The ~~Director of Finance~~**Chief Finance Officer** shall ensure that the arrangements for providing the payroll service are supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures; and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies

11.10. Under the delegated authority of the ~~Director of Finance~~Chief Finance Officer, the **Head of Payroll** shall:

11.10.1. specify timetables for submission of properly authorised time records and other notifications

11.10.2. agree the final determination of pay and allowances

11.10.3. arrange to make payment on agreed dates

11.10.4. agree allowed methods of payment.

11.11. **Nominated managers** shall ensure that the electronic staff record, including the approved staff establishment, is kept up to date. Nominated managers shall ensure that all staff are keeping their records complete, including requirements to:

11.11.1. submit time records, and other notifications in accordance with agreed timetables

11.11.2. complete time records and other notifications in accordance with the ~~Director of Finance~~Chief Finance Officer's instructions

11.11.3. submit forms notifying change in circumstances and termination of employment in the prescribed form, as soon as these changes are reported to them

Travel and subsistence expenses

11.12. Reimbursement of expenses incurred by Trust staff shall be made by the Payroll Service in accordance with the Trust's relevant current policy and procedures; and subject to verification and authorisation of the claim by an officer with delegated authorisation for this purpose.

Use of self-employed management consultants and contractors

11.13. The **People Division** shall establish procedures to ensure that the Trust's interests are protected in the contractual arrangements entered into with self-employed consultants and contractors. These procedures shall ensure that the contractual arrangements do not contravene HM Revenues and Customs' requirements regarding the avoidance of tax and national insurance contributions through the use of intermediaries, such as

service companies or partnerships, known as Intermediaries Legislation, or "IR 35".

11.14. All Trust officers responsible for procuring services from self-employed individuals shall ensure that they comply with the procedures established.

12. Insurance, including risk pooling schemes administered by the NHS Litigation Authority

12.1. The **Trust Board** shall determine the Trust's arrangements for insurance cover, including the option to insure through the risk pooling schemes administered by NHS Resolution; or to self-insure for some or all of the risks covered by the risk pooling schemes.

12.2. If the Trust Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers and third-party liability) covered by the scheme, this decision shall be reviewed annually.

12.3. The ~~Director of Finance~~Chief Finance Officer shall ensure that:

12.3.1. documented procedures cover the Trust's insurance arrangements, including for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed

12.3.2. the arrangements entered into are appropriate and complementary to the risk management programme.

12.3.3. the Trust Board is informed of the nature and extent of the risks that are self-insured in the event that the Board decides not to use the risk pooling schemes administered by the NHSR for one or other of the risks covered by the schemes

12.4. The ~~Director of Finance~~Chief Finance Officer shall determine the level of insurance cover to be held by the Trust in the three discrete areas where the Trust can use commercial insurers:

12.4.1. insuring motor vehicles owned by the Trust including insuring third party liability arising from their use

12.4.2. where the Trust is involved with a consortium in a PFI contract and the other consortium members require that commercial insurance arrangements are entered into

12.4.3. where income generation activities take place, which are not covered by the NHSR risk pool

13. Capital investment, private financing, fixed asset registers and security of assets

13.1. The ~~Director of Finance~~Chief Finance Officer is responsible for compiling and submitting for Board approval an annual capital programme, which is affordable within available resources over the lifetime of the investment.

13.2. The ~~Director of Finance~~Chief Finance Officer shall report to the Board, the progress of delivery of the capital programme, against plan, during the year.

13.3. The **Chief Executive** shall ensure that:

13.3.1. there is an adequate appraisal and approval process in place for determining capital expenditure priorities and supporting systems to identify and assess the financial effect of each proposal on business plans

13.3.2. all stages of capital schemes are managed and controlled adequately; and that schemes are delivered on time and to cost

13.3.3. capital investment is risk assessed against the declared commissioning strategic plans of significant commission organisations and is consistent with the Trust's long term strategic plans

13.4. For every capital expenditure proposal, the Chief Executive shall ensure that a business case, or statement of need, is produced in accordance with the Trust's approved procedures and is considered by the **Finance and Performance Committee**, where required. The business case shall set out, as a minimum:

13.4.1. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs

13.4.2. the involvement of appropriate Trust personnel and external agencies

13.4.3. appropriate project management and control arrangements

13.5. The approval of a capital programme shall not constitute approval for expenditure on any scheme.

13.6. The ~~**Director of Finance**~~**Chief Finance Officer** shall:

13.6.1. review the costs and revenue analysis, including revenue consequences included in the business case

13.6.2. ensure that, in higher cost, or higher risk investments, advice has been sought from the ~~NTDA~~NHS England & Improvement; and that appropriate Risk Evaluation for Investment Decisions (REID) analysis has been completed

13.7. For approved capital schemes, the ~~Director of Finance~~Chief Finance Officer shall:

13.7.1. issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes

13.7.2. agree arrangements for managing stage payments

13.7.3. maintain procedures for monitoring and reporting on the progress of delivery of contracts; and capital expenditure and commitments against plans and against the Trust's capital programme

13.8. The Trust's **Procurement Service** shall advise the ~~Director of Finance~~Chief Finance Officer, on the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

13.9. Authorisations issued to the manager(s) responsible for any scheme shall be made in accordance with the value limits set out in the Scheme of Delegated Authorities:

13.9.1. specific authority to commit expenditure;

13.9.2. authority to proceed to tender

13.9.3. approval to accept a successful tender

Private Finance Initiatives (PFI)

13.10. The ~~**Director of Finance**~~**Chief Finance Officer** should normally test for PFI when considering capital procurement. If this test supports a proposal to use finance which is to be provided through PFI arrangements, the ~~Director of Finance~~Chief Finance Officer shall:

13.10.1. demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector

13.10.2. refer any investment proposal over £1 million to the NTDA for a risk assessment and decision to approve the borrowing

13.11. Any PFI proposal shall be specifically agreed by the **Trust Board**.

13.12. Where a capital scheme is funded using the PFI, any variations to the contract will be dealt with under procedures for variations in capital contracts and shall be authorised by the Trust Board.

Instructions specific to the Southmead Hospital PFI

13.13. The **Trust Board** shall approve and authorise the schedule of payments payable by the Trust to the PFI Project Co (Hospital Company (Southmead) Limited), as documented in the Project Agreement made between the Trust and the PFI Project Co dated 25 February 2014 ("Project Agreement").

13.14. The Schedule of Service Payments (Project Agreement, Schedule 18, Appendix I) shall be fixed for the duration of the Project Term save in respect of

13.14.1. inflationary adjustments

13.14.2. procurement of additional works (i.e. Small Works etc.)

13.14.3. variations in accordance with Schedule 22 of the Project Agreement.

13.15. Inflationary adjustments shall be calculated annually and presented to the Trust Board for approval. Arrangements for the procurement of additional works and variations shall be dealt with in accordance with the procedures for variations in capital contracts and shall be authorised by the Trust Board.

13.16. During the Operational Term, the **Director of Facilities** 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.

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~~Chief Finance Officer is required

13.18. The ~~Director of Finance~~Chief Finance Officer**,** or in their absence, the **Chief Executive** shall approve any decision to withhold, or delay payment of invoices, at the risk of incurring penalties and interest charges for the late payment of amounts due.

13.19. The **Assistant ~~Director of Finance~~Chief Finance Officer (Financial Services)**, or their nominated deputy, shall process payments of invoices submitted by the Project Co in accordance with Schedule 18, subject to the approval of the Director of Facilities and, where appropriate, the ~~Director of Finance~~Chief Finance Officer.

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~~Chief Finance Officer shall maintain registers of assets and shall maintain procedures for keeping the registers up to date, including provision for arranging for physical confirmation of the existence of assets against the asset register to be conducted once a year.

13.22. The ~~Director of Finance~~Chief Finance Officer shall maintain procedures for verifying additions and amendments to the assets recorded in the asset register. These procedures and records will include:

13.22.1. additions to the fixed asset register clearly identified to an appropriate budget manager

13.22.2. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties

13.22.3. records of costs incurred within the Trust, on stores, requisitions and labour including appropriate overheads

13.22.4. lease agreements in respect of assets held under a finance leases

13.23. The ~~Director of Finance~~Chief Finance Officer shall maintain procedures for controlling the disposal of assets and updating of asset registers and financial records to reflect the event. These procedures will include the requirement for the authorisation and validationof the de-commissioning and disposal of the asset.

13.24. The ~~Director of Finance~~Chief Finance Officer shall approve procedures for:

13.24.1. applying depreciation charges and indexation valuation adjustment to assets, using methods and rates as specified in the Manual for Accounts issued by the DH

13.24.2. reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers

Security of assets

13.25. The **Chief Executive** shall maintain procedures for controlling the security of assets, including fixed assets, cash, cheques and negotiable instruments. The procedures will include:

13.25.1. recording managerial responsibility for each asset

13.25.2. identification of additions and disposals

13.25.3. identification of all repairs and maintenance expenses

13.25.4. physical security of assets

13.25.5. periodic verification of the existence of, condition of, and title to, assets recorded

13.25.6. identification and reporting of all costs associated with the retention of an asset

13.25.7. reporting, recording and safekeeping of cash, cheques, and negotiable instruments

13.26. **All employees** are responsible for the security of property of the Trust and for following such routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices, or damage and losses to Trust property shall be reported in accordance with agreed procedures.

13.27. Where practical, assets should be marked as Trust property.

Disposals and condemnations

13.28. The ~~Director of Finance~~Chief Finance Officer shall prepare procedures for the disposal of assets including condemnations and ensure that these are notified to managers. The procedures will include arrangements to be followed for:

13.28.1. condemning and disposing of unserviceable and redundant assets

13.28.2. maintaining records of assets disposed of, including confirmation of destruction of condemned assets

13.28.3. specific processes to be followed in instances where assets are passed on for future use to another organisation

13.28.4. the sale of assets, including through competitive bids and negotiated bids; and sales linked to larger contracts for work, such as assets arising from works of construction, demolition or site clearance

13.29. The **departmental manager** responsible for the decision to dispose of an asset shall advise the ~~Director of Finance~~Chief Finance Officer of the estimated market value of the asset, taking account of professional advice where appropriate.

14. Bank accounts and Government Banking Service accounts

14.1. The **Trust Board** shall:

14.1.1. approve the banking arrangements for the Trust.

14.1.2. As the Corporate Trustee, approve separate banking arrangements for the Trust's Charitable Funds

14.2. The ~~Director of Finance~~Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of bank accounts. This advice will take into

account guidance and Directions issued by the Department of Health.

14.3. The ~~Director of Finance~~Chief Finance Officer shall:

14.3.1. establish and maintain necessary commercial bank accounts and Government Banking Service (GBS) accounts

14.3.2. establish separate bank accounts for non-exchequer funds, including charitable funds

14.3.3. advise the Trust's bankers, formally in writing, of the conditions under which each account will be operated (the bank mandate)

14.3.4. seek to limit the use of commercial bank accounts and the value of cash balances held within them

14.3.5. conduct the Trust's main banking services and financial transactions using accounts provided by the GBS

14.4. Only the ~~Director of Finance~~Chief Finance Officer, or their nominated representative, is authorised to open, operate and control a bank account, where monies owned by the Trust, including charitable funds, are received or expended. All such accounts must be held in the name of the Trust. It is a disciplinary offence for any other officer of the Trust to establish and operate such an account.

14.5. The ~~Director of Finance~~Chief Finance Officer shall:

14.5.1. Ensure that payments made from bank or GBS accounts do not exceed the amount credited to the account

14.5.2. monitor compliance with DHSC guidance on the level of cleared funds.

Where such processes are undertaken by a Shared Business Service (SBS) these will be specified in a Service Level Agreement with the SBS.

Banking procedures

14.6. The ~~Director of Finance~~Chief Finance Officer shall prepare detailed instructions on the operation of bank and GBS accounts which shall include:

14.6.1. the conditions under which each bank and GBS account is to be operated

14.6.2. details of those authorised to sign cheques or other orders drawn on the Trust's accounts

14.6.3. details of limits to delegated authority, including the number of authorised signatories required, and arrangements for authorising alternative mechanisms for 'signing' cheques and orders

Tendering and review

14.7. The ~~Director of Finance~~Chief Finance Officer shall review the commercial banking arrangements of the Trust at regular intervals to ensure they continue to reflect best practice and represent best value for money.

14.8. Competitive tenders should be sought at least every five years. The ~~Director of Finance~~Chief Finance Officer shall report to the Trust Board the reason(s) for continuing existing banking arrangements for longer than five years, without competitive review.

14.9. The ~~Director of Finance~~Chief Finance Officer shall report the results of any tendering exercise to the Board. This review is not necessary for GBS accounts.

Trust credit cards

14.10. The ~~Director of Finance~~Chief Finance Officer shall approve the allocation and operation of credit cards on behalf of the Trust; implement arrangements to monitor whether the credit cards are being used appropriately; and take action where inappropriate use is identified.

Security of cash, cheques and other negotiable instruments

14.11. The ~~Director of Finance~~Chief Finance Officer shall:

14.11.1. approve the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable

14.11.2. maintain adequate systems for ordering and securely controlling any such stationery

14.11.3. provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, and procedure notes for the safe storage of keys, and for coin operated machines

14.11.4. prescribe systems and procedures for handling cash and negotiable securities on behalf of the Trust

14.12. Where such issues are undertaken by the Shared Business Service, detailed requirements will be specified in a Service Level Agreement with The Shared Business Service.

14.13. The Trust's money shall not under any circumstances be used for the encashment of private cheques.

14.14. All cheques, postal orders, cash etc, shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the ~~Director of Finance~~Chief Finance Officer.

14.15. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisations or individuals absolving the Trust from responsibility for any loss.

15. Investments

15.1. Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board. The current rules require that surplus funds are held in the Trust's GBS accounts.

15.2. The ~~Director of Finance~~Chief Finance Officer shall advise the Charity Committee on investments made with endowment funds held; and prepare detailed procedural instructions on the operation of investment accounts and on

the records to be maintained.

16. Management of debtors

16.1. The ~~Director of Finance~~Chief Finance Officer shall:

16.1.1. maintain effective processes for the appropriate recovery action on all outstanding debts

16.1.2. deal with instances of income not received, in accordance with losses procedures

16.1.3. maintain effective processes to prevent, or detect overpayments and initiate recovery when this occurs

17. Stores and receipt of goods

17.1. The ~~Director of Finance~~Chief Finance Officer shall determine procedures for the management stocks of resources, defined in terms of controlled stores and departmental stores. These will address the procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses; and include the principles that stocks are:

17.1.1. managed so that best value for money can be achieved whilst maintaining minimum safe stock levels

17.1.2. subjected to annual stock take as a minimum, where rolling stock checks are not in place

17.1.3. valued at the lower of cost and net realisable value

17.2. The **Director of Facilities** 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~~Chief Finance Officer any evidence of significant overstocking and of any negligence or malpractice in the

management and use of stocks

18. External borrowing and Public Dividend Capital

18.1. The ~~Director of Finance~~Chief Finance Officer shall advise the Board on the Trust's ability to pay dividend on, and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the Department of Health. The ~~Director of Finance~~Chief Finance Officer shall also provide periodic reports to the Board concerning the PDC debt and all loans.

18.2. The **Trust Board** shall agree the list of employees authorised to make short term borrowings on behalf of the Trust. This shall include the Chief Executive and the ~~Director of Finance~~Chief Finance Officer.

18.3. The ~~Director of Finance~~Chief Finance Officer shall prepare detailed procedural instructions concerning applications for loans and shall ensure that:

18.3.1. all short-term borrowings are kept to the minimum period of time possible, consistent with the Trust's overall cashflow position, represent good value for money, and comply with the latest guidance from the DH

18.3.2. the Trust Board is made aware of all short term borrowings at the next meeting

18.4. The **Finance and Performance Committee** shall ensure that all proposed long-term borrowing is consistent with the Trust's financial plans; and is approved by the Trust Board.

19. Losses and special payments

19.1. The ~~Director of Finance~~Chief Finance Officer shall prepare procedural instructions for maintaining a register of losses and special payments, including write-offs, condemnations and ex- gratia payments; and on the recording of and accounting for losses and special payments, including ex-gratia payments. The records will include:

19.1.1. the nature, gross amount (or estimate if an accurate value is not available), and the cause of each loss

19.1.2. the action taken, total recoveries and date of write-off where appropriate

19.1.3. the category in which each loss is to be noted

19.2. The ~~Director of Finance~~Chief Finance Officer shall determine the nature and/or value of losses which must be reported immediately to the ~~Director of Finance~~Chief Finance Officer or **Chief Executive**:

19.2.1. where fraud or bribery is suspected, this shall be reported to the Local Counter Fraud Specialist, in accordance with the Trust Counter Fraud and Bribery Policy

19.2.2. where a criminal offence is suspected, the ~~Director of Finance~~Chief Finance Officer must immediately inform the Local Security Management Specialist who may inform the police if theft or arson is involved

19.2.3. where losses, other than those that are clearly trivial, are apparently caused

by theft, arson, neglect of duty or gross carelessness, the ~~Director of Finance~~Chief Finance Officer must immediately notify the external auditor and the Trust Board

19.3. **Any employee** discovering or suspecting a loss of any kind shall immediately inform their head of department and ensure that the loss is recorded in accordance with instructions.

19.4. The **Trust Board** shall approve the write off of losses, compensations and ex-gratia payments, within the limits delegated to it by the Department of Health.

19.5. The **Audit Committee** shall receive regular reports of losses, compensations and ex-gratia payments made.

19.6. The ~~**Director of Finance**~~**Chief Finance Officer** and the Shared Business Service shall be authorised to:

19.6.1. take any necessary steps to safeguard the Trust's interests in the event of bankruptcies and company liquidations

19.6.2. investigate whether any insurance claim can be made

20. Patients' property

20.1. The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival (see "Guidance for NHS organisations on the secure management of patients' property", NHS Protect, July 2012; and Health and Social Care Act 2008, (Regulated Activities) regulations 2010).

20.2. The **Chief Executive** shall ensure that patients or their guardians, as appropriate, are clearly and suitably informed before or on admission into hospital that the Trust will not accept responsibility or liability for patients' property brought into NHS premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

20.3. The ~~**Director of Finance**~~**Chief Finance Officer** shall provide procedural instructions on the collection, custody, banking, recording, safekeeping, and disposal of patients' property. (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. These instructions will include arrangements for:

20.3.1. managing large amounts of money handed over by longer stay patients

20.3.2. restricting the use of patients' monies for purposes specified by the patient, or their guardian

20.4. In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

20.5. **Departmental and senior managers** shall inform staff of their responsibilities and duties for the administration of the property of patients.

21. Funds held on Trust

21.1. The **Trust Board**, as Corporate Trustee, is responsible for the management of funds it holds on trust and for meeting the requirements of the Charities Commission.

21.2. The **Trust Board's** corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

21.3. Trustee responsibilities for non-exchequer funds for charitable and non-charitable purposes shall be discharged separately and full recognition shall be given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

21.4. The Charity Committee shall ensure that each trust fund for which the corporate trustee is responsible is managed appropriately in terms of its purpose and requirements.

22. Retention of records

22.1. The **Chief Executive** is responsible for managing all NHS records, regardless of how they are held; and shall require policy and procedures to be followed that ensure compliance with the current DHSC best practice guidelines on records management. These procedures will include arrangements for:

22.1.1. managing archives of all records required to be retained in accordance with DHSC guidelines

22.1.2. records held in archives to be accessible for retrieval by authorised persons

22.1.3. destruction of records in accordance with the DHSC "Records Management: NHS Code of Practice" Part 1 (30 March 2006) and Part 2 (8 January 2009)

22.2. Where documents are held by a Shared Business Service detailed records storage requirements will be set out in a SLA with the Shared Business Service.

23. Information Technology and data security

23.1. The ~~**Director of Finance**~~**Chief Finance Officer** shall be responsible for the accuracy and security of the performance and financial data of the Trust and shall devise and implement any necessary procedures to ensure:

23.1.1. computer assets and data programmes are protected from theft or damage

23.1.2. adequate and reasonable protection of the Trust's data from deletion or modification; accidental or intentional disclosure to unauthorised persons, having due regard for the Data Protection Act 1998

23.1.3. adequate controls operate over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data

23.1.4. controls exist such that the computer operation is separated from development, maintenance and amendment

23.1.5. adequate audit trails exist through the computerised system; and that these are subjected to periodic reviews as the Director may consider necessary

23.2. Where computer systems have an impact on corporate financial systems, the ~~Director of Finance~~Chief Finance Officer shall ensure that new systems and amendments to existing financial systems are developed in a controlled manner and thoroughly tested prior to implementation. The ~~Director of Finance~~Chief Finance Officer shall gain assurance that:

23.2.1. systems acquisition, development and maintenance are delivered in line with contractual agreements and Trust procedures

23.2.2. new systems that have an impact on, or are replacing existing financial systems are developed in a controlled way and thoroughly tested before they are put into practice. External organisations providing this service will need to provide assurances that what they do is adequate

23.2.3. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management audit trail exists

23.2.4. finance staff have the necessary levels of access to such data

23.2.5. such computer audit reviews as are considered necessary are being carried out

23.3. The **Chief Executive** shall maintain a Freedom of Information (FOI) Publication Scheme, consistent with models approved by the Information Commissioner.

Contracts for computer services with other health bodies or outside agencies

23.4. The ~~**Director of Finance**~~**Chief Finance Officer** shall ensure that any contract for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract shall also ensure rights of access for audit purposes.

23.5. Where another health organisation or any other agency provides a computer service for financial applications, the ~~Director of Finance~~Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

Risk assessment

23.6. The **Chief Information Officer** shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered; and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

24. Risk management

24.1. The **Chief Executive** shall ensure that the Trust has adequate procedures for managing risk and meeting current DHSC requirements for assurance frameworks, which shall be approved and monitored by the Trust Board.

24.2. The programme of risk management shall include:

24.2.1. arrangements for identifying and quantifying risks and potential liabilities

24.2.2. promotion, to all levels of staff, of a positive attitude towards the identification and management of risk

24.2.3. procedures to ensure all significant risks and potential liabilities are assessed and addressed, including through maintenance of effective systems of internal

control, cost effective insurance cover, and decisions on the acceptable level of retained risk

24.2.4. contingency plans to offset the impact of adverse events

24.2.5. arrangements for reviewing the effectiveness of the risk management processes in place, including: internal audit; clinical audit; and health and safety review

24.2.6. arrangements for reviewing the risk management programme

24.3. The Chief Executive shall ensure that the existence, integration and evaluation of the risk management system is used to inform the Annual Governance Statement within the Annual Report and Accounts as required by current DHSC guidance.

25. Audit

25.1. In accordance with Standing Orders, the Board shall formally establish an **Audit Committee**, with clearly defined terms of reference. The Committee will seek assurance for the Board on the range of issues in accordance with guidance from the NHS Audit Committee Handbook, which will provide an independent and objective view of internal control by:

25.1.1. overseeing internal and external audit services

25.1.2. reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments

25.1.3. reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives

25.1.4. monitoring compliance with Standing Orders, Standing Financial Instructions, delegations and reservations

25.1.5. reviewing schedules of losses and compensations and advising the Board where necessary

25.1.6. reviewing the arrangements in place to support the application of the Assurance Framework on behalf of the Board and advising the Board accordingly.

25.2. Where the Audit Committee considers there is evidence of *ultra vires* transactions, or improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health (to the ~~Director of Finance~~Chief Finance Officer in the first instance).

25.3. It is the responsibility of the ~~Director of Finance~~Chief Finance Officer to ensure an adequate internal audit service is provided. The Audit Committee shall be involved in the selection process when the internal audit service provision is subjected to market testing.

25.4. In the case of the Shared Business Service, the ~~Director of Finance~~Chief Finance Officer shall ensure that maintenance of an adequate internal audit service is specified in any service level agreement and shall further specify assurance arrangements between the Trust's internal and external auditors and the Shared Business Service's auditors.

25.5. The ~~**Director of Finance**~~**Chief Finance Officer** shall ensure that:

25.5.1. there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an independent and effective internal audit function

25.5.2. the Head of Internal Audit is sufficiently qualified and experienced to perform that role; to facilitate the effective discussion of the results of internal audit work with senior management

25.5.3. the internal audit service is adequate and meets the NHS Internal Audit Standards (DH, April 2011)

25.5.4. the internal audit service provides the Audit Committee with an annual report of the coverage and results of the work of the service. The report must address, as a minimum:

- a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health
- major internal financial control weaknesses identified
- progress on the implementation of internal audit recommendations
- progress against plan over the previous year
- strategic audit plan covering the forthcoming three years
- a detailed audit plan for the next financial year

25.5.5. the police are informed at the right time, in cases of misappropriation and other irregularities not involving fraud or bribery

25.5.6. there is effective liaison with the Trust's appointed Local Counter Fraud Specialist (LCFS), or NHS Counter Fraud Authority on all suspected cases of fraud and bribery and all anomalies which may indicate fraud or bribery

25.6. The ~~**Director of Finance**~~**Chief Finance Officer** and designated auditors are entitled to require and receive, without necessarily giving prior notice, the following:

25.6.1. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature

25.6.2. access at all reasonable times to any land, premises or members of the Board or employees of the Trust

25.6.3. sight of any cash, stores or other property of the Trust under the control of any member of the Board or Trust employee

25.6.4. explanations concerning any matter under investigation

Internal Audit

25.7. The internal audit service shall:

25.7.1. provide an independent and objective assessment for the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance arrangements support the achievement of the Trust's objectives.

25.7.2. operate independently of the decisions made by the Trust and its employees; and of the activities which it audits. No member of the team providing the internal audit service will have executive responsibilities.

25.8. The **Head of Internal Audit** shall develop and maintain an Internal Audit Strategy for providing the Chief Executive with an objective evaluation of; and opinions on the effectiveness of the Trust's risk management, control and governance arrangements. The planned programme of work will inform the Head of Internal Audit's opinion. This will contribute to the framework of assurance that supports completion of the Annual Governance Statement, which forms part of the annual financial accounts.

25.9. The **Head of Internal Audit** shall ensure that the audit team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience needed to deliver the internal audit plan in line with the NHS Internal Audit Standards (DH, April 2011).

25.10. The **Head of Internal Audit** will normally attend Audit Committee meetings and has an independent right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

25.11. The **Head of Internal Audit** shall be accountable to the ~~Director of Finance~~Chief Finance Officer. The reporting system for internal audit shall be agreed between the ~~Director of Finance~~Chief Finance Officer, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards.

25.12. The internal audit service will review, appraise and report upon:

25.12.1. the extent of compliance with and the financial effect of, relevant policies, plans and procedures

25.12.2. the adequacy and application of financial and other related management controls

25.12.3. the suitability of financial and other related management data

25.12.4. the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from

25.12.5. fraud and other offences

25.12.6. waste, extravagance and inefficient administration

25.12.7. poor value for money or other causes

25.13. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the ~~Director of Finance~~Chief Finance Officer must be notified immediately.

25.14. In obtaining third party assurance from other auditors, for example SBS's auditors, the Head of Internal Audit should follow the Internal Auditors Practitioners Group (IAPG) assurance guidance.

External Audit

25.15. The **External Auditor** is appointed by the Trust's Auditor Panel and paid for by the Trust. The Audit Committee shall ensure that a cost-effective service is provided. If the Trust Board has concerns about the service provided by the External Auditor, which cannot be resolved by the Board, this should be raised with the External Auditor.

Counter Fraud and Bribery

25.16. In line with their responsibilities the Trust **Chief Executive** and **~~Director of Finance~~Chief Finance Officer** shall ensure compliance with section 24 of the NHS Standard Contract;

25.17. The **~~Director of Finance~~Chief Finance Officer** 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~~Chief Finance Officer and shall work with staff in NHS Counter Fraud Authority, when required;

25.19. The Local Counter Fraud Specialist will provide a written report to the Audit Committee, on an annual basis at least, on the counter fraud work completed within the Trust;

25.20. In accordance with the Trust's Counter Fraud Policy, any suspicions involving financial crime must be reported to the Local Counter Fraud Specialist, and/or the ~~Director of Finance~~Chief Finance Officer or via the NHS Fraud and Bribery Reporting Line.

All reported concerns will be treated in the strictest confidence and professionally investigated in accordance with the Fraud Act 2006 and Bribery Act 2010.

Where evidence of Fraud and/or is identified all available sanctions will be pursued against offenders. This may include internal and professional body disciplinary sanctions, criminal prosecution and civil action to recover identified losses.

Security Management

25.21. The **Director of Facilities** shall ensure that a qualified Local Security Management Specialist is appointed to provide security management services to the Trust, in accordance with the requirements of the NHS Standard Contract (currently 2013/14).

25.22. The **Local Security Management Specialist** will provide a written report to the Audit Committee, on an annual basis at least, on the security management work completed within the Trust.

ENDS

Appendix 3 – Scheme of Delegated Authorities

1. Trust Policies and procedural guidance

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Adoption (and responsibility for currency of): - Trust Policies	Relevant Director to be appointed as Policy owner	SFI 2 *Policy on Policies*
	- Procedural guidance (Procedure notes, Standard Operating Procedures, Protocols, Guidance)	Officer nominated by the Relevant Director	SFI 2 *Policy on Policies*
	Maintain and update Trust's financial procedures (eg administrative procedure notes, desktop guides, guidance to Budget Managers)	~~Director of Finance~~Chief Finance Officer	SFI 2.14

2. Planning and budget management

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Financial Framework Advising the Board on the financial framework within which the Trust operates	~~Director of Finance~~Chief Finance Officer	SFI 3.1
	Compliance with and update of Trust financial framework	~~Director of Finance~~Chief Finance Officer	SFI 3.1
	Business and budget plans		SFI 4
	Preparation of strategic and annual plans for the Trust	Chief Executive	SFI 4.1
	Preparation of annual (and longer term) financial budget for the Trust	~~Director of Finance~~Chief Finance Officer	SFI 4.3
	Contribute to the preparation of annual budgets	All nominated Budget Managers	SFI 4.4

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Budget management (and responsibility levels)		SFI 5
	i. at individual cost centre level	Budget Manager or nominated deputy	SFI 5
	ii. at department level	Departmental Manager or nominated deputy	SFI 5
	iii. division level	Clinical Director / Corporate Manager (some or all of the Division Management Team as authorised by the Clinical Director / Corporate Manager)	SFI 5
	iv. at Executive Director level	Executive Director, or nominated deputy	SFI 5
	Recognition and adoption of the annual budget at cost-centre level	Budget Managers	SFI 5.9
	Variations from reserves (additional funds provided to address inflationary pressures and/or investments and/or risks) *Report periodically to the Finance & Performance Committee*	~~Director of Finance~~Chief Finance Officer or nominated deputy	SFI 5

Approval of variation of budgets, including authority to vire

SoDA	Delegated Authority	Between budget lines	Capital to revenue & *vice versa*	SFI reference
	Within a cost centre	Budget manager **plus** one of: Head of Nursing, Matron, Divisional Operations Director, Assistant Department Manager	Agreement between Business Partner and	SFI 5.9
	Within a department, or specialty; between cost centres	Department Manager **plus** one of: Director, Deputy Director, Head of Nursing, Matron, Divisional Operations Director		SFI 5.9

	Within a division; between departments and specialties	Director, **or** Deputy Director **or** Divisional Operations Director	Director of Operational Finance , with the express agreement of the ~~Director of Finance~~Chief Finance Officer	SFI 5.9
	Between divisions, up to **£5,000**	Deputy Director of both divisions		SFI 5.9
	Between divisions, over **£5,000**	Executive Director of both divisions		SFI 5.9

Preparation of financial reports and returns

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Preparation of annual financial accounts and associated financial returns For Board approval	~~Director of Finance~~Chief Finance Officer	SFI 6.1
	Preparation of Annual Report (or equivalent) For Board approval	Chief Executive	SFI 6.3
	Preparation of monthly and quarterly financial returns to NHSI	~~Director of Finance~~Chief Finance Officer or nominated deputy	SFI 6.1

3. Contracted Income and Expenditure[1]

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Setting of fees and charges for NHS services		SFI 7
	Agree service level agreements, in accordance with NHS standard contract		SFI 7.6
	i. under £1 million	i. ~~Director of Finance~~Chief Finance Officer, or nominated deputy	
	ii. over £1million	ii. Chief Executive and ~~Director of Finance~~Chief Finance Officer	
	Subject to any required approvals being obtained, execute Agreements/Contracts (including Service Level Agreements and Deeds of Variation[2]) with NHS and non-NHS bodies for the purchase or provision of goods and/or services ii. under £1 million iii. over £1million	i. ~~Director of Finance~~Chief Finance Officer ii. Chief Executive and ~~Director of Finance~~Chief Finance Officer	SFI 7.6 SFI 7.7 SFI 7.8 SFI 9.5 SFI 9.6
	Contract management, monitoring and reporting	~~Director of Finance~~Chief Finance Officer or nominated deputy	SFI 7.9 SFI 7.10
	Private Patients i. set pricing policy and price structure	i. ~~Director of Finance~~Chief Finance Officer ii. ~~Director of Finance~~Chief Finance Officer iii. ~~Director of Finance~~Chief Finance Officer, Medical	SFI 7.3

[1] All legally binding documentation must be entered into in the name of "North Bristol NHS Trust" as the relevant legal entity
[2] If any variation is not included within the original Agreement/Contract, such variation shall require approval as if a new Agreement/Contract (SFI 10.18)

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	ii. set payment policy, including use of deposits, income guarantees, arrangements with insurance companies iii. approve service coverage policy (i.e. clinical services offered)	Director, Chief Executive	
	Overseas visitors i. set pricing policy and price structure ii. set payment policy, including use of deposits, income guarantees	~~Director of Finance~~Chief Finance Officer	SFI 7.3
	Authorise sponsorship deals i. Approve and execute Agreements to receive sponsorship from third parties (including funding of staff and loan of equipment):up to £15,000 ii. £15,000 to £50,000 iii. over £50,000	i. Divisional Operations Director ii. ~~Director of Finance~~Chief Finance Officer iii. Chief Executive	SFI 7.13
	Authorise and execute concession arrangements	~~Director of Finance~~Chief Finance Officer	SFI 7.15
	Authorise research projects and clinical trials, including approvals to apply for research funding and approvals to undertake research, once considered by the Research and Development Committee i. execute required Agreements/Contracts and authorise grant submission ii. execute documentation where the Trust Seal is required	i. Deputy Director of Research or nominated Deputy ii. As per SFI 8e	SFI 7.12

SoDA	Delegated Matter	Authority Delegated to	Delegation Ref.
	Authorise funded training posts	Head of Learning and Development	Not within SFIs
	Tenancy agreements and licences Prepare and execute all tenancy agreements and licences for staff (subject to Trust policy on accommodation)form of tenancy agreements i. signature of individual tenancy agreements ii. extensions to existing agreements	i. Director of Facilities 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~~Chief Finance Officer ii. As per SFI 8e	SFI 7.4
	Approve rent based on professional assessment	~~Director of Finance~~Chief Finance Officer or nominated deputy	SFI 7.4
	Legal Services i. authority to engage with legal advisors ii. maintenance of framework arrangements with approved legal advisors iii. approval of call off of services	i. Chief Executive ii. Trust Secretary iii. Trust Secretary (delegated to Commercial and Legal Services Manager)	SFI 8

4. Approval of Business cases

Before any case can progress through the approval processes detailed below, divisional and corporate support is needed for both capital and revenue cases as follows:

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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; • Test and confirm procurement strategy • Monitor development and delivery of business case pipeline

The business case process outlined below applies to all contract renewals and extensions as well as new revenue spend

Approval Process - ~~Revenue~~ Business Cases

Full life cost of new expenditure - Revenue, Capital or Combined (for recurring revenue commitments - annual costs)				
	<£1m	≥£1m, <£2.5m	≥£2.5m, <£15m	≥£15m
~~Director of Finance~~Chief Finance Officer (or nominated deputy)	Approval	Approval	Approval	Approval
Chief Executive	-	Approval	Approval	Approval
Finance & Performance Committee	-	-	Approval	Approval
Trust Board	-	-	Approval	Approval
NHSI	-	-	-	Approval

Value	<£100k	≥£100k, <£500k	≥£500k, <£15m	≥ £15m
Business Case type required	CFO business case	Single-stage Business Case	OBC and FBC	SOC, OBC and FBC

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~~*Approval Process – Capital Business Cases.*~~

Key
CFO – ~~Director of Finance~~Chief Finance Officer
SOC – Strategic Outline Case
OBC – Outline Business Case
FBC – Full Business Case

Order of Approvals

Approvals are sequential and all steps in the process need to be followed in order i.e. for a revenue scheme of £1m+ the order of approvals are:

5. Approvals to Award from Tenders and quotations (revenue and capital)

Definitions	
Non-Contracted spend	Spend that cannot be demonstrated as assigned to a valid contract Spend that should the proposed action not be completed will become unsupported by a contract (ie. spend approaching contract expiry date or contract extension date)
Compliant Procurement Process:	A procurement activity that complies with PCR (Public Contracts Regulations)
Recommendation Report:	Report created by BWPC seeking approval of the outcome of a compliant procurement process, prior to contract award or extension Value contained within recommendation report identifies the initial contract term, plus extensions. However, initial approve is ONLY for contract term, secondary recommendation report required to extend contract
Exception Report:	Report created by BWPC, seeking directional guidance on a procurement process where a non-compliant outcome is preferred by the Trust, prior to contract award or extension
STA:	A document used to seek approval, with justification, for award of contract or out-of-scope extension without documented proof of value of money via direct comparison

BWPC remit	As custodians of the Procurement Process, BWPC are tasked with two aspects of validation: 1. Adherence to Trust SFI's; in simplified terms a requirement to ensure due process has been performed that will prove value for money 2. Adherence to The Public Contracts Regulations 2015 and other relevant legislation The intention of BWPC is to offer insight into the compliance of both aspects of validation for all relevant procurement activities As the element of risk concerning exceptions to Trust SFI's &/or PCR/OJEU non-compliance resides with the individual Trust/s, BWPC remit remains one of guidance and not decision maker.

Management of non-Contracted Spend			
	Description	**Consortium**	
1. Up to £5,000	*No requirement to evidence value for money*	5,000	Budget manager
2. £5,000 to £25,000	*Trusts responsible for quotation provision, BWPC operate a validation activity*	25,000	Divisional Operations Director or Executive Director or nominated Deputy
Written Quote Requirement	*The number of quotes required prior to a Purchase Order being progressed*	3	

Procedure (between SFI threshold & £25K)	**Procedure Detail**	**Consortium**
Quotation Process	*3 or more valid quotes provided*	PO Progressed
Quotation Process	*2 or less valid quotes*	STA
3. Above £25,000	Outcome Detail	Consortium
Tender Process (Local, OJEU, Quote)	*3 or more competitively priced bids received*	Recommendation Report
Tender Process (Local, OJEU, Quote)	*Less than 3 competitively priced bids received*	Recommendation report~~, followed by STA if approved~~
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~~
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

6. Contract Signature

The following applies for contract signatures (after all relevant approvals have been given):

- **Up To EU threshold – Divisional Operations Director or relevant Corporate Director**
- **EU threshold to £2m~~500,000~~ – ~~Director of Finance~~Chief Finance Officer**
- **Over £2m~~500,000~~ - Chief Executive**

7. Contract Management

Other tendering and contractual arrangements

	Delegated matter	Authority delegated to	Delegation ref.
	Approve insurance policies i. Schemes administered by the NHSR ii. Other insurance arrangements	i. ~~Director of Finance~~Chief Finance Officer or nominated deputy. ii. ~~Director of Finance~~Chief Finance Officer or nominated deputy.	SFI 12.1 SFI 12.4
	Affix Trust Seal to contract documentation Including property documentation and contractual arrangements where there is no consideration	Chair and Chief Executive, or in their absence, the designated acting Chair or Chief Executive	SO 30

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~~Chief Finance Officer	SFI 10.2
	Identify the Trust's approved supply arrangements (controlled procurement systems, framework agreements)	~~Director of Finance~~Chief Finance Officer	SFI 10.4

Trust-wide ***(excepting elements of delegated authority for specific disciplines specified in the subsequent tables)***

8. Ordering limits (EROS)

Up to £2,500	Authorising manager approved by Divisional Operations Director/Corporate manager
Over £2,500	Vetting manager approved by Divisional Operations Director/Corporate manager

9. Oracle Limits - Invoice processing

a. General Oracle Limits

Up to £25,000	Budget holder/manager designated by Divisional Operations Director or equivalent
£25,000 to £100,000	Divisional operations Director//Corporate Manager
£100,000 to £1m Grouped NHS Supply Chain invoice up to £500K	Executive Director Director of Procurement

Over £1m	~~Director of Finance~~Chief Finance Officer/Chief Executive

b. Subsidiary Systems

Subsidiary Systems where grouped requisitions are used:

	Pharmacy	**Capital Estates**
Grouped requisitions up to £500k per week	Director of Pharmacy or nominated deputy	Capital estates Mailbox
Grouped requisitions over £500k per week	Director of Pharmacy	Director of Facilities 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~~Chief Finance Officer (Financial Services) or Assistant ~~Director of Finance~~Chief Finance Officer (Planning & Income) (or nominated deputies in their absence)
Over £10m	Director of Operational Services or ~~Director of Finance~~Chief Finance Officer

10. Workforce and payroll

Appointment of Senior Medical Staff and team (investment may include capital elements)

		Replacement posts	New posts / clinical teams[1]	
		Within existing budget	**Up to £500k**	**Over £500k**
	Approval / Sign-Off[2] by:			
	Trust Management Team		Agree project mandate and priority	
	Finance Business Partner	Sign	Sign	Sign
	HR advisor	Sign	Sign	Sign
	Divisional Operations Director or equivalent corporate manager	Sign	Sign	Sign
	Clinical Director	Sign	Sign	Sign
	Chief Operating Officer	-	Sign	Sign
	~~Director of Finance~~Chief Finance Officer	-	Sign	Sign
	Consultant Post Panel	**Approve**	**Approve**	Recommend
	Finance & Performance Committee			OBC & FBC in accordance with Business Case approval limits
	Trust Board			**Approve** FBC in accordance with Business Case approval limits

[1] New clinical teams to deliver new services. Approach follows the same sign-off steps as for new service developments

[2] Signature indicates sufficient understanding and confidence in the details of the business case to confirm responsibility for support for the proposal

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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~~Chief Finance Officer
	- over **£500k** gross commitment	-	Chief Executive
	- over 6 months length of contract	-	Chief Executive

[1]Need to ensure fit with workforce plans

Bank, agency and locum staff	**Within establishment**		**Extra to establishment**	
	Within budget	**Without budget**	**Within budget**	**Without budget**
SoDA reference	11g		11h	
Nursing	(Deputy) Budget Manager	Director of Nursing **or** Medical Director and ~~Director of Finance~~Chief Finance Officer **or** Chief Executive	Budget Manager	Director of Nursing **or** Medical Director and ~~Director of Finance~~Chief Finance Officer **or** Chief Executive
Clerical support services	(Deputy) Budget Manager		Budget Manager	
Medical	(Assistant) General / Corporate Manager		Divisional Operations Director/ / Corporate Manager	
Through non-framework agency	As above, plus Executive Director approval		As above, plus Executive Director approval	

Approvals relating to staff on the payroll

	General approvals	Approval / sign off
	Grant additional increments to staff (outside of Department of Health national T&C)	Director of People & Transformation **and** ~~Director of Finance~~Chief Finance Officer
	Authorise (electronic and paper) timesheets and other positive reporting forms which will affect the amount of salary to be paid to confirm: attendance at work; sickness and absence records; overtime and unsocial hours	Line Manager **or** Authorised Signatories
	Authorise travel and subsistence claims (only available through e-expenses)	Line Manager
	Approve departure under compromise agreement (excluding mutually agreed resignation scheme (MARS) arrangements) i. directors and very senior managers ii. other staff	i. Remuneration and Nominations Committee and ~~Director of Finance~~Chief Finance Officer ii. Director of People & Transformation and ~~Director of Finance~~Chief Finance Officer
	Approve redundancy (and mutually agreed resignation schemes, or similar arrangements) **i.** payment up to **£100k** **ii.** payment over **£100k**	i. Director of People and Transformation and ~~Director of Finance~~Chief Finance Officer ii. Remuneration and Nominations Committee and ~~Director of Finance~~Chief Finance Officer

11. Approval for variations to capital plan~~s~~

~~Change to Total Annual Capital Expenditure Plan~~~~Delegated authority~~	~~Variations to approved sum~~Delegated Authority

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Up to **£**500~~100k~~	Capital Planning Group
£5~~1~~**00k** to **£**1m~~500k~~	Finance & Performance Committee
Over £1m~~500k~~	Trust Board

Funding capital investments through Private Finance Initiative

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Assess comparative merit of progressing scheme through PFI	Finance and Performance Committee, advised by ~~Director of Finance~~Chief Finance Officer	SFI 13.10
	Authorise payment of the sums identified in the schedule of the unitary payment (being the annual service payment defined in Schedule 18 of the Project Agreement) to be made to the PFI partner over the lifetime of the scheme (project term). Authorise annual Retail Price Index (all items) adjustment, in accordance with the PFI Project Agreement.	Trust Board	SFI 13.13
	Oversee delivery of the PFI contract terms, ensuring appropriate delivery and monitoring of the PFI contract; and including agreement of fee adjustments resulting from facilities management service and performance issues, to verify the invoice total.	Director of Facilities	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~~Chief Finance Officer	SFI 13.16
	Process payment of monthly account to the PFI partner, in accordance with the Trust Board authorisation.	Assistant ~~Director of Finance~~Chief Finance Officer (Financial Services), or nominated deputy	SFI 13.17

Fixed assets records and accounting for fixed assets

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Maintain register of (fixed) assets Including verification of additions and disposals, revaluations, calculation of annual capital charges	~~Director of Finance~~Chief Finance Officer	13.19 to 13.22

12. Bank and cash and investments

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Day to day operation of bank accounts i. maintain list of approved signatories ii. approval to pay	i. Shared Business Services (SBS), under terms of contract with the Trust ii. SBS following confirmation of availability of cash required by Head of Financial Control	SFI 14.5
	Determine when to subject commercial bank service supplier to competitive tendering	~~Director of Finance~~Chief Finance Officer	SFI 14.8
	Establish, or close a petty cash facility	~~Director of Finance~~Chief Finance Officer (or nominated deputy)	Not within SFIs
	Approve the use of Trust credit cards (in the name of North Bristol NHS Trust only)	~~Director of Finance~~Chief Finance Officer (or nominated deputy)	SFI 14.10
	Investment of funds i. surplus exchequer funds ii. charitable fund cash balances	i. ~~Director of Finance~~Chief Finance Officer ii. Investment advisors appointed by the Charity Committee	SFI 15

13. External borrowing and Public Dividend Capital

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Short-term borrowing (temporary borrowing limit)	Trust Board	SFI 18.2 SFI 18.3
	Borrowing, including commercial loans	Trust Board	SFI 18.4
	Borrowing of Public Dividend Capital	Trust Board	SFI 18.1 SFI 18.4

14. Disposals, write-offs losses and special payments

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Terminate lease and rental arrangements early at cost to the Trust	~~Director of Finance~~Chief Finance Officer **and** Director of Facilities	SFI 13.21
	Condemn and arrange for disposal of equipment assets Items that are obsolete, redundant, irreparable or cannot be repaired cost effectively i. with a current or estimated purchase price up to £1,000 ii. with a current purchase price of £1,000 - £5,000 iii. with a current purchase price over £5,000.	i. Budget manager ii. General / Corporate Manager iii. Executive Director	SFI 13.26
	Dispose of x-ray films	Radiology Departmental Manager\Clinical Director	SFI 13.26

SoDA	Delegated matter	Authority delegated to	Delegation ref.
	Disposal of mechanical engineering plant. With replacement value estimated at: i. up to £10,000 ii. £10,000 to £100,000 iii. over £100,000	i. Head of Estate Maintenance ii. Director of Facilities iii. Director of Facilities **and** ~~Director of Finance~~Chief Finance Officer	SFI 13.26
	Approve sale, or transfer (eg donation) of equipment assets to another organisation for continued use i. clinical equipment ii. IT equipment iii. other equipment	i. Medical Director ii. ~~Director of Finance~~Chief Finance Officer iii. ~~Director of Finance~~Chief Finance Officer **and** relevant Executive Director	SFI 13.26
	Approve losses, write-offs and compensation payments due to / made under: • theft, fraud, overpayment of salaries and overpayment of third parties; • fruitless payments, including abandoned capital schemes; • bad debts and claims abandoned, including in respect of Private Patients, Overseas Visitors and other third parties; • damage to buildings, fittings, furniture, equipment and property in stores and in use due to culpable cause (e.g. fraud, theft, arson); • additional payments made to third parties in connection with or arising out of contractual liabilities, including sums payable under agreed settlements and court judgments; • personal injury claims involving negligence (legal advice must be obtained and guidance applied); • ex-gratia payments patients and staff for loss of personal	i. Assistant ~~Director of Finance~~Chief Finance Officer (Financial Services) or nominated deputy in their absence ii. ~~Director of Finance~~Chief Finance Officer or deputy iii. Audit Committee	SFI 19 Schedule of reservations 3

	effects; i. up to £1,000 ii. £1,000 up to £50,000 iii. Over £50,000 *All to be reported to the Audit Committee.*		
SoDA	**Delegated matter**	**Authority delegated to**	**Delegation ref.**
	Report incidents to the Police i. general ii. where a fraud is involved	i. departmental manager (inform General / Corporate Manager or Director as soon as possible. Also inform Local Security Management Specialist) ii. ~~Director of Finance~~Chief Finance Officer or Local Counter Fraud Specialist	SFI 19 *Counter Fraud and Bribery Policy*

15. Patients' property

Delegated authority	Holding	Receive and safeguard valuables	Discharge patients' valuables
Valuable items	Ward safe	Any member of nursing staff	Any member of nursing staff
Cash under **£5k**	Ward safe	Ward Manager	Ward Manager

16. Access to charitable funds

Delegated authority	Approve expenditure from charitable funds
Up to £1,000	One fund signatory
£1,000 to £10,000	Two fund signatories
Delegated authority	**Approve expenditure from charitable funds**
£10,000 to £50,000	Two fund signatories plus the ~~Director of Finance~~Chief Finance Officer (or nominated deputy)
Over £50,000	Two Fund signatories and the Charity Committee.

Spending plans will be submitted to the Charity Committee for approval in March each year. Approval is delegated to approve additional spending plans that arise during the year as follows:

Delegated authority	Approve expenditure from charitable funds
Up to £10,000	Assistant ~~Director of Finance~~Chief Finance Officer (Financial Services) or nominated deputy in their absence
£10,000 to £50,000	~~Director of Finance~~Chief Finance Officer (or nominated deputy)

Over £50,000	Charity Committee.

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.

17. Glossary of terms and acronyms

BC	**Business case**
CEO	**Chief Executive Officer**
Director	Non-Executive or Executive Director, with or without voting rights at Trust Board. The term excludes Clinical Directors, who are identified separately
CFO	~~**Director of Finance**~~**Chief Finance Officer**
FBC	**Full Business Case**
Divisional Operations Director /Corporate Manager	The senior operational manager(s); and their formally nominated deputy, for the division or specialty, as designated by the Executive Director.
OBC	**Outline Business Case**
PMO	**Programme Management Office**
SBS	**Shared Business Services.** The Trust's provider of accounts transactions and ledger process
SFI	**Standing Financial Instruction.** Reference to the detail in the full SFIs
SOC	**Strategic Outline Case**
SoDA	**Scheme of Delegated Authorities**. Reference to the detail in the full SoDA

Report To:	Trust Board		
Date of Meeting:	25 November 2021		
Report Title:	Patient & Carer Experience Committee Report		
Report Author & Job Title	Kate Debley, Deputy Trust Secretary		
Executive/Non-executive Sponsor (presenting)	Kelvin Blake, Non-Executive Director and Committee Chair		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	The Trust Board is recommended to receive the report for assurance.		
Report History:	The report is a standing item to each Trust Board meeting following a Patient & Carer Experience Committee meeting.		
Next Steps:	The next report to Trust Board will be to the January 2022 meeting.		

Executive Summary	
The report provides a summary of the assurances received, issues to be escalated to the Trust Board and any new risks identified from the Patient & Carer Experience Committee Meeting held on 17 November 2021.	
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

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 17 November 2021.

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 Staff Story

The Committee received a video Staff Story from the Learning Disability & Autism Liaison Team, which outlined how the team has adapted during the Covid pandemic. The Committee heard that patients supported by the team are some of the most vulnerable to Covid.

The Committee noted that at the start of the pandemic the team was expanded from two to four Whole Time Equivalents and the service was made available seven days a week. Changes in ways of working also included basing one member of the team in the

Emergency Department to provide support, and to review any care plans already in place from the community for patients who are admitted.

The Committee heard that a key part of the team's role is advocacy and helping to ensure that people with learning disabilities and autism are accessing the treatment that they need. The team works on behalf of patients and their families, and this has been particularly important at a time when attendance on site by carers and families was restricted.

The Committee heard examples of the team's creativity in helping to ensure inclusion and engagement, including facilitating hoist training for the parents of a patient with autism who had a long admission following a brain injury and who found it very difficult to manage in an inconsistent hospital setting. The training allowed his parents to take him out at regular times each day and help provide some consistency and routine to the day. Another example was creative engagement with a patient who needed a CT scan. A treasure map was created with the CT scanner at the end, and a member of the team wore a mask featuring the patient's favourite TV character. Resources have also been put in place that can be helpful for patients who need to engage with physiotherapy sessions, such as 'Magic Tables' that project interactive images, and sensory lights that can be used to help those who find the stimulation levels in a hospital setting challenging.

The team have also delivered bespoke training to teams in the hospital, including Ultrasound, Medirooms, the Acute Medical Unit, and Pre-Operative Assessment Clinics. Plans are in place to continue this training with other teams including receptionists, security teams and students who come into the Trust. Virtual drop in training and information sessions are also provided via the Trust's intranet and all staff with an interest are welcome to attend.

The Committee acknowledged and discussed the challenges of working with individuals with multi-faceted impairment, including visual impairment, who may also have complex physical health needs. They were reassured that this is an area of planned focus and improvement going forward.

The Committee congratulated the team for all the work they are doing and also asked that the Staff Story video be made available to the public via the Trust's website.

3.2 Learning Disability & Autism Annual Report

The Committee received the Learning Disability and Autism Annual Report 2020/21 and noted the achievements set out within. The Report is attached at Appendix 1 for the Trust Board's information.

The Committee were reassured that along with the clear creativity and energy that the team apply to continuous improvement, there is also rigorous analysis of available data,

such as benchmarking, mortality review and LeDeR outcomes, in order to better understand the experience and treatment of people with learning disabilities and autism within the Trust. Learning is also shared with consultants and other clinicians to identify whether there are any specific trends or additional consideration required around decision making.

3.3 Patient Property Internal Audit Report and Action Plan

The Committee received an Internal Audit Report on Patient Property, together with an update on associated actions, from the Head of Professions & Nursing, Core Clinical Services, who is Senior Responsible Owner (SRO) of the Trust's Patient Property Project. It was noted that the Report had a rating of partial assurance with improvements required and that Audit Committee had asked that Patient & Carer Experience Committee oversee the delivery of the actions within this Audit.

The Committee were reassured that the Trust's entire approach to patient property is being reviewed, with the intended outcome to streamline, simplify and strengthen processes, whilst recognising inherent challenges that need to be addressed. The Committee emphasised the importance of this work and in not underestimating the potential financial and personal impact on patients when items are lost or damaged.

The Committee asked that they receive regular updates on progress against the actions set out in the Report, and that an appropriate schedule for reporting should be agreed between the Project SRO and the Director of Nursing & Quality.

3.4 Patient Experience Risk Report

The Committee reviewed the Patient Experience Risk Report and noted that there were no new risks that require escalation to Trust Board. The Committee asked that a more in-depth review of all patient experience risks be undertaken at its next meeting and that the Divisional Directors of Nursing be invited to attend that meeting in order to provide additional background and assurance around each of the risks in their respective divisions.

3.5 End of Life Steering Group Highlight Report

A highlight report from the End of Life Steering Group was received by the Committee, including in relation to work on the purple butterfly scheme, an update that Equality Diversity and Inclusion will be a focus for the Group over the next year, and also an outline of some challenges in relation to communication around Respect forms.

The Committee also noted an update from the Director of Nursing & Quality that unfortunately there have been a series of incidences where there had been a shortfall in last offices. The Committee were reassured that this is being addressed as a key dignity issue, and that as well as investigation into each individual incident with the teams involved as is standard practice, the Medicine division have also been tasked with

undertaking a thematic review in order to identify if there are any key areas of concern. The Committee asked that this review also include reassurance being sought that all aspects of last offices are being performed consistently for deceased patients.

3.6 Additional updates received on:

- Learning Disability & Autism Steering Group Highlight Report
- Integrated Performance Report – Complaints and Concerns (October data)

4. Escalations to the Board

4.1 No risks or items of concern were identified for escalation to Trust Board.

5. Recommendations

5.1 The Board is recommended to receive the Report for assurance and to note the Learning Disability & Autism Annual Report at Appendix 1.

North Bristol NHS Trust

Learning Disability and Autism Annual Report:

September 2020 – October 2021

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

Working 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 of NBT's quality priorities for 20/21 was meeting the identified needs of patients with learning difficulties, autism, or both. The Learning Disability and Autism (LD/A) Steering Group has remained the working group since its establishment in 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 two. It highlights the achievement throughout September 2020 and October 2021 including learning through these achievements. It is important to acknowledge that Covid-19 though challenging, brought in creative solutions and innovation to help improve the experience of people with Learning Disability and Autism/ or both. As part of reviewing the year and prioritising the coming year, 6 virtual workshops were organised through the month October 2021 with the aim to engage frontline staff to create awareness to make Learning Disability and Autism everyone's business and also engage staff to explore the challenges of the year, what has worked well and how we prioritise meeting the needs of people with LDA. This was done in collaboration with the Quality and Safety Improvement Team and the Learning disability Team with support from the Head of Patient Experience.

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.

North Bristol NHS Trust

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 has continued to provide governance and leadership for the programme of work and is represented by all divisions and professional groups chaired by the recently appointed Head of Patient Experience.

North Bristol NHS Trust has made some great improvement in achieving the Learning Disability and Autism Plan and recorded great successes. Our staff have fully embraced the plan and sought to go further and deliver more and supported the work to implement the plan. We now have over 120 champions from a wide range of roles and grades. Despite the challenges of Covid-19, there has been 6 virtual workshops organised for champions and front-line staff to assess the current work across the divisions and to prioritise the actions for the following year.

The Learning Disability Liaison Team have worked dynamically with clinical staff to close the gaps in supporting patients when visiting from carers and families have been limited due to Covid-19 restrictions. This has helped improved the quality of care and the experience of people with LDA.

The Trust has continued to engage with the wider Bristol, North Somerset, and South Gloucestershire Clinical Commissioning group (BNSSG) to work on improvement across the system to improve the experience of care for people with LD/A. NBT has played a key role in working with the BNSSG Provider Network to oversee the actions and improvement plan for the Oliver McGowan multi-agency review action plans.

The Trusts had reviewed and reported on the NHS benchmarking standard, BNSSG LeDeR annual reports looking at actions to align to its priorities for the coming year. The Trust has registered to take part in the 2021 NHS Benchmarking standard to participate in reviewing its work against the 3 standards required for all acute hospitals:

Respecting rights
Inclusion and engagement
Workforce

NBT has collaborated with the BNSSG CGG, UHBW to undertake a peer led coproduced audit that started in October 2021 reviewing all emergency departments through the perspective of autistic patients. This will be reported to the steering group and to the Patient and Carer Experience Group once finalised. The Trust has continued to work with the Provider Network, LD/A Programme Board, and the LeDeR Governance Group to ensure learning is shared across the Trust and work is consistent with other areas within BNSSG. The Trust continues to engage in actions arising from the Oliver McGowan Action plan ensuring learning is acknowledged and taken to improve the experience of those with LD/A.

The Trust has been able to register over 20 staff across different disciplines, onto the Pilot Oliver McGowan training, run by Gloucestershire Health and Care NHS Trust and continue to work with the Bristol Autism Spectrum Service (BASS) to work on delivering bespoke training for staff who work with complex patients with Learning disability &/or Autism.

NBT have collaborated with UHBW, BSSG CGG to develop Autism posters for our Emergency department as a result of the peer led audit of the emergency department following the feedback from the first audit at the Bristol Eye Hospital.

Uniform Policy has been updated in line with the needs of service users with LDA and the organisation's Transitions to Adult Care Policy is currently under review in line with the needs of services users with LDA.

Achievements

With the pandemic continuing 18 months later, it continues to provide many challenges for patients with Learning Disability & Autism. It is for this

NHS North Bristol NHS Trust

reason that the Sirona Learning Disability and Autism Liaison Team (LDALT) have now received permanent funding for an increased service of 4 WTE specialist LD nurses to provide a **7-day service** in NBT. This enables the team to review patients within one working day of referral, and ensures families and carers are kept informed, clinical teams have support, advice and guidance and patients' individual needs are identified and being met.

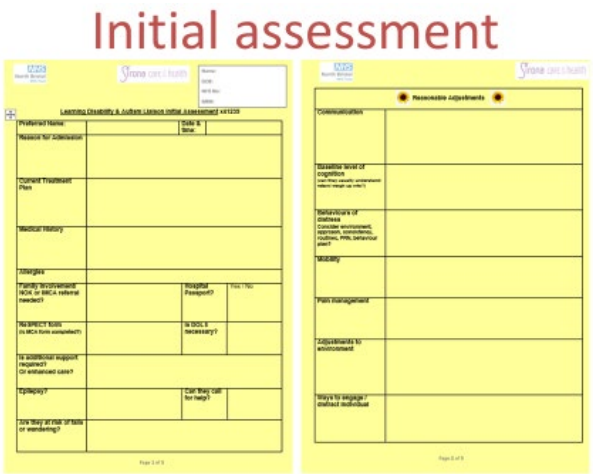
Business Intelligence now sends out a daily list of inpatients with a Learning Disability or Autism flag on Lorenzo, and the team document care needs on Careflow connect, Flow and contemporaneously in the medical records.

LD Nurses Best Friend!!!

CareFlow CONNECT

- Introduced rapidly across hospital in 1st month of pandemic.
- Electronic Patient Handover – inc SBAR Vitals & NEWS scores (Red if high).
- Receive direct Referrals.
- Can add Tags : Learning Disability, Autism, Enhanced Care, Hospital Passport, DOLS, Eating Drinking Guidelines etc.
- Can write LD Nurse Recommendations for staff handover – ie Reasonable Adjustments.

Following a Pilot/PDSA QI Project, a summary of care needs are now written on yellow paper as an initial assessment, and a sticker is added to the medical notes each time the patient is reviewed



Learning Disability & Autism Liaison Team Review x41239

Please read:

☐ Hospital passport (in bedside notes)
☐ Initial learning disability & autism assessment, dated .....

☐ ReSPECT framework	☐ Shared bay needed
☐ Epilepsy protocol	☐ Single room needed
☐ DOLS	☐ Behaviour Support Plan
☐ Physio Guidelines	☐ Has family / carer support
☐ Eating & drinking guidelines	☐ Enhanced care / 1-1
☐ Food or fluid chart	☐ Stool chart

Print name.....Date.....

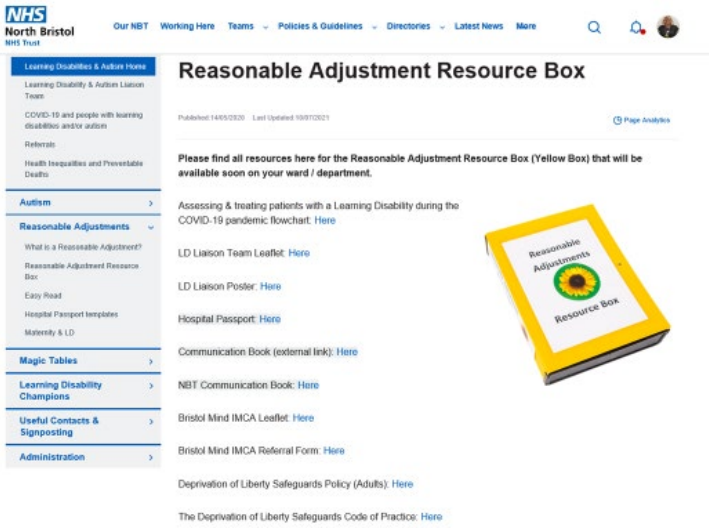
Signed.....Time.....

Additional electronic notes recorded on EMIS

Reasonable adjustment resources on LD LINK page*

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 Team intranet page for staff, and these resources are also provided in a yellow box file for every ward and clinical area. LD&A Champions will keep the file up to date. The resource box includes communication books, sensory lights, MCA and best interest paperwork.



Due to limitations imposed during Covid-19, training opportunities have been reduced, but the LD & A Liaison Team have instead provided bespoke training to individual teams, including Pre- Operative Assessment, Medirooms

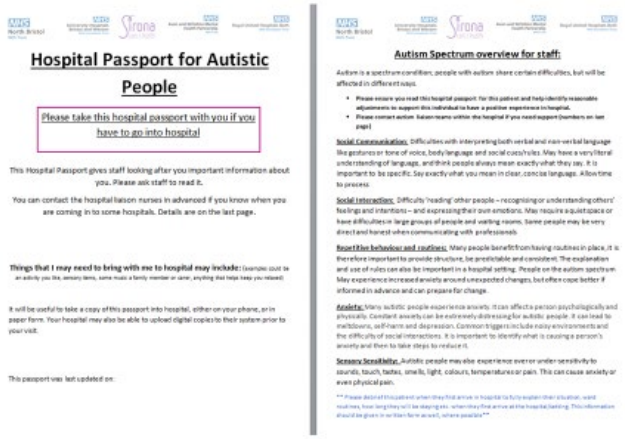
Physiotherapist, Radiology Team, Midwifery, Security, Inpatient ward teams including, Receptionists and Student Nurses

.

Bristol Autism Spectrum Service (BASS) have previously provided joint training to the LD&A Liaison Team, Mental Health Liaison Team and some members of ED to increase their knowledge around Autism.

The relationship between NBT and BASS has developed further in the past year, ensuring a programme of Autism training for staff is available, and we've also been working collaboratively, with a focus group of people with Autism to develop a Hospital Passport and Reasonable Adjustment Checklist for Autistic People, incorporating their sensory, and communication needs. This is being used across BNSSG in the acute hospitals, and BASS service users are sending in their passports to be added to Lorenzo with an Autism alert added.

Hospital passport for autistic people



Hospital Passport for Autistic People

Please take this hospital passport with you if you have to go into hospital

This Hospital Passport gives staff looking after you important information about you. Please ask staff to read it.

You can contact the hospital liaison nurses in advanced if you know when you are coming in to some hospitals. Details are on the last page.

Things that I may need to bring with me to hospital may include:

It will be useful to take a copy of this passport into hospital, either on your phone, or in paper form. Your hospital may also be able to upload digital copies to their system prior to your visit.

This passport was last updated on:

Autism Spectrum overview for staff:

Autism is a spectrum condition, people with autism share certain difficulties, but will be affected in different ways.

- Please ensure you read this hospital passport for this patient and help identify reasonable adjustments to support this individual to have a positive experience in hospital.
- Please contact autism liaison teams within the hospital if you need support (numbers on last page)

Social Communication: Difficulties with interpreting both verbal and non-verbal language like gestures or tone of voice, body language and social cues/rules. May have a very literal understanding of language, and think people always mean exactly what they say. It is important to be specific. Say exactly what you mean in clear, concise language. Allow time to process.

Social interaction: Difficulty 'reading' other people – recognising or understanding others' feelings and intentions – and expressing their own emotions. May require a quiet space or have difficulties in large groups of people and waiting rooms. Some people may be very direct and honest when communicating with professionals.

Repetitive behaviour and routines: Many people benefit from having routines in place, it is therefore important to provide structure, be predictable and consistent. The explanation and use of rules can also be important in a hospital setting. People on the autism spectrum may experience increased anxiety around unexpected changes, but often cope better if informed in advance and can prepare for change.

Anxiety: Many autistic people experience anxiety. It can affect a person psychologically and physically. Constant anxiety can be extremely distressing for autistic people. It can lead to meltdowns, self-harm and depression. Common triggers include noisy environments and the difficulty of social interactions. It is important to identify what is causing a person's anxiety and then to take steps to reduce it.

Sensory Sensitivity: Autistic people may also experience over or under-sensitivity to sounds, touch, tastes, smells, light, colours, temperatures or pain. This can cause anxiety or even physical pain.

*** Please detail if this patient when they first arrive in hospital to fully explain their situation, ward routines, how long they will be staying etc. when they first arrive at the hospital/setting. This information should be given in written form as well, where possible***

BASS also continues to offer the LD&A Liaison Team specialist advice around specific patient needs and provides Peer Support sessions, as necessary.

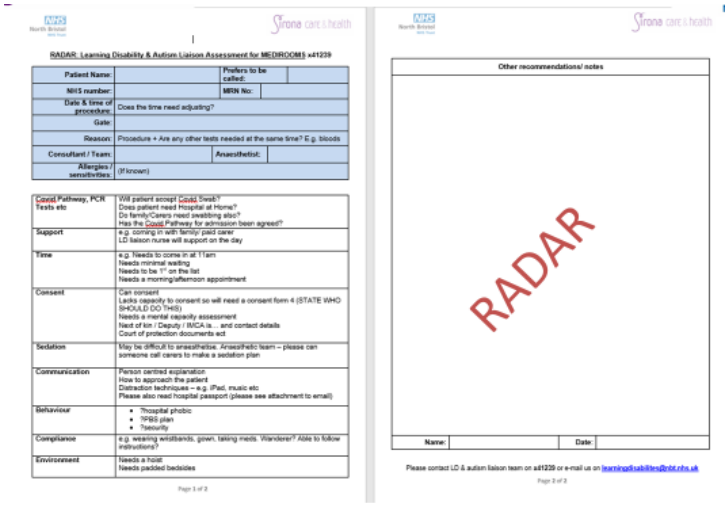
Being employed by Sirona, the LD & A Liaison Team also work closely with the Adult Community Health Services across BNSSG and joint work with patients who are coming into hospital or being discharged, and need additional health support.
As a service the LD & A Liaison Team have also demonstrated creative ways of working to encourage patients to have medical procedures or therapy e.g.:

Dr Who (aka LD Nurse with mask) taking patient to CT Scan using a treasure map!

4 x Magic Tables (projectors) have been funded by Southmead Charity for 2 years, to increase stimulation and improve mobility for patients with Learning Disabilities and Autism, who don't respond to traditional therapy approaches.

Projectors & Staff training has been provided to:
1) ED
2) Complex Care (9A & 9B)
3) Physio Team
4) LD & A Liaison Team
and ongoing training is available to more staff from social ability.

In the last year there has also been a lot more outpatient appointments and planned procedures, and this has enabled the hospital to improve their pathway for admission to theatres for patients with Learning Disabilities and Autism. As another Quality Improvement (QI) Project the team developed a Care Plan for Medirooms and Theatres known as a **RADAR**, where information is gathered in advance either by phone or at pre-op and then staff are allocated in advance, ensuring care plans are read, and reasonable adjustments supported. This process has improved the communication between teams and the experience for patients with Learning Disability or Autism coming in for procedures.


RADAR: Learning Disability & Autism Liaison Assessment for MEDIROOMS x41239

Patient Name:	Prefers to be called:
NHS number:	MRN No:
Date & time of procedure:	Does the time need adjusting?
Gate:	
Reason:	Procedure + Are any other tests needed at the same time? E.g. bloods
Consultant / Team:	Anaesthetist:
Allergies / sensitivities:	(If known)
Covid Pathway, PCR Tests etc	Will patient accept Covid Swab? Does patient need Hospital at Home? Do family/Carers need swabbing also? Has the Covid Pathway for admission been agreed?
Support	e.g. coming in with family/ paid carer LD liaison nurse will support on the day
Time	e.g. Needs to come in at 11am Needs minimal waiting Needs to be 1st on the list Needs a morning/afternoon appointment
Consent	Can consent Lacks capacity to consent so will need a consent form 4 (STATE WHO SHOULD DO THIS) Needs a mental capacity assessment Next of kin / Deputy / IMCA is… and contact details Court of protection documents ect
Sedation	May be difficult to anaesthetise. Anaesthetic team – please can someone call carers to make a sedation plan
Communication	Person centred explanation How to approach the patient Distraction techniques – e.g. iPad, music etc Please also read hospital passport (please see attachment to email)
Behaviour	• Thospital phobic • ?PBS plan • ?security
Compliance	e.g. wearing wristbands, gown, taking meds. Wanderer? Able to follow instructions?
Environment	Needs a hoist Needs padded bedsides

Other recommendations/ notes

RADAR

Name: Date:

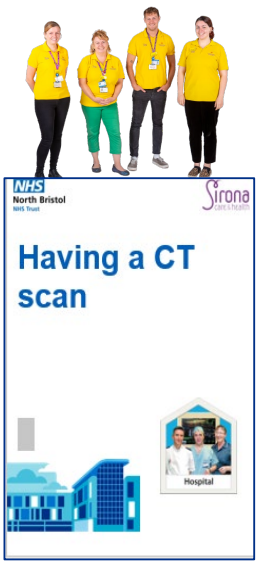
Please contact LD & autism liaison team on x41239 or e-mail us on learningdisabilities@nbt.nhs.uk

Some of these patients have been very complex with significant levels of additional needs and behaviours that challenge, and with the support of the MDT from the Positive Behaviour Management Group and significant planning; and the use of MAYBO trained staff for therapeutic clinical holds, there have been some successful admissions for procedures. LD Liaison Team have also forged a relationship with a local specialist LD Dentist. This has been an excellent resource and has enabled a patient to receive a dental check-up during an operation. This is an excellent example of reasonable adjustment for this gentleman.

One mother was very happy with the treatment for her son and sent these to LD Liaison Team, Anaesthetist, Security & Medirooms staff:

The LD & A Liaison Team have now also received formal MAYBO training within the Trust to offer additional support and safe holds for patients who need additional support for clinical treatment such as bloods.

In the past year, we have also spent time working with Photosymbols, a local organisation, building up additional photos of our team for hospital use, and for accessible information used nationally throughout the pandemic.



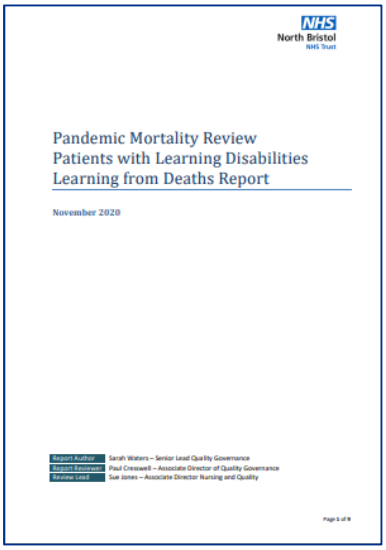
Having access to these photosymbols have enabled the LD & A Liaison Team to also develop many tailored social stories for patients coming in for procedures, which has helped people to understand their procedure in advance, reducing anxiety.

The hospital staff really engaged in Learning Disabilities Week this year also by completing a Board about reasonable adjustments for a competition judged by our Director of Nursing and Quality, Helen Blanchard, and an expert by experience. It was really heartening to see so many teams engaged including, Children's centre, frailty team, maternity, ED, ICU, fracture clinic, theatres and many wards. It really was a whole hospital approach which provided teams with awareness and opportunities to discuss as teams.

The LD& A Liaison Team have also been engaged in supporting many patients coming through **Transitions** into Adult Services in the past year.

The team have also been spreading awareness of what to expect in an acute Adult hospital with families and carers, and with staff in Children's services, via online workshops. This is to help inform and educate families on the differences, but also on some of the similarities and to try and help manage the young person and their families' anxieties. This has also been in collaboration with our LD Liaison Nurse colleagues at UHBW, to provide a joined-up approach in the information we share.

The team have also been working in collaboration with UHBW LD Liaison Team recently to develop a **SOP for patients who struggle to tolerate oxygen administration**. This has been an MDT approach with Respiratory Consultants, Specialist nurses and Physio's, to try and consider all alternative options available and to develop a clear pathway for staff to follow. It is currently in final stages of development.


Pandemic Mortality Review
Patients with Learning Disabilities
Learning from Deaths Report

November 2020

NBT are also engaged in the **LeDeR** process attending BNSSG LeDeR meetings, to look at learning from deaths and follow reccomendations to try and reduce the mortality rate in this vulnerable population. As a Trust we report every death of a patient with Learning Disability to the NBT Mortality Review Team, who report it to LeDeR. The team also carry out independent **Structured Judgement Reviews** (SJR's) of every death of a patient with Learning Disability within the hospital, which includes an independent Senior Consultant and an LD Liaison Nurse (not involved in patients care) in order to ensure that there is direct learning and development, as a result of each review.

The LD & A Liaison Team continue to work closely with the Safeguarding Team, including

North Bristol NHS Trust

Safeguarding Midwife, to report concerns, but also to address any issues raised via Datix (incident reporting) and to reduce risks identified or consider near misses.

SUMMARY OF ACHIEVEMENTS

In summary we have:

- Increased the Liaison Team to include weekend working, lowered eligibility for service, included autism. These posts are now permanently funded by the CCG.
- Increased the number of referrals received by developing notifications with BI daily report from alerts and has increased staff awareness for need for referrals.
- Improved communication with clinical teams using all electronic forms (Care - Flow and flow) for updates and to add reasonable adjustments
- Delivered quality improvement projects – initial assessment and stickers in notes and reasonable adjustments resource file on intranet page and hard copy delivered to wards.
- Received support from Southmead hospital Charity to purchase sensory equipment including 4 x Magic Tables
- Continued attending Positive Behaviour Management Group – multi professional membership to improve experiences for patients that challenge services.
- LD Liaison team now provided with MAYBO training for therapeutic holds.
- Continued work on Transitions seeking to support patients coming from Children's Hospital, Lifetime, Paediatricians, Jessie May and Children's Hospice South West.
- Developed a RADAR Pathway from Pre-op to Medirooms & Theatres with Anaesthetists
- Developed relationship with local Specialist LD Dentist service to offer check-up and treatment during surgery as a reasonable adjustment.
- LD & Autism Champions – 120+, Quarterly training sessions & 1 day masterclasses planned (currently on hold due to Covid pressures, but under review to start in the new year)
- Developed a BNSSG Hospital Passport and Reasonable Adjustment Checklist for Autistic People – with BASS, and with people with Autism.
- Provide joint working approach with Adult Community Health Teams.
- Working more collaboratively with UHBW Liaison Nurse Team to provide a consistent approach, including Transitions and Standard Operating Procedure for Oxygen administration.
- Provided Multiple teams throughout hospital with bespoke Learning Disability and Autism Awareness Training.
- Developed Links with Photosymbols, and developed Easy Read Social Stories.
- Completing Independent SJR's for learning from deaths of patients with Learning Disabilities.

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Preparing for Year 3 of Strategic Plan:

In order to refresh our priorities, 6 online workshops have been held throughout October 21 with various professions across the hospital with the support from the Quality and Safety Improvement Team (QSIT) to develop the workshop. Participants were updated on our work so far and we identified gaps in knowledge, and individual and team priorities for training and any

initiatives teams could introduce. These are additional to the BNSSG LeDeR priorities and recommendations from the August 2021 National LeDeR report.

Action and learning in 2020/21 from National LeDeR(This is part of the wider BNSSG actions plan which NBT will be working on)

- DNACPR–Do Not Attempt Cardio-Pulmonary Resuscitation
- End of Life Care
- Reasonable Adjustments
- Annual Health Checks (AHCS)
- STOMP-STAMP (medication)
- Inequalities for people from minority ethnic communities

Learning and Recommendations from BNSSG LeDeR:

Annual Health Check – Health Action Plans.

- Constipation -73/100 had issues with constipation.
- Catheter Care (poor management of catheters for people with LD often leading to sepsis and people being admitted to hospital).
- Reasonable adjustments (current work in progress with NHS Digital).
- Epilepsy (needs regular review by a consultant neurologist for poor seizure control or review of medication).
- Mental Capacity Assessments, Best interest meetings (documentation was poor and process not clear, not much involvement with IMCA's when there was no NOK).
- Cancer Screening – (need to proactively promote this with reasonable adjustment in mind - 34% eligible women with LDA attend compared to 75% of the general population).
- Aspiration Pneumonia - highest cause of death and need more work on this across the system.
- Record Keeping and communication - consistent theme across all reviews and more work needs doing to improve this.

- Sharing Learning Themes - through Provider networks to support improvements locally.

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

Action and learning- the 2020 NHS Benchmarking Standards for Learning Disability:

- Awareness training of access to appointments (Part of training plan)-
- Sharing of lessons and learning from death of LDA patients.
- DNACPR
- Patient and Family involvement
- Easy read information when a complaint is made.

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All identified learning and recommendations will form part of our action plans from this report in the for the 3rd year)

Year 3 Plan (with continuation of Year 2 goals, acknowledging Covid pressures)

- Provide further 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 use of resources including Autism passport, reasonable adjustments request form and for staff to access BASS autism training
- To work with EPR Transformation Teams in NBT to ensure Learning Disabilities and Autism needs and alerts are included in the new electronic system.
- Update and revise our training plan, taking into consideration the introduction of Oliver McGowan Mandatory Training
- Continue improvement pathways including Poo Matters, dysphagia, food and fluids, O2 therapy, and the theatre RADAR pathway.
- Prioritise setting up a Hospital User Group (HUG) of experts by experience and actively use their feedback in development of services.
- Continue to Improve the Maternity training and pathway for prospective parents
- Ongoing promotion of reasonable adjustment support / improvements in the hospital
- Support complex patients to access our services and reduce admissions
- Continue to work in collaboration with services to improve transitions process.
- Improve easy read resources across the trust.

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 Adult Learning Disability Health Services.

Feedback of Patient Experience

Sent: 12 October 2021 07:28
To: Learning Disabilities Service <LearningDisabilities@nbt.nhs.uk>
Subject: [EXTERNAL] Quick update

Hi Michelle

I wanted to put in writing just how very grateful my husband and I are for the planning that went into yesterday's surgery. We were kept up to date every step of the way, so throughout the process we felt supported and reassured. The day ran really smoothly and the care that we both received was exemplary. My special thanks to Kate the anaesthetist and Wendy the nurse who stayed with us throughout the process. I think The Little One, as she seems to have been affectionately named by the team, could not have been in better hands.

I think it's fair to say we were apprehensive of the transition from the children's hospital to Southmead, but yesterday just goes to prove we had nothing to worry about.

Thank you for all your incredibly hard work pulling all of this together and ensuring that we were so well looked after.

With very best wishes to you and to all the team,

Mum , Dad & The Little One x

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Sent: 29 July 2021 10:53
To: Learning Disabilities Service <LearningDisabilities@nbt.nhs.uk>
Subject: [EXTERNAL] Appointment - Feedback

Hello,

I'm writing on behalf of XXXXX who came to Southmead for an MRI under GA yesterday. I'd just like to say how grateful we are for the experience he received courtesy of the LD team, the nurses / doctors and anesthetist on Gate 20. XXXX has only ever experienced medical appointments as a traumatic experience, this was not the case yesterday.

Thanks to the respect for his care staff's expertise with him and the ability to adapt approaches for him the appointment was a success.

I felt very proud too, you worked in partnership with your colleagues to achieve this outcome for XXXXX and I hope our thanks can be passed to them. XXXX's mum is also full of praise for the staff involved in yesterday's appointment. Thank you again on XXXX's behalf for helping him to experience a positive appointment that afforded him the same access to medical treatment as any other member of society.

Kind Regards
Care Manager

Report To:	Trust Board		
Date of Meeting:	25 November 2021		
Report Title:	Fit and Proper Persons Update		
Report Author & Job Title	Kate Debley, Deputy Trust Secretary		
Executive/Non-executive Sponsor (presenting)	Xavier Bell, Director of Corporate Governance & Trust Secretary		
Purpose:	**Approval**	**Discussion**	**To Receive for Information**
			X
Recommendation:	That the Trust Board: • Note that all directors have submitted a 2021 fit and proper person regulation (FPPR) self-declaration. • Note that all FPPR checks are up-to-date and complete.		
Report History:	This is an annual report to the Trust Board.		
Next Steps:	N/A		

Executive Summary
All board members have completed an annual FPPR self-declaration for 2021 (see template form at **Appendix 1**), confirming that they are fit and proper persons to hold office within the Trust, as defined in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition, the full suite of FPPR checks have been conducted for the Executive Directors appointed since the previous report: Chief Executive, Medical Director and Chief Financial Officer.

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	This report is not linked to any specific risks, but aligns to the Well-Led CQC domain.
Other Standard Reference	CQC Fit & Proper Person Regulation CQC Well-Led Inspection Framework
Financial implications	The costs of undertaking updated FPPR checks on board members have a small financial implication (approximately £300 per DBS check and £10 per Trust-Online check). This is covered by the People and Trust Secretary budgets respectively.
Other Resource Implications	N/A
Legal Implications including Equality, Diversity and Inclusion Assessment	Failure to ensure that all members of the board comply with Regulation 5 (FPPR) may result in regulatory action being taken by the CQC.
Appendices:	Appendix 1 – FPPR self-declaration form

1. Purpose

1.1 To present the outcome of the annual FPPR self-declaration checks.

1.2 To present the outcome of FPPR checks for the three Executive Directors appointed since the July 2020 report: Maria Kane, Chief Executive, Glyn Howells, Chief Financial Officer and Tim Whittlestone, Medical Director.

1.3 To provide evidence of the Trust's compliance with the Care Quality Commission (CQC) regulation 5 relating to fit and proper persons.

2. Background

2.1 The Trust's Fit and Proper Person Requirement (FPPR) for Directors Policy establishes the Trust's commitment to ensuring that all persons appointed as directors, or performing the functions of, or functions equivalent or similar to those of a director satisfy the Fit and Proper Person Requirements as directed by the CQC Regulation 5.

The scope includes executive, non-executive, permanent, interim and associate directors who are members of the board, no matter whether they fill existing, interim or permanent posts, and irrespective of voting rights.

2.2 In line with Trust policy, NBT Directors have each year since 2015 completed an annual self-certification form (Appendix 1) to confirm that they are a 'fit and proper person' and do not fall within any of the categories listed and to confirm they are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

2.3 Additionally, three Executive Directors (Maria Kane, Chief Executive, Glyn Howells, Chief Financial Officer and Tim Whittlestone, Medical Director) have been appointed since the previous Report and have undergone the required FPPR checks for the first time.

3. Executive and Non-Executive Directors Status November 2021

3.1 The annual self-declaration returns have been completed and all directors have confirmed compliance with the regulation.

3.2 FPPR checks have been completed for Maria Kane, Chief Executive, Glyn Howells, Chief Financial Officer and Tim Whittlestone, Medical Director, who have both been appointed since the last Report to the Trust Board in July 2020. An updated DBS has been requested for Tim Whittlestone on his appointment as Medical Director, but the result is currently awaited.

4. Summary and Recommendations

4.1 The Trust Board is asked to **note** that:

- All directors have submitted a 2021 fit and proper person regulation (FPPR) self-declaration.
- FPPR checks for all Directors are up-to-date and complete.

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"FIT AND PROPER PERSON" SELF DECLARATION

1. Non-Executive and Executive roles in the NHS are positions of significant public responsibility and it is important that those appointed can maintain the confidence of the public, patients and NHS staff. The Trust has a duty to ensure that those we appoint to NHS boards are of good character, will ensure an open and honest culture across all levels of the organisation. The "Fit and Proper Person" requirements are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2. By signing the declaration below, you are confirming that you are a "fit and proper person" outlined at (3), that you do not fall within any of the categories outlined at (4) or (5) below and that you are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

3. The regulations require you are:

   (a) of good character;
   (b) have the necessary qualifications, competence, skills and experience; and
   (c) are able by reason of your health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position.

4. Do any of the following conditions apply to you? You are asked to confirm that you are not:

   (a) a person who has an unspent conviction (unless you are being appointed to a role which requires a standard or enhanced DBS Check, in which case full disclosure of both spent and unspent convictions is required) in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence;
   (b) a person who has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals;
   (c) an undischarged bankrupt, or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
   (d) the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
   (e) a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40);
   (f) a person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
   (g) included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
   (h) a person who has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

DECLARATION

☐ I confirm that I do not fit within any of the categories listed and that there are no other grounds under which I would be ineligible for appointment. If appointed, I undertake to notify the Trust immediately of any change of circumstances that may affect my eligibility to remain in post.

☐ I wish to declare the following information which may be relevant to my eligibility for this role:

Signature:
Name:
Date: